

Spire Leeds Hospital







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

Overall summary

Services we rate

Spire Hospital Leeds is operated by Spire Healthcare Limited. The hospital itself is set in landscaped grounds on the outskirts of Leeds with good travel links and off-street parking. The building was wheelchair accessible. The older part of the hospital was a listed building, and this was where, mainly, the administrative side of services were dealt with. All patient rooms on the wards were single with en-suite facilities and a TV. In

addition, on the ground floor, there were ample consulting rooms for staff to use when pre-assessing patients. The oncology service had its own consulting room just down from the oncology suite. The oncology suite consisted of six chairs with pull around curtains.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 2 and 4 March 2020.

Summary of findings

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

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005. The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service level.

We rated the hospital as **Good** overall.

- Staff worked hard to ensure patients had a good experience while receiving care and treatment. Staff recognised and responded to the individual needs of patients through the whole patient journey from the first referral before admission to when they were discharged from the hospital.
- There was a visible person-centred culture. Staff told us this had greatly improved since the previous inspection and the culture now centred on openness and improvement of the patient experience. Staff were motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were caring, respectful and supportive. These relationships were valued by staff and promoted by leaders. Equipment and premises overall were well maintained and plans were in place to address any shortfalls. The hospital controlled infection risk well. Staff used an audit system to understand that policies were embedded. Staff ensured equipment and premises were clean. They used control measures to prevent the spread of infection.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support from the multi-disciplinary team when necessary.
- The hospital planned and provided services in a way that met the needs of local people. It put people's needs central to the delivery of tailored services.
- Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes.
- The hospital had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff, teams and services were committed to working collaboratively and had found efficient ways to deliver more joined-up care to people who used services. For example, patients appointments were arranged over one day to reduce the number of visits they had to make.
- All staff we spoke with were proud of the organisation, the improvements that had been made across departments and in the management of the hospital as a place to work and staff at all levels were actively encouraged to speak up and raise concerns. There were high levels of satisfaction across all staff groups.
- Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent, high-quality sustainable care. The hospital was led by managers who had the right skills and abilities and were compassionate, inclusive and effective.
- A new leadership team had quickly gained an understanding of issues, challenges and priorities in the service, and had prioritised actions to secure improvement. Leaders had a shared purpose and strived to deliver and motivate staff to succeed.
- Effective systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected had been relatively recently implemented. Services demonstrated commitment to ensuring these were understood and implemented. Staff at all levels had the skills and knowledge to use the systems and processes effectively.

Summary of findings

- There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.
- Constructive engagement with staff and people who used services, including various equality groups was high. Services were developed with the full participation of those who used them. For example, the hospital worked with the Macmillan service and patients and their families who had experience of illness such as dementia.

However,

- The hospital should consider how it can improve the environment (including where relevant, the equipment) for the endoscopy service and the environment for the oncology service, which posed challenges in terms of privacy and dignity.
- Not all records of patient consultations in outpatients were legible and clear.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good 	Medical care was a small proportion of hospital activity. We rated this service as good. The safe, effective, caring, responsive and well-led domains were rated as good.
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service overall good because we rated safe, effective, caring, responsive and well-led as good.
Services for children & young people	Good 	Children and young people's services were a small proportion of hospital activity. We rated this service as good because it was safe, effective, caring, responsive and well led.
Outpatients	Good 	Outpatients services were a significant proportion of hospital activity. We rated this service as good because it was safe, caring, responsive and well led. We do not rate effective in outpatients.
Diagnostic imaging	Good 	Diagnostic imaging was a small proportion of hospital activity. We rated this service as good because it was safe, caring, responsive and well led. We do not rate effective in diagnostic imaging.

Summary of findings

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Good



Spire Leeds Hospital

Services we looked at

Medical care (including older people's care); Surgery; Services for children & young people; Outpatients; Diagnostic imaging

Summary of this inspection

Background to Spire Leeds Hospital

Spire Leeds Hospital is operated by Spire Healthcare Limited and is a private hospital in north Leeds, West Yorkshire. The hospital primarily serves the communities of North and West Leeds, Ilkley in West Yorkshire, and Harrogate and surrounding areas in North Yorkshire. It also accepts patient referrals from outside this area.

The hospital opened in 1989 and has been under varied ownership during that time. Since 1 October 2007, the hospital has been in the ownership of Spire Healthcare Limited. The hospital has had a registered manager in post since 1 October 2005. The hospital director has been in post, at this site, since 2019.

The hospital is registered to provide the following relevant regulated activities:

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Management of supply of blood and blood derived products
- Surgical procedures
- Family planning

Our inspection team

The team that inspected the service comprised four CQC lead inspectors, a pharmacist and ten specialist advisors

with expertise in across the core services and the governance of the hospital. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Spire Leeds Hospital

The hospital provides care for both adults and children. We inspected and rated all five core services at the Spire Leeds Hospital.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Medical care (including older people's care)

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

Information about the service

Spire Leeds Hospital is operated by Spire Healthcare Limited. For the medical services, facilities included an endoscopy service that was Joint Advisory Group (JAG) accredited from November 2019, and an oncology service that provided six chairs for cancer related treatment, in an open plan arrangement.

The hospital itself is set in landscaped grounds on the outskirts of Leeds with good travel links and off-street parking. The building was wheelchair accessible. The older part of the hospital was a listed building, and this was where, mainly, the administrative side of services were dealt with. The modern part of the hospital, so far as medicine was concerned, consisted of a shared reception area with waiting area. From here, patients could access a ground floor oncology suite consisting of six chairs with pull around curtains, and within the theatre complex on the upper floor, an endoscopy theatre. Both oncology and endoscopy patients had use of a ward on the upper floor where theatres were situated. All patient rooms on the ward were single with en-suite facilities and a TV. In addition, on the ground floor, there were ample consulting rooms for staff to use when pre-assessing patients, although the oncology service had its own consulting room just down from the oncology suite.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 3 and 4 March 2020.

Medical care (including older people's care) is provided to children aged 16 to 17 years old and adults aged 18 to over 75 years old. However, oncology services (such as,

anti-cancer treatments, biological therapy, immunotherapy, anti-hormonal therapy, symptom control, palliative care and haematology therapy) are only provided to adults between 18 to over 75 years old.

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

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

Medical care (including older people's care)

Summary of findings

We rated this service as **Good** overall.

We found good practice:

- The service had enough staff to care for patients and keep them safe. Medical staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. 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, in line with national best practice guidance, 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.
- 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 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 staff were committed to improving services.

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

Medical care (including older people's care)

Are medical care (including older people's care) safe?

Good 

Last time we inspected this domain we rated it as good. This time we rated it as **good**.

Mandatory training

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

The service had systems and processes in place to ensure that staff could access mandatory training. Staff we spoke with confirmed they had enough time to complete mandatory training.

All new staff underwent an induction period. At focus groups we ran prior to the inspection staff spoke positively about the induction process used by the hospital. We saw the hospital had an up to date policy for induction of new starters.

Staff were supported to complete mandatory training using an electronic training platform. Modules that were mandatory, called 'core' training, were: Anti-bribery; compassion in practice; equality and diversity; fire safety; health and safety; infection control; information governance; manual handling; and safeguarding adult level two and safeguarding children level two.

Data supplied by the hospital showed that oncology staff were 100% compliant with mandatory training completion, whereas theatres staff (in which the endoscopy service sat) were 98% compliant. This met the target of 95%.

Staff we spoke with in the endoscopy and oncology departments confirmed that they were up to date with their mandatory training and where it was possible to do so, we saw records that confirmed this.

As mandatory training was provided through an electronic platform the hospital management could receive reports on staff compliance and drill down and chase up individual non-compliance.

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.

The hospital had systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was regarded as being everyone's responsibility.

A safeguarding lead was in post plus staff had access to two staff that were trained to level four for adult safeguarding.

The service had an up to date safeguarding policy for protecting vulnerable adults and children.

In the last twelve months prior to inspection there were no safeguarding referrals made by the medicine services.

The clinical staff had completed safeguarding training as part of their mandatory training to level two for adults and children. Consultants who worked on the site under practising privileges had completed safeguarding training to level three with their main employer and this was checked as part of the process the medical advisory committee (MAC) operated for approval of consultants working at the hospital. The safeguarding training included PREVENT and child sexual exploitation (CSE) and female genital mutilation (FGM).

Staff that we spoke with told us that they would raise any safeguarding concerns with the safeguarding lead in the first instance. Staff described no safeguarding issues that they had to report in the last 12 months. Nevertheless, staff we spoke with were able to describe circumstances where they would make a referral which showed a good understanding of safeguarding issues. For example, where there was a suspicion of financial abuse.

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.

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene.

Medical care (including older people's care)

In the period October 2018 to September 2019 the hospital reported no cases of clostridium difficile (C.diff), methicillin-resistant staphylococcus aureus (MRSA), methicillin susceptible staphylococcus aureus (MSSA) or E.Coli.

We saw the hospital had an up to date policy for infection prevention and control (IPC) and had appointed a director of IPC who was also a member of the senior management team.

The hospital used environmental audits and observational hand hygiene audits to promote cleanliness and control infection. We saw observational hand hygiene audits for July to September 2019 with a score of 100% based on having observed four sessions.

Patient led Assessments of the Care Environment (PLACE) scores in 2019 for cleanliness for the site was 99%.

All areas we visited displayed information about infection prevention and handwashing.

Hand washing facilities and antibacterial gel dispensers were available on the wards and at the entrance to areas and on corridors. Services had access to isolation rooms on ward two for infectious patients and signs could be placed on the doors to alert people to an infection risk. For example, each day, a room on ward two was set aside to cater for an oncology patient who may be at risk of infection because of a compromised immune system.

We observed staff using personal protective equipment when required, and staff we observed adhered to 'bare below the elbow' guidance. Staff were seen using personal protective equipment and handwashing before and after patient contact. Patients we spoke with said that staff were very good with handwashing.

To support staff in maintaining levels of infection control, wards benefited from dedicated housekeeping services. We saw staff cleaned equipment after use and a sticker was used to indicate equipment that had been cleaned.

Staff took steps to address the control of risk from legionella. For example, we saw in the endoscopy theatre a water flushing log for the taps in the theatre which was up to date with no gaps.

All wards visited had a link nurse for infection control.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, it was clear that improvements could be made to the environment and equipment.

We found all of the environments we visited had secure access (and/or access controlled by a supervised nurses' station), were clutter free, wheelchair accessible, and with enough equipment for staff to carry out their role, all of which supported staff in keeping patients safe.

Rooms used for pre-assessment of endoscopy patients were on the ground floor and set up in the same way, with secure access, a sign showing whether the room was being used, handwashing facilities, a trolley bed, desk, chairs and a computer. For oncology patients, there was a dedicated consulting room close to the oncology suite, (this was the six-chair open plan area used to treat patients).

Access to theatres was controlled by a magnetic swipe access and/or a nurses' station and signing in and out log for visitors. We observed that patients attending theatres always had a staff member with them at all times.

Ward two, that was used by endoscopy patients before and after their procedure, (and sometimes used by the oncology service's patients) consisted of single rooms with en-suite facilities and a TV. Access was controlled by use of a nurses' station.

Broadly, the description of the environment for both the endoscopy service and the oncology service had not changed appreciably since it was described in the last inspection report in 2017.

Looking specifically at the endoscopy service, there was no physically separate facility. This meant patients undergoing an endoscopy procedure had to be admitted to ward two and escorted to the theatre where the procedure took place and then discharged from ward two. This presented access and flow issues that are dealt with below (see under 'Responsive: access and flow').

The theatre environment was safe but there were areas for improvement. For example, the area used to disinfect endoscopes after having been used in a procedure consisted of one room, split into a dirty side and a clean side. The space in the room did not allow there to be a back-up washer disinfectant (used to clean the endoscopes after the procedure). While it was not unsafe to have one

Medical care (including older people's care)

washer dis-infectors, if the one washer disinfector broke down (as it did on the day of our inspection) this meant the list had to be cancelled, unless a vacuum-packed endoscope could be sourced (which staff tried to obtain, without success).

We found the ventilation system used in the endoscopy theatre was adequate for the procedures undertaken in the theatre.

Whilst the equipment seen in the endoscopy theatre was safe, it was not the same as that used in other Spire locations, which also posed limitations in terms of loaning endoscopes from other sites (because other sites had different equipment). An added advantage of making the equipment match would be that the latest equipment could be used. This had advantages. For instance, better image capture of certain landmarks of the anatomy of the patient. A business case had been approved by Spire Health care to align the equipment at Spire Leeds with the other equipment at other sites so equipment if needed could be shared.

Staff told us that the drying cabinet, used to dry the endoscopes after having been washed, was due to be replaced. The current drying cabinet used trays to store the endoscopes while other drying cabinets hung the endoscopes. A benefit of replacing the drying cabinets was that more endoscopes could be available. This would avoid the current practice of needing to clean endoscopes between procedures. It would also negate the need, potentially, for a back-up washer dis-infectors because more scopes could be stored in such a cabinet.

Staff in the endoscopy service showed us the system used to track and trace any medical equipment or devices used on a patient. We found this was safe. However, being a manual system, this was a time-consuming exercise for staff to undertake. Staff explained that a bar code reader system would have made this process more efficient.

Similarly, looking at the oncology service, whilst the environment was safe, improvements could have been made. Currently, patients receiving oncology treatment sat in one of six chairs facing the nurses' station. The space occupied by each chair could be screened off by use of a curtain and the chairs could be moved, say, to face the garden. The open plan nature of the environment posed challenges in terms of privacy and dignity. Staff told us they regularly asked their patients about the environment and

analysis showed some patients preferred the open plan environment whilst others preferred the option of a private room. Whilst written for similar environments in an NHS setting, Health Building Note '02-01 – Cancer treatment facilities', gives best practice guidance on design and planning of healthcare environments. It stated that a mixture of open-plan and individual treatment spaces was recommended.

The room used by senior staff and specialist cancer nurses was small and had to be shared. This posed challenges if one of the nurses had to have a difficult conversation with a patient about their cancer because of background noise.

Male and female patients had to share a toilet on the suite. It was noted during an infection prevention society audit, the shared toilet was not an ideal size for patients with mobility issues. There was a further assisted toilet adjacent to the unit which was used where patients required further space, such as those with mobility issues.

Some improvements to the oncology service's environment had been made. For example, the dedicated pharmacist who worked in the service now had their own room, separate from the main pharmacy in the hospital, to store and check the treatments patients were due to receive.

Staff were proud of the fact that Macmillan (a national cancer charity) had awarded the service an environmental quality mark. This involved a Macmillan assessor using a detailed quality framework to assess whether the cancer care environment met the standards Macmillan mandated for people living with cancer. The quality mark was due for re-assessment.

PLACE scores for 2019 for the condition, appearance and maintenance scored 99%.

Both endoscopy and oncology services had easy access to a resuscitation trolley and we saw that weekly and monthly checks of the trolley were in date. Staff had to scan and send the checks to a resuscitation lead. This process ensured any missed trolley checks were addressed.

We saw that sharps bins seen were signed, dated, not over full and stored safely when unattended.

Staff were aware of the need to keep patients safe from substances hazardous to health. We found all such substances seen were locked away or in a locked room when not in use. For example, the room in the oncology

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service, used to store cytotoxic drugs, was locked. We saw staff had easy access to personal protective equipment (including equipment to address any spillage of chemotherapy drugs).

Fire exit signage was visible and exits were free of obstructions, and all fire extinguishers seen were in date for their next maintenance check. General signage was easy for patients to follow and patients were met at main reception by a staff member to escort them, this was sometimes a volunteer.

Medical equipment was monitored and maintained by a dedicated team of engineers. All equipment we saw was in date for maintenance checks. For instance, we checked the weighing scales in the oncology service and found them to be in date for maintenance. Equipment seen in the endoscopy theatre was all in date for its maintenance.

Waste was separated and disposed of in appropriate colour coded bins. Cytotoxic waste was dealt with safely by pharmacy staff and disposed of in purple bins.

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.

In both the endoscopy and oncology service we saw that staff had various tools that they used to assess and respond to patient risk.

All patients receiving care at the hospital were risk assessed for venous-thromboembolism (VTE). In the period October 2018 to September 2019 (apart from April to June 2019 when it dropped to 60%) 100% of patients had been risk assessed for VTE.

For the endoscopy service, all patients undergoing an endoscopic procedure were seen first by a consultant. At this consultation issues that could negatively impact on the safety of the procedure, such as, epilepsy or diabetes, or presence of a pacemaker, could be picked up and addressed.

The consultation was followed by a pre-assessment by a registered nurse. However, while on inspection, we observed the endoscopy specialist nurse we were speaking with taking calls from nurses outside the department doing pre-assessment. After the call we queried the fact that the

pre-assessment nurses appeared to be asking basic questions about endoscopic procedures. For example, around sedation. This suggested this was an area for improvement. Staff we spoke with confirmed that there were discussions ongoing about endoscopic nurse specialists doing the pre-assessment for endoscopic procedures.

Prior to starting the procedures for the day, we saw that staff discussed the list and re-checked that everything was safe to proceed. Staff used a team brief template introduced by the recently appointed theatre manager. This addressed equipment issues as well as patient specific information.

Staff had a standard operating procedure to follow in the event that a patient suffered a gastro-intestinal bleed. However, staff were not able to show us a written protocol for dealing with patients undergoing an endoscopic procedure that had Creutzfeldt-Jakob disease, who because of their disease, required special care with, amongst other things, de-contamination of endoscopes. We did ask staff whether such patients were excluded from being treated at the hospital and staff confirmed they were not excluded. Staff told us they would ensure this was addressed. Following the inspection we were sent a copy of a policy that specifically addressed management of patients with CJD but on inspection staff we spoke with were not aware of this policy.

In addition, staff described additional checks they did with each patient. This was done pending introduction of an endoscopic specific safer surgery checklist which we saw.

Pending the revised checklist, we saw that staff used the world health organisation five steps to safer surgery (WHO) checklist. We saw WHO action plans and surgical safety checklist record audits with, in October to December 2019, compliance at 99% plus observational audits, compliance at 100%.

During the endoscopic procedure staff explained (and patients we spoke with confirmed) that there was a staff member who acted as advocate for the patient, holding the patient's hand, while another nurse looked after the patient's airways and vital signs. This team was in addition to the consultant doing the procedure, and another nurse who maintained the records whilst the procedure was taking place.

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Staff explained that they could summon anaesthetists and had easy access to a resuscitation trolley should a patient require emergency life-saving intervention.

Within the oncology service, all cancer patients, before being accepted into the service, and prior to treatment starting, had a multi-disciplinary team meeting (MDT). This was governed by a service level agreement with a local NHS trust. The cancer nurse specialists who worked in the service attended the MDT to provide information and enhance communication.

If a patient was accepted into the service, they would then be seen by a consultant with the cancer specialist nurse present. This would then be followed by a detailed pre-assessment with a cancer nurse specialist. We saw an example of the forms staff used to conduct the pre-assessment and these covered, in detail, every aspect of a patient's life.

To ensure that the above processes were safe and working as they should, we saw that the oncology service audited the records and scored its performance and tracked progress in a clinical scorecard dashboard.

Each morning the lead for oncology services and the oncology pharmacist met to discuss the patient list for the coming day. This would include deferring treatment if it was judged not safe for the patient to receive treatment that day.

The oncology service had standard operating procedures in place to deal with issues that affect patients undergoing chemotherapy. For instance, safety procedures to deal with escape of the chemotherapy drug into surrounding body tissues (called 'extravasation') or neutropenic sepsis.

Further, the oncology service operated a 24-hour telephone triage service for its patients. This used a detailed set of questions, and a red, amber, green score. If a patient phoned in and needed treatment, this could be arranged, or the patient could be signposted to care elsewhere, so keeping the patient safe.

Staff we spoke with in both services described meetings that took place to help staff to keep patients safe such as morning safety huddles, and heads of meetings, so that important information that may affect patient safety could be received and acted upon.

We also saw that the practising privileges policies and procedures ensured that consultants could respond to patient need within an agreed timescale. In addition, the oncology service had specific agreements with its consultants about response times.

All inpatients were assessed, as necessary, for risks, such as, for falls, or manual handling.

Nursing and support 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.

To support staff in planning staffing levels based on patient needs, bed meetings took place and staff used a safe staffing nursing care tool, and professional judgment, together with an electronic rostering system to ensure staffing remained safe, both during the day and night. In theatres, staffing was based on the association of perioperative practice guidelines.

A senior manager and senior clinician was available on-call for any escalation and out of hours a bleep was held for this purpose and there was a clear policy of escalation.

At focus groups we attended, prior to the inspection, staff spoke positively about the induction they had received and the efforts the hospital had made to recruit additional staff.

The endoscopy service was not a standalone service and so its staff, apart from a permanent and part time specialist endoscopist registered nurse, was added to as required. For example, for pre-assessments, the service used staff within the hospital that did pre-assessments. When the patient was admitted and discharged from the ward, the service made use of the ward staff already there. When doing a procedure, there were always two registered nurses and a healthcare assistant, and if the list was busy, there would be an additional staff member disinfecting the scopes between procedures.

We saw a procedure in theatre and the staffing was as had been described to us.

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Staff described no issues with staffing the endoscopy service apart from occasionally ward staff not being able to bring a patient to theatre. This meant the healthcare assistant had to do so instead, which could cause a delay in preparing the theatre.

We discussed this with senior staff and we were told there were plans in place to train more staff in theatres in disinfecting scopes, which would then release the endoscopy specialist nurse to do other things.

Within the oncology service we saw that care was given to patients on a ratio of one specialist cancer registered nurse to two patients. This met national cancer guidelines for staffing such a day unit. The service benefited from five specialist cancer nurses which was made up of three cancer specialist nurses (with one to move into colorectal cancer), two breast care and one gynaecological.

Data supplied by the hospital showed, in the last twelve months, little or no vacancies and low or no sickness of relevance to the medicine services.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. No locums were used.

Given the private nature of the hospital, and that emergency care was not supplied at the site, which meant that all procedures were planned in advance, there were no shortages in available consultants in the required specialisms. For example, the oncology service worked with seven consultant oncologists and two consultant haematologists. Equally, the endoscopy service had access to as many consultant endoscopists as required.

We saw that the endoscopy service kept a record of which consultants were authorised to do which endoscopic procedure. The oncology service had details of which consultant was covering if a consultant was unavailable.

Out of hours staff had access to a registered medical officer but for the medicine services offered at the site, it would very unusual for a patient to be staying overnight.

For example, the endoscopic procedures were day case procedures. If anything untoward happened, for example, an upper gastro-intestinal bleed, the patient would have been transferred to a local NHS hospital trust.

Similarly, with the oncology service, it was open Monday to Friday until 5pm, and so although there was scope for a patient who deteriorated to be transferred to ward two at the site, this would only be a temporary arrangement pending safe transfer to a local NHS trust.

The oncology service benefited from a dedicated oncology pharmacist. Out of hours there was access to an on-call pharmacist.

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.

We reviewed nine sets of records (including medicine charts). We found them to be legible, detailed, and safely stored when not in use.

Records were a mixture of paper and electronic records, with the oncology service being mainly electronic, with a back up paper copy record printed out for use by the wider hospital as required.

The endoscopy service used a mixture of paper and electronic records. The patient would arrive into theatre with their paper ward notes, that included the consent form. The procedure in the theatre would generate some paper notes. For example, the track and trace documentation and the printouts relating to the cleaning of the endoscope used, plus a drugs chart for any sedation offered, theatre notes, and safer surgery checklists. In addition, the consultant would complete an electronic record which captured data required for safe patient care, but also for data collection mandated by JAG accreditation.

The oncology service used mainly an electronic system which linked into the cancer patient pathway so that all healthcare staff looking after the patient, whether at the site or in the local NHS trust, could share and view the patient record. Also, the service used a tailored electronic chemotherapy prescribing system, which could also be accessed by NHS staff looking after the patient. For example, the consultant in the NHS looking after the patient.

Medical care (including older people's care)

Records reviewed showed that, as necessary, patient risk assessments were completed. For example, for VTE, falls, moving and handling, and pressure damage. In the oncology service we saw that records showed a comprehensive review of whether it was safe to commence chemotherapy at each visit and before treatment started.

However, our review of records did show that the sedation offered and the oxygen prescribed in endoscopy procedures was not necessarily written up on the patient's prescription chart. Rather, the information was noted on the patient pathway documentation. Whilst not inherently unsafe in a day case procedure, by adopting such a practice, there was a risk. The risk was that, if the patient did require further medication, staff who did not consult the patient pathway and instead relied solely on the prescription chart, may miss what medicine the patient had received, before administering the further medication.

Paper records were held in lockable trollies situated at or near the nurses' station. To access electronic systems staff used a password individual to them.

Patients received a paper discharge summary. Oncology patients were not yet able to access their data remotely using an application on a phone. Staff told us this was something that was being planned. All discharge information, with patient consent, was shared with the GP of the patient.

Medicines

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

We checked the storage of medicines, fluids and gases on the theatres and wards we visited. We found that medicines, fluids and gases were stored securely in appropriately locked rooms and fridges and room temperatures were checked and stocks were in date.

The medicine policy was up to date. The hospital director was the controlled drugs accountable officer. Every quarter there were medicine management meetings with any concerns fed up to the clinical governance committee. The senior pharmacist on site had access to a national senior pharmacist who could feedback any lessons learned from the group.

The hospital used electronic prescribing in the oncology service and paper charts for the endoscopy service.

With one minor exception in endoscopy theatres, we found the storage, recording and administration of controlled drugs was safe. Controlled drugs were locked away in a metal cupboard in a locked room. In the endoscopy theatre, the controlled drugs register contained an error in a balance of drugs received into the theatre. We pointed this out to staff and it was rectified immediately. The next day we saw the incident had been reported on the hospital's incident reporting system.

All rooms where medicine was stored were checked daily for temperature. Drugs that required refrigeration were stored in fridges (lockable where necessary) and temperatures checked daily. Staff knew what to do if the temperature went out of range.

We found oxygen cylinders used were in date and stored securely and safely.

Medicine used for chemotherapy was not prepared on site. Instead, the oncology pharmacist took delivery from a third-party manufacturer of pre-prepared treatments. Chemotherapy medicine was stored in a separate locked room that was used by the oncology pharmacist. All necessary checks were made prior to administering any chemotherapy to a patient. We saw that there was a process in place to ensure un-used chemotherapy was appropriately disposed of.

Medicines trolleys we saw were all locked when not in use.

Patient records seen showed patients were receiving medicines promptly and any allergies were clearly recorded.

The pharmacy team ran audits to support best practice in medicine management. For example, a pharmacy interventions audit for July to September 2019 showed incorrect or incomplete prescribing by the resident medical officer was at 35% and consultants at 63%. Action taken was to appoint drug chart champions and review the process for to take home medicine. This audit noted there was possible under reporting of interventions and near misses owing to staffing issues. However, we found no issues with staffing in pharmacy and saw staff were reporting. Also, from January 2020, the pharmacy team were using a dashboard to monitor key performance indicators, such as, to take home medication turnaround times.

Medical care (including older people's care)

An emergency duty pharmacist was available 24-hour and otherwise pharmacy at the site operated 8.30am-5.00pm Monday to Friday and on Saturday 09.00 to 12:00.

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.

The hospital had a policy for the reporting and investigation of incidents, near misses and adverse events which was in date, including a system for dealing with central safety alerts.

Staff were encouraged to report incidents using the hospital's electronic reporting system. The staff we spoke with could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses. For instance, on the second day of our inspection we saw that staff had reported the medication error and broken washer unit, which had both occurred the day before in the endoscopy service.

Staff we spoke with said feedback from incidents was shared in various ways, morning huddles, the senior staff meeting at 10 o'clock, or through a regular staff newsletter or a 48-hour flash update. The hospital used a twice weekly rapid response committee and clinical briefs to also discuss and share learning from incidents. The provider produced a monthly National Safety Update to highlight new guidance, updated policies and internal and external safety alerts. These also included shared learning from other Spire hospital sites, which was circulated to the Spire Leeds hospital.

All serious incidents and near misses were investigated by a local governance team which was then validated by a senior central governance committee. Mortality and morbidity meetings took place twice a year to review cases. We saw that a mortality and morbidity report was a regular item on the clinical governance minutes.

We saw from minutes supplied by the hospital that there were quality improvement projects in progress to support staff. Projects included reporting incidents within the

60-day timeline, to increase staff numbers who had been trained in root cause analyses, and to ensure all serious incidents were submitted to a central patient safety team within 48 hours of logging onto the system.

The hospital reported zero never events in the last two years.

The duty of candour (DoC) 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.

The hospital had a lead for speaking up which included DoC. Staff we spoke with understood the importance of being open and honest with patients. We saw from the quarterly quality report that leaders received that DoC was reported and was being complied with.

Are medical care (including older people's care) effective?

Good 

Last time we inspected this domain we rated it as good. This time 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.

The hospital had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the hospital's intranet, guidelines, policies and procedures relevant to their role.

The hospital had recently appointed a clinical governance lead at the site to act as a support to staff and link with the governance team. Endoscopy staff described how the governance team had assisted them with completing JAG audits, for example, around sedation doses or patient comfort.

Medical care (including older people's care)

The hospital had a procedure for implementing best practice guidance, including all types of NICE guidance. Although the current process was being looked at on a groupwide basis, broadly the system was that for each piece of new guidance, the hospital's clinical effectiveness committee (CEC) identified a lead to complete an assessment of the hospital's compliance. Actions were put in place and progress reported back to the CEC. Sign off took place at the clinical governance committee with input from the MAC.

We saw from minutes of meetings that we reviewed that there was evidence of pathways, policies and procedures being amended to comply with revised guidance. For example, a new guideline was issued in relation to perioperative fasting.

Each speciality developed an audit plan annually for sign off and approval by the CEC which included participation in national as well as local audits.

In endoscopy, each quarter, staff performed observational and records-based audits of safe surgery in addition to audits required (noted above) for JAG accreditation. In the oncology service, staff carried out each quarter drug chart audits.

The hospital was in the process of doing a gap analysis of its clinical audit programme against the health quality improvement programme (HQIP) best practice guidance for clinical audit. The results were not available at the time of our inspection. As part of a governance improvement plan for 2020 we saw that staff were to be given protected time to conduct audits.

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.

We found that the services had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.

Patients in both services could choose from a menu for their food needs which could change depending on religious, cultural or other needs. PLACE results for 2019 for ward food were at 98%.

In terms of fasting patients, those undergoing an endoscopy procedure that required bowel preparation or sedation were given appropriate fasting advice as part of the pre-assessment. We saw an example of this when speaking with the endoscopy staff when they took a call from a pre-assessment nurse who asked about fasting advice.

While not specific to medicine services, we saw that the hospital monitored compliance with fasting. A recent audit showed that fasting guidance compliance improved from 45 to 60%. A fasting working committee group was meeting twice a year and we saw an action plan was in place. The target being aimed for was 65% compliance.

Dietetic services were available to support oncology and medical specialities, as necessary.

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.

We found that the service had systems and processes in place to effectively support staff to meet the pain relief needs of patients.

For example, in the endoscopy service, patients had a nurse who held the patient's hand during the procedure and acted as their advocate in relation to comfort and pain and who could call the procedure to a stop. Also, at pre-assessment, the consultant agreed with the patient what pain relief was required for the procedure. For instance, whether a throat spray, or conscious sedation.

In the oncology service pain was assessed throughout the patient's stay on the unit and adjustments made as necessary to the treatment regime.

The hospital did not do a specific audit into pain relief but did ask patients whether their pain was managed appropriately. The patient satisfaction survey results for quarter three showed that 84% of patients responded that their pain was managed "to a great deal".

Going forward, as a group, the hospital told us the clinical scorecard would look at pain management. This had been achieved by adding a pain trigger to action a quarterly audit.

Medical care (including older people's care)

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 had systems and processes in place to monitor patient outcomes including groupwide performance, plus submission of data to JAG for endoscopy procedures, or maintaining a clinical dashboard of outcomes for the oncology service.

Key performance indicators were monitored through a group quarterly national clinical scorecard. This scorecard looked at unplanned returns to theatre, readmissions, inpatient falls, VTE incidence, surgical site infections, pressure ulcers, unplanned transfers and benchmarked against other hospital sites within the group and long-term rates.

We saw from minutes of meetings supplied to us that performance was reviewed at the clinical audit and effectiveness committee, at the clinical governance committee and at the MAC.

The hospital took part in submission of four data sets to the Private Healthcare Information Network (PHIN) such as patient satisfaction, adverse events, and a master data set as well as patient reported outcome measures (PROMS).

The hospital told us it had agreed new commissioning for quality and innovation (CQUINS) targets around safety thermometer and medicines review, healthy food, maintaining human body temperature, and five steps to safer surgery.

The oncology service had a clinical dashboard that staff told us was discussed and changed each year. This looked at a series of patient outcome measures. This included: the CQC rating; the Macmillan environment rating; evidence of attendance at a multi-disciplinary team meeting with presence of detailed notes; proper completion of the telephone triage tool; proper completion of the electronic chemotherapy prescribing; quality of the initial baseline pre-assessment; placement and care of the ports used to access the patient's arteries; nutrition; and the Macmillan psychological and emotional assessment. All scores seen on the scorecard were rated green.

In the endoscopy service, as part of JAG accreditation, data was collected on issues such as correct level of sedation

and patient comfort. These results were discussed in several forums including the endoscopy end users meeting which happened twice yearly, however the endoscopy service did not have a clinical dashboard.

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.

We saw the hospital had systems and processes in place to ensure staff competence for their role was assessed and then re-assessed at an annual appraisal. Consultants practising at the hospital had been recommended to do so by the MAC who monitored their right to continue to practice at the site.

Staff we spoke with confirmed they had received specific competency training relevant to their role. For instance, in endoscopy, training on how to effectively de-contaminate the scopes used. In oncology, staff had received specific training. For example, in delivering chemotherapy treatments, or how to reverse the effects of extravasation, or deliver challenging news. We reviewed a random sample of three staff files and found evidence of competency assessment completion.

All staff we spoke with confirmed that they were up to date with their annual appraisal. Data supplied by the hospital showed staff appraisals were running at 98% for most staff groups.

Practising privileges are a discretionary licence to a consultant to use the hospital's facilities in accordance with the consultant handbook policy. The granting and maintenance of practising privileges was set out in a consultant handbook policy which was up to date.

The MAC considered all applications and advised the hospital director which consultant to accept or remove. Each consultant had to have a whole year appraisal. Also, the policy required the consultant to provide indemnity insurance, details of who their covering consultant was, a disclosure barring service (DBS) check, and evidence of their occupational health status regarding immunisations.

Expiry of key documents was monitored centrally and reported each week. Reviews by the hospital took place at least every two years or sooner if required. The review

Medical care (including older people's care)

looked at compliance with the policy as well as re-validations and annual appraisal, incidents, complaints and staff or patient feedback. Minutes of meetings we saw showed the system was being operated.

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, we saw different teams and health professionals working together as a multi-disciplinary team (MDT).

For example, in the endoscopy service, we saw the consultant and registered nursing staff and healthcare assistant take part in a safety huddle prior to the list starting. We saw them work well as a team to carry out the procedures we observed.

In records we reviewed we saw how the oncology service staff had attended an MDT that took place at the local NHS trust and also worked closely with the on-site oncology pharmacist.

Health promotion

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

The hospital engaged with patients in health promotion activities onsite and through social media.

For example, on entering the building visitors were encouraged to wash their hands.

Also, near reception, there was a table offering a free bottle of water with information about the importance of staying hydrated.

In the oncology service, for example, staff had created an information room that contained lots of information and leaflets (mainly but not solely provided by Macmillan) about leading a healthier life.

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 knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards. For example, we saw that prior to an endoscopy procedure starting patient consent was checked by the team.

We saw that the hospital had an up to date mental capacity act and consent policy.

Given the private nature of the hospital, and that these were elective procedures, we did not see any documentation about best interest decisions or deprivation of liberty safeguards, because it was not usually relevant to the patients seen at the hospital.

However, all clinical staff completed mental capacity training using a mandatory training portal and this included awareness of deprivation of liberty, dementia awareness and PREVENT (to address anti-radicalisation).

All patient records that were seen contained comprehensive pre-assessment notes, risk assessments and completed consent forms.

Are medical care (including older people's care) caring?

Good 

Last time we inspected this domain we rated it as outstanding. This time 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.

We found that patients received compassionate care from staff which supported their privacy and dignity.

Several interactions we observed between staff, both nursing and medical, demonstrated how staff maintained confidentiality and supported patient dignity and provided

Medical care (including older people's care)

compassionate care. For instance, we saw that staff pulled curtains around patients when providing care if needed. On the ward, doors to the patient's bedroom were closed. We saw staff introduced themselves to patients.

In the oncology service, while there were challenges posed in maintaining patient privacy, because all that divided one chair from another was a curtain, patients we spoke with described how staff made the effort to speak with them discreetly and quietly. Given the environmental challenges, patients described staff doing all they could to keep their personal information confidential. All patients we spoke with at the oncology service said they had not experienced any issue with their privacy while on the unit.

Patients we spoke with in the oncology service said staff were "excellent", and described being "very satisfied overall", or "very satisfied" with their treatment. Patients attending the oncology service had been attending the service, sometimes for years, and patients described staff knowing their preferences. The hospital told us one of the oncology nurse specialists had been voted nurse of the year in a local paper in recognition of their outstanding care and treatment of patients in the service.

In the endoscopy service, the turnover of patients was different from the oncology service, yet all patients we spoke with described staff who answered their questions, treated them with compassion, and were attentive about their privacy and dignity. One patient described the service as being "friendly and helpful".

All staff seen spoke with patients in a kind and compassionate way, encouraging the patients and chatting with them.

The October 2019 friends and family test score were 96% with a 19% response rate. The highest response rate was 26% in July 2019.

Although not specific to the medicine service, PLACE scores for 2019 for privacy, dignity and wellbeing were 94%.

Emotional support

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

We found that staff offered emotional support to patients.

For example, in the endoscopy service, patients mentioned how nice it was to have a nurse with them, while in theatre, holding their hand and giving them re-assurance.

In the oncology service, patients described the detail staff went into with them at the baseline pre-assessment consultation, which covered all their issues.

Staff we spoke with described how a prayer room could be set up in one of the rooms in the hospital to cater for different faiths. However, there was no chaplain service or similar on site. The hospital had a multi faith box with resources for different faiths should a patient, visitor, staff member or consultants want to pray. Chaplains were available for spiritual support and a list of local multi-denominational chaplains was available.

Prior to undergoing an endoscopy procedure, patients received a booklet that explained the procedure to them and what to expect.

In the oncology service staff were working with local hospices and charities to build links so that they could signpost their patient cohort to free psychological support, including around bereavement.

Staff in the oncology service had been trained in delivering challenging news.

Understanding and involvement of patients and those close to them

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

We found the staff tried to understand patients, involve them and those close to them.

The hospital had recently appointed a patient experience manager who met with patients wishing to complain to understand their issues and try and address them quickly.

The hospital ran an annual 'pink day' for its breast cancer patients to raise awareness and funds for cancer research.

Also, the hospital had installed three patient satisfaction pods to support patients in providing real time feedback.

Patients in both services, endoscopy and oncology, described staff answering their questions and providing support to them to help them make their decision.

Medical care (including older people's care)

For instance, in the endoscopy service, patients were supported in deciding whether to have a throat spray or conscious sedation. Patients were also accompanied by a friend, relative, or carer, as following the procedure, it was not safe for the patient to be left to go home alone. We spoke with some relatives or carers and they described how they were allowed to go to the pre-assessment appointment with their loved one and have their questions answered too.

In the oncology service, patients were spoken with at each attendance, and before chemotherapy treatment was given, to assure the patient that it was safe to start treatment on that day. Patients we spoke with were knowledgeable about their condition and were involved in decisions about whether to start or delay treatment.

Staff in this service could also provide support and signposting to help patients and their families make decisions about things such as prosthetics and wigs.

Lastly, recognising the strong bonds that patients with cancer have with their treating consultants, staff described how they had involved patients in coping with a change of consultant owing to the retirement of a long-standing consultant.

Are medical care (including older people's care) responsive?

Good 

Last time we inspected this domain we rated it as outstanding. This time 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.

The hospital had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

We spoke with staff who described a system where heads of departments met monthly to look at service development.

Services that were offered were dependant on consultant expertise and the capability and capacity of the hospital to offer responsive care.

Staff told us that they maintained links with local NHS trusts and local GPs and often new services were designed in response to needs identified through these links.

For example, in the oncology service, genetic testing for cancer was being explored because one of the consultants that the service worked with wished to explore this area. This was discussed by leaders in the oncology service at a national spire cancer services working group.

In the endoscopy service, staff we spoke with were looking at how the service could be re-configured so that patients did not need to be admitted to a ward and then be discharged from the ward. This would increase throughput so benefiting local people who could receive treatments more easily. Staff explained that the current service was designed, in part, to support reduction in the long waiting times for colonoscopy procedures (looking at the large intestine) in the local area.

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.

We saw that staff cared for patients as individuals and strived to meet their individual needs.

The hospital could give patients a choice of consultants, and, depending on the medicine service concerned, appointment times could be arranged in the evenings and at weekends. The oncology service offered a one stop clinic for breast care patients.

As noted above, patients using the oncology service had an MDT that was chaired at a local NHS trust. Oncology staff attended the MDT to help coordinate the patient care between their service and the NHS.

Staff in the oncology service strived to meet the individual needs of their patient cohort. For example, through patient feedback, patients had identified that parking at the site was causing them inconvenience. In response, the oncology staff designed parking permits for their cancer patients which enabled them to park closer to the hospital.

Medical care (including older people's care)

Patients we spoke with, who used the oncology service, described how staff took account of their individual preferences. For instance, which chair they liked and whether it faced the garden. If they had to attend an emergency department, oncology patients were given a cancer alert card which they could show to staff.

The hospital had a dementia awareness programme and a dementia lead. The lead could provide advice and support to staff if they were caring for a patient with dementia. Staff awareness of dementia was enhanced by requiring staff to complete online training about dementia.

Staff told us leaflets could be translated into a language other than English and staff could access translation services if needed.

The services followed up on all patients post-discharge with a telephone call to check on their wellbeing, ensure they had everything they needed and provided an opportunity for patients to ask questions and raise any concerns.

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, where relevant.

The services had systems and processes in place to monitor access and flow and to ensure that they were responsive to the needs of patients.

Neither service, whether endoscopy or oncology, reported any issues with patients accessing the service when they needed to. Patients had access to an online booking tool, although the oncology service looked after its own appointments, which reflected the highly individualised nature of the treatments it gave. The absence of any issue with access was also evident by the fact that neither service had a key performance indicator on its clinical dashboard (noting endoscopy had no endoscopy specific clinical dashboard) to monitor waiting times.

The hospital at site level did spot audits on waiting times but there was no data specific to the medicine services.

From an access and flow standpoint, the model currently used for the endoscopy service, with the environmental issues noted above, and the way patients had to be

admitted and discharged from a ward, could have been improved. We saw on the day of our inspection how the list had to be cancelled towards the end because the decontamination unit had broken down.

Staff we spoke with were aware of this and talked us through a different model. A different model involved recognising that a ward admission was not required. With more space, additional equipment could be available in the event of breakdown, or the need for more equipment could be addressed by different equipment that stored more scopes.

However, whilst this had been discussed, staff confirmed it was not noted in any departmental meeting notes. This meant we were not assured there was a definitive plan to address improving access and flow issues within the endoscopy service.

The oncology service booked in its own patients and because of the nature of the treatment, the electronic diary staff maintained could change daily. For instance, a treatment could be delayed because the patient was not judged well enough to receive it.

One issue that affected the oncology service for a short period of time concerned turnaround times for patient blood results. This could impact on access and flow because without the blood results staff could not consider whether treatment should be started. Staff addressed this by auditing the process and identifying what was causing the delay, working with the hospital's pathology laboratory. Since July 2019 staff reported that 96% of bloods for their patients are turned around within one hour.

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 services had a system in place to encourage complaints and compliments with a view to improving services for patients.

We saw that the hospital had an up to date complaints policy.

Medical care (including older people's care)

Staff told us they would seek to resolve a concern informally first but complaints were dealt with formally if necessary. Escalation was to the head of the relevant department and the newly appointed, patient experience manager. Patients were offered a face to face meeting.

Ultimately, NHS patients could ask for their complaint to be reviewed by the Parliamentary and Health Service Ombudsman (PHSO) or private patients by the Independent Sector Complaints Adjudication Service (ISCAS).

Formal complaints were acknowledged within three working days with a full response within 20 working days for private patients and as agreed with NHS patients, albeit there was guidance that most NHS complaints should be responded to within 25 working days.. The target was to achieve those response rates 75% of the time. Results for showed the target had been met. If a complaint would take longer to be resolved staff told us the patient would be told.

The governance arrangements in place ensured that lessons from complaints were shared. The patient experience manager oversaw investigation of complaints and trends and reported lessons learned. We saw they used a complaints tracker. We spoke with the manager who confirmed that they had weekly meetings with the senior management team. Updates were also given at monthly heads of meeting, at the fortnightly clinical audit and effectiveness committee and process review meeting and quarterly at the MAC.

We saw examples of staff using 'You said, we did' boards. We saw that complaints were a regular item on meeting minutes that we reviewed.

We saw notices displayed within the services which signposted patients or their carers or relatives about how to complain. Patients could feedback in person, in writing, by telephone or by email through the website, by social media or by using one of the feedback pods. Patients knew how to complain. One of the patients we spoke with had an ongoing complaint unrelated to either medicine service.

We discussed complaints with staff. The oncology service had no complaints, apart from parking, whilst the endoscopy service had three complaints. Staff told us what the hospital had done to address the endoscopy complaints and to learn from them.

The hospital provided examples of how they had learnt from complaints. For example, in the oncology service, complaints about parking were resolved by creating parking permits so patients receiving cancer care could park near the hospital.

Are medical care (including older people's care) well-led?

Good 

Last time we inspected this domain we rated it as outstanding. This time 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 business leadership team was made up of a hospital director who had direct reports including on operations, business, finance, and a director of clinical services (site matron).

The clinical leadership team was made up of the director of clinical services who had direct reports from the cancer services manager (responsible for oncology services) and a theatre manager (responsible for endoscopy).

The managers we spoke with had relevant experience to lead their service having held senior posts at previous employers. For example, the hospital director had attended a leadership development programme.

Staff told us their leadership team, both hospital-wide and locally, was approachable and visible.

Vision and strategy

The hospital 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.

Medical care (including older people's care)

The vision used by the services we visited was principally the hospital's vision, which was to be recognised as a world class healthcare business. This was underpinned by six core values: driving clinical excellence; doing the right thing; caring is our passion; keeping it simple; delivering on our promises; and succeeding and celebrating together.

To help the hospital achieve its vision there were seven strategic objectives which were agreed and communicated to all staff. The objectives were: be good, open and transparent; maintain private patient growth; staff development and enhancing behaviours; deliver high standards of customer experience; oncology – specialty development; maintain operating margin; and succeeding and celebrating together.

The purpose, which drew the vision and values together was to 'make a positive difference to our patients' lives through outstanding personalised care'.

However, we saw that the endoscopy service, (albeit it was not a service in its own right because it sat within theatres), had created its own vision for endoscopy. It was not clear how this linked into the wider hospital vision and strategy. We did not see a written strategy that sat behind it to make it objectively measurable. It was not referenced in the departmental strategy and engagement plan 2020 for theatres.

Similarly, the oncology service had its own oncology vision for 2020. We did not see a written strategy that sat behind it to make it objectively measurable. For example, one vision was to deliver oncology workshops to staff. While staff could provide evidence that this was happening, they could not show us the written strategy where it had been agreed how many workshops were to be delivered and by when. This meant it was difficult to objectively measure whether the vision had been met or how far off staff were from meeting it. The hospital told us that such measures were addressed at individual staff appraisals.

The group quality account for 2018-2019 was not wholly reflected in the hospital's strategy or the strategies of the services we looked at. The group quality account identified three priorities for 2019-2020: obtaining an overall good rating from CQC if a hospital in the group was inspected; completing the getting it right first-time (GIRFT) programme; and increasing the number of hospitals with

VTE exemplar status. Only the first priority was specifically referenced in the hospital's strategy. However, the hospital told us that it was progressing with VTE exemplar status and had recently had a GIRFT review.

Culture

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

We found that staff felt respected, supported and valued and were resolutely focussed on providing safe care to their patients and were keen to hear from their patients about their experience.

Staff at focus groups we ran prior to the inspection described morale as being quite low following a focussed inspection into surgery and children and young people's services in 2018/ which received poor ratings. However, staff told us that, following that inspection, senior management closed the hospital for a week to conduct what was called a 'pause week'. This enabled the leadership team to embed the hospital purpose with staff. Staff were also asked about the vision and strategy. We saw in the staff canteen a reflection tree which had been created by staff following the pause week. Staff said they often read the comments and it made them feel proud to work at the hospital. Following the pause week staff morale had improved staff we spoke with described their place of work in positive ways.

Staff had various ways they could shape the culture including floor level meetings or appraisals. Staff were aware of the hospital's freedom to speak up guardian and ambassador programme all of which helped create a culture that was free of bullying or harassment.

Staff told us about the benefits package that was available to them which also included a suite of clubs that staff could join, such as a walking or jogging club.

The hospital ran a recognition programme to recognise and reward good behaviours in staff. Staff we spoke with enjoyed this scheme.

Medical care (including older people's care)

The hospital had recently appointed a patient experience manager who supported the existing structures in place to encourage patients, their family or carers to speak out about anything that concerned them.

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 saw a committee structure which consisted of a clinical governance committee to which several sub-committees reported. The clinical governance committee had a direct line of reporting through the senior management team to the hospital director. The committee structure included the MAC that advised the hospital about granting and withdrawal of practising privileges.

The structure ensured that clinical governance was reviewed in several places, including the MAC, the clinical governance committee, and the senior management team (SMT) meeting. This ensured there were various channels of information flowing from these forums to the hospital director. Policies and procedures were examined at the health and safety committee and these minutes were considered by the SMT meeting as necessary with a similar process feeding in from the clinical governance committee.

We reviewed a range of clinical governance minutes. Items discussed included updates on projects, review of incidents, lessons learnt, clinical effectiveness, patient safety and emerging themes, children and young people's issues, patient experience and feedback, regulatory updates, the risk register, targets, policy reviews, reviews of policies, feedback from sub-committees, escalation to the MAC, and any other business.

Also, we reviewed minutes of the MAC for August and November 2019. Evidence was seen of active practice privilege management (in terms of granting reviewing and withdrawing) and two-yearly reviews of consultants with privileges.

However, not all minutes of meetings we reviewed demonstrated sound governance. For example, there was an endoscopy end-users meeting that occurred twice yearly. The minutes we were shown showed that the

consultant who was meant to attend those meetings had not attended them for a year albeit reasons were supplied. However, this potentially rendered the meetings less effective as senior clinical members of the team were not represented. When we asked staff what had been done about this consultant non-attendance, staff were frank that they had not reported this, even though there was a reporting mechanism in place that staff could have used. Following the inspection, the hospital shared with us the latest minutes of the endoscopy end-users meeting which showed an improving picture.

Managing risks, issues and performance

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

We saw that senior staff made use of systems to generate information which they analysed and created risks on a risk register as necessary. Staff we spoke with were clear that quality care came before financial pressures.

The hospital had an up to date risk management policy to guide staff in identifying and dealing with risk.

Staff used various sources of information to help them identify and flag potential risks. For example, incidents reported by staff or complaints data. We saw this on the day of our inspection when the decontamination unit broke down. Staff used this information to discuss whether the lack of a back-up washer disinfectant required a risk record being created.

The hospital had recently appointed a risk manager whereas previously the role of overseeing risk sat with the operations manager. The role of the risk manager was to support the SMT with review and renewal of risks.

Whilst the oncology service had its own local risk register we found that the endoscopy service did not, albeit any risks in endoscopy would be reflected in the theatres local risk register.

Medical care (including older people's care)

Staff told us that the only risk showing for the endoscopy service related to rust on trolley carts. We did not consider this reflected the risks we found on inspection and covered earlier in this report.

The oncology service had three main risks. The first risk related to the lack of a separate dispensary. This had been addressed by the dedicated dispensary for the oncologist pharmacist. The second risk related to extravasation in patients. We saw staff had developed a staged approach in consultation with the consultant body to address this. The last risk related to lack of a back-up oncological pharmacist in the event the post holder was unavailable. This was being addressed by training a pharmacist colleague.

We saw that if a local risk scored over eight it would move from the department risk register to the hospital-wide risk register.

Staff we spoke with confirmed that, while the hospital was in business to generate income, patient quality care came first.

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.

We saw that all services we inspected collected data, whether to maintain an accreditation, such as JAG for the endoscopy service, or to maintain a quality mark, such as the Macmillan quality mark in the oncology service and collected other data to help improve the services.

Leaders had access to a quarterly governance and quality report. As an example, we reviewed the report for quarter three, July to September 2019. This supplied data on various topics including: activity; new services; practising privileges; agency spend; incidents and never events; cancellations; safe staffing; various patient outcome measures; safety alerts; risk; complaints and policy updates.

Each data set in the report was followed by a short explanation about what had been done to address the issues raised by the data.

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.

The hospital had a marketing team that ran a series of events throughout the year designed to engage with the public and local healthcare stakeholders.

Staff were engaged by use of a staff survey as well as through an awards and recognition programme. Staff we spoke with were supported to go to national conferences of interest to their field of practice. In addition, in both services we visited, staff attended group wide specialist meetings. Staff also benefited from access to a freedom to speak up guardian.

Staff in the oncology service were trying to establish better pathways with local charities so that they could signpost their patients to free psychological support or therapies and bereavement support.

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.

Staff in the oncology service told us they attended, each year, a group wide cancer workshop to learn about new treatments which may benefit their patients.

Staff in the endoscopy service attended, each year, a group wide endoscopy meeting to learn about new procedures and the latest developments in endoscopy so that they were better informed about what could potentially benefit their patients.

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

Information about the service

Spire Leeds hospital provided a range of elective surgery treatments for NHS and other funded (insured and self-pay) adults, children and young people, with a range of specialities including general surgery, orthopaedics, urology, ophthalmology, ear nose and throat, gynaecology and cosmetic surgery.

The adult surgery service had an in-patient ward, (ward two) with 37 inpatient beds, across 33 single and two double rooms. Ward one, had 18 beds, which were closed at the time of our inspection. Managers we spoke with told us they opened beds periodically, to accommodate a maximum of nine day surgery patients, when unable to accommodate them on ward two. Pre-assessment clinic was also situated on ward one.

There was an ambulatory care unit, with ten 'pods'; each had a reclining chair. There were seven operating theatres and a dedicated endoscopy suite.

Our inspection was unannounced (staff did not know we were coming). At our previous inspection in 2018, we rated surgery services overall as requires improvement. This was because we rated safe and effective as requires improvement, caring and responsive as good and well-led as inadequate.

Summary of findings

At this inspection we inspected and rated all five key questions. To help us make our judgements, we visited wards one and two, operating theatres, post anaesthetic care unit, pre-assessment clinic and ambulatory care. We looked at the environment and spoke with two patients. We spoke with 23 staff members including all grades of medical, nursing, administrative, facilities staff and therapists. We also met the senior management team for the service.

We observed practice, staff interactions with patients and viewed 12 sets of care records. Before and after our inspection, we reviewed performance information about the service and information provided to us by the hospital.

We rated surgery as good overall because;

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

The service controlled infection risk well.

The design, maintenance and use of facilities, premises and equipment kept people safe. We saw improvement in emergency equipment checks, safe storage of substances hazardous to health and theatre air handling plant now met health technical memorandum (HTM) minimum standards.

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Staff completed and updated risk assessments for each patient and removed or minimised risks. We found improved completion of patient risk assessments, national early warning scores (NEWS2) and world health organisation (WHO) safety checks.

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

Records were clear, up-to-date and stored securely. We saw improved record-keeping and evidence of daily reviews by consultants.

The service managed patient safety incidents well. We found consistency of incident reporting, sharing of lessons learned and compliance with duty of candour improved since our last inspection.

The service provided care and treatment based on national guidance and evidence-based practice. There was improved compliance with national guidance for venous thromboembolism (VTE) since our last inspection.

Staff gave patients enough food and drink to meet their needs. We saw improved fasting times since our last inspection.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. We saw improved and consistent compliance with consent procedures.

Staff treated patients with compassion and kindness.

The service treated concerns and complaints seriously, and shared lessons learned. There was improved documentation in meeting minutes, since our last inspection.

Leaders had the skills and abilities to run the service. They were visible and approachable. Staff felt respected, supported and valued. There was improved leadership since our last inspection.

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. We saw improvement in the way the risk register was managed.

However, we also found;

Processes to improve VTE risk assessment and prophylaxis prescribing compliance were not yet fully embedded. For example, 2019 clinical scorecard data for the standard reporting period November 2018 to October 2019, provided by the hospital, showed there was an average compliance of 62.5% against a target of 80%, for prophylaxis given within the correct timescale.

Although the service had improved systems and processes to prescribe, administer, record and store medicines, we found some medicines governance processes were not yet fully embedded.

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Are surgery services safe?

Good 

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 section.

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

Mandatory training

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

Mandatory training modules were described in the hospital mandatory training guide. Key subjects included, anti-bribery, compassion in practice, equality and diversity, fire safety, health and safety, infection control, information governance, manual handling, safeguarding adults level two and safeguarding children level two. In addition, staff received resuscitation training appropriate to their role.

Resuscitation training figures provided by the service indicated high compliance rates. For example, for eligible staff, compliance for basic life support was 95%, advanced life support 100%, immediate life support 86% and European paediatric advanced life support 100%. We saw evidence that for those staff whose training had recently expired, all were booked on to the next available refresher sessions.

Staff we spoke with told us they took responsibility for completing their mandatory training. In addition, managers monitored mandatory training and alerted staff when they needed to update. The hospital also had a clinical educator in post, who had overview of training needs and records. Staff we spoke with told us training was considered important and was rarely cancelled.

The hospital set an annual target (April to March) of 95% compliance for all modules. Mandatory training was mostly accessed by staff on line, with some face to face practical skills sessions. Information provided prior to inspection and training records seen during inspection, indicated the target was exceeded overall, with compliance ranging between 95.8 to 99.7% across all modules.

Sepsis training was not identified in the hospital's training matrix as a mandatory module. However, in January 2020, the service trialled a sepsis e-learning module for acute inpatient and day care ward staff. The service aimed to roll the training out to all registered nursing staff and other key frontline registered practitioners by the end of September 2020. In addition, some nursing staff we spoke with told us they had completed sepsis training within acute illness management (AIMS) training.

Medical staff received and kept up to date with their mandatory training. Managers we spoke with explained consultant staff attended mandatory training at their employing NHS trust, and this was monitored through the appraisal process and at review of practising privileges.

Resident medical officers (RMOs) were employed through a national agency and completed mandatory training with the agency. The hospital received confirmation of the training and kept a record of attendance.

The RMO had received advanced life support and European paediatric advanced life support training.

Safeguarding

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

The hospital had safeguarding and chaperone policies in place to safeguard children and adults. The policies were in date and contained references to appropriate legislation and best practice guidance. They contained specific advice on female genital mutilation (FGM) and child sexual exploitation (CSE).

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. We saw telephone numbers to report safeguarding concerns, displayed on the ward for quick reference.

Staff received training specific for their role on how to recognise and report abuse. Compliance for level three training across the service, was 99% against a target of 95%. There were three named nurses for safeguarding children, educated to level four. These were the director of clinical services, the children and young people lead, and the head of governance. They had links with the local clinical commissioning group (CCG) health advisory group and the Yorkshire and Humber named nurses forum. In

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addition, the hospital was part of the Leeds safe place scheme for vulnerable adults. The hospital also worked with the local 'changing places' scheme, to raise awareness and show support.

The RMO received safeguarding training via their agency. Consultants completed safeguarding training at their employing NHS trust. This was monitored through the appraisal process and at review of practising privileges. A record of this was kept on their practising privileges file.

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.

Staff accessed hospital infection prevention and control policies on the intranet.

The policies described the hospital's standard precautions relating to infection prevention and control, management of methicillin resistant staphylococcus aureus (MRSA), and hand hygiene. The policies were in date and referenced current best practice guidance.

The hospital had a named infection prevention and control lead, and an infection control committee, which met quarterly. Meeting minutes were kept. Water safety was discussed at these meetings. We saw up to date legionella flushing records in theatre.

Cleaning of the environment was mainly undertaken by housekeeping staff. They used colour-coded disposable mop heads for specific tasks. We observed staff had access to spillage kits.

Cleaning of clinical equipment was the responsibility of clinical staff, supported with cleaning schedules and documented evidence of completion. Most equipment cleaning records we saw were up to date and demonstrated regular cleaning. The exception was records for point of care testing equipment on ward two. Between May and December 2019, compliance was below 50%. However, we saw there were no gaps January to March 2020. Managers we spoke with explained they were aware

of poor compliance and now allocated routine checks and cleaning duties on the duty rota and daily allocation board. They told us they monitored compliance through ongoing audit.

Clinical areas we visited looked clean and had suitable furnishings which were well-maintained. For example, upholstered couches and patient seating were impermeable and could be wiped clean. We saw disposable curtains labelled with the date they were last changed. Staff cleaned equipment after patient contact and labelled equipment with 'I am clean' labels, to show when it was last cleaned.

However, wall cabinets in the clean utility room on ward two had several notices and posters taped to the door fronts, which may prevent effective cleaning of hard surfaces. In other departments, posters were held in place by magnetic strips, which were removable for cleaning.

We also reviewed 2019 patient led assessments of the care environment (PLACE) reports for Leeds Spire hospital and noted the service scored 99.78% for cleanliness. This was better than the England average of 98.6%.

Mandatory infection control training data provided by the hospital, showed a compliance rate of 98.4%, which exceeded the provider's target of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as aprons and non-latex gloves. We observed staff complied with arms 'bare below the elbows' policy, in accordance with national institute for health and care excellence (NICE) guidance.

Hand hygiene compliance was monitored through observational hand hygiene audits; the most recent results were displayed and showed 95% compliance.

Hand washing facilities were available in all clinical areas and patient en-suite bathrooms. Clinical wash hand basins had elbow taps and adequate supplies of liquid soap and paper towels. In addition, there were posters near clinical basins, showing correct hand washing technique. We observed staff washed their hands and used hand sanitising gel between patient interactions. This was also confirmed by patients we spoke with.

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In theatres, we observed surgical scrub techniques, performed in accordance with the association for perioperative practice (AFPP) recommendations for safe practice.

Sterile services department (SSD) equipment, such as surgical instruments, was processed on site. This department held quality management system EN ISO13485:2016 certification.

We observed the instrument traceability process. After use, the patient case number was recorded on the instrument tray list and this was sent to SSD. Stickers with unique numbers from the instrument trays were placed in the patient record. The process was underpinned by a standard operating procedure, which was updated in March 2020.

At our last inspection in 2018, we told the provider they must ensure ventilation systems to the four theatres and anaesthetic and preparation rooms complied with health technical memorandum (HTM) minimum standards; and continue to monitor hip replacement surgical site infection rates. At this inspection, we found the provider had addressed the concerns we raised, and the required work was completed. For example, we saw documented evidence the ventilation systems were re-balanced, tested by an external independent provider and there was an alarm system installed to alert staff if air changes were low. Monitoring reports we reviewed during inspection showed air change results now consistently met HTM standards. In addition, the service no longer used the preparation rooms to set up, as this was not in accordance with best practice guidance.

In addition, the hospital continued to monitor infection rates. For example, data we reviewed at this inspection for quarters one to three 2019, indicated one hospital acquired infection out of 292 cases, which was a rate of 0.3%. This showed improvement since our last inspection.

However, managers we spoke with explained the air handling units for theatres were old and were to be replaced as part of a rolling programme. This was on the risk register for theatres.

Surgical patients were screened for healthcare acquired infections and the assessments of patients who were at risk of developing a healthcare infection were incorporated into nursing assessment documentation as part of the nursing record.

Hospital incident data from November 2018 to October 2019 showed no public health England (PHE) reported cases of hospital acquired MRSA, (Methicillin sensitive staphylococcus aureus (MSSA), Escherichia-coli (e-coli) or Clostridium difficile.

Rooms were available for patients requiring isolation. At the time of inspection, there were no patients who required isolation.

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.

All fire extinguisher appliances inspected had been serviced within an appropriate timescale. Exits and corridors were clear of obstructions.

The fabric of the wards and theatres was mostly in good order. The exception was the dirty utility room floor on ward two, which required refurbishment, to enable effective cleaning. In addition, the dirty utility room door on ward two did not have a lock, which meant there was a risk of unauthorised access.

The pre-assessment clinic was located on ward one, on the ground floor. This had been newly refurbished at the end of December 2019. All clinical rooms were arranged the same, with the same equipment.

At our last inspection in 2018, we were concerned emergency equipment checks were not always completed consistently well. At this inspection, we saw improvement. For example, staff carried out robust daily safety checks of specialist equipment. On the wards, pre-assessment and theatre suite, we observed emergency resuscitation equipment trolleys were sealed with numbered, tamperproof tags. Tags were checked daily and the contents were checked weekly. In addition, compliance with checks was audited by the service. We reviewed audit data for the period July 2019 to November 2019 and this indicated good compliance with checks.

We also checked a paediatric emergency care pack, adult anaphylaxis box, lipid rescue box, difficult intubation trolley and major haemorrhage trolley. We found all checks were completed in accordance with local policy.

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Four operating theatres had laminar airflow. Laminar airflow is used to separate volumes of air or prevent airborne contaminants from entering an area.

Theatres one and three were used for laser surgery procedures. These were compliant with medicines and healthcare products regulatory agency (MHRA) laser safety guidance.

We reviewed records for anaesthetic machine checks and found they were complete. The breathing circuits were changed weekly and had a dated sticker.

The post anaesthesia care unit (PACU) had six individual spaces, screened with curtains. Each space had appropriate monitoring equipment, oxygen and suction. One space was allocated for paediatrics; it was child friendly and decorated with animal stickers.

There was also an enhanced recovery area (ERU). Staff we spoke with explained it was staffed separately and only open if patients needed an extra hour or two of close observation, following opiate medication, for example. This was not in use at the time of inspection.

The ambulatory care unit, situated near ambulatory care theatre, had ten 'pods', each with a reclining chair and space for the patient's companion. There were separate male and female areas. These were used for local anaesthesia cases only; no regional anaesthetic blocks or general anaesthetic cases. There were male and female toilets and showering facilities.

At our last inspection in 2018, we had concerns about storage of substances hazardous to health in theatre. At this inspection, we found improvement and saw harmful products were stored in lockable flame-resistant cabinets. On the ward, domestic cleaning trolleys containing products subject to control of substances hazardous to health regulations (COSHH), were not left unattended and were locked away after use.

We inspected two patient ready-bedrooms and found them to be welcoming, bright, clean and fit for purpose. The ward also had a room specifically for people living with dementia. This had dementia-friendly signage on the bathroom door. A dementia box was available which contained a clock, games, single-patient use twiddle muff (to keep hands occupied), ergonomic cutlery and a radio.

The hospital had systems in place for recording the service and maintenance of equipment identified through

compliance stickers, which indicated the dates tests were due. We inspected several pieces of equipment, including intravenous pumps, monitors, suction machines, anaesthetic machines, blood warmer, diathermy and pneumatic compression units. All were clean, had been serviced and were maintained appropriately.

The patient hoist on the ward was serviced in accordance with the lifting operations and lifting equipment regulations 1998 (LOLER) and patient weigh scales we inspected were labelled as calibrated.

Linen was stored appropriately and decanted in small amounts onto lidded linen carts, when required.

Staff we spoke with told us they had enough suitable equipment to help them to safely care for patients.

There were call bells within patients' reach and we saw monitors opposite the nurses' station, which showed the number of minutes elapsed before bells were answered. We noted that staff responded quickly when called.

The hospital conducted environmental audits, and these indicated high compliance scores. For example, the service scored 99.51% for condition, appearance and maintenance of the environment in the 2019 PLACE audit.

Staff disposed of clinical waste in accordance with best practice guidance described in HTM 07-01, safe management of healthcare waste. For example, all sharps disposal bins we saw were assembled correctly, labelled and stored off the floor. None were overfilled. Waste bins were pedal operated and contained the correct liner for each waste stream.

Assessing and responding to patient risk

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

The hospital had a health and safety policy, which incorporated a statement of organisation arrangements. This outlined the requirements for health and safety and was referenced to legislation and national guidelines.

At the time of inspection, the high dependency unit was closed, as the hospital only admitted patients requiring

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level zero to level one care. Managers we spoke with explained this was due to a current lack of appropriately skilled personnel to staff the unit, to care for level two patients.

Level zero patients are those whose needs can be met through normal ward care in an acute hospital. Level one patients are those at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team. Level two patients are those requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.

There was a formal service level agreement in place with the local NHS trust for emergency transfer of patients. Unplanned transfer data provided by the hospital showed from January to September 2019, there were 12 patient transfers. This was a rate of 0.74% of inpatients. Theatre staff and PACU staff received patient transfer training and staff we spoke with stated the correct procedures to follow.

The hours of work for most of the ward nursing day-staff was from 7.30am to 8pm. The nurse in charge gave a verbal hand-over to the next nurse in charge. All other staff received a printed handover sheet and an audio-recorded hand over.

Departments conducted safety huddles at the start of each day. We attended pre-assessment and theatre huddles and a daily 'ten at ten' safety meeting. The content was informed by a comprehensive list of prompts and led by the hospital director. We observed representation from all departments, although the RMO did not attend on that occasion, due to clinical duties. Themes discussed included incidents, training, equipment availability, clinical workload, staffing and operational risks. The meeting was recorded on a computerised template, which was accessible to staff unable to attend the huddle.

The hospital had a resuscitation policy which staff accessed on the intranet. The RMO was advanced life support (ALS) and European paediatric life support (EPLS trained). The RMO and nursing staff we spoke with told us they participated in periodic emergency resuscitation scenarios, to test skills, and they received feedback and shared learning afterwards.

All patients were assessed clinically prior to admission and in consideration of the hospital's elective surgical admission criterion policy. Staff followed the pre-operative assessment standards, policy and standard operational procedure. A pre-admission medical questionnaire (PAMQ) was completed for all patients ahead of admission and discharge planning was considered at this stage; especially requirements for home care packages or periods of convalescence.

There was also an electronic alert system in place to ensure staff on the ward and theatres were aware of any risks and potential safety issues in advance of admission. For example, latex allergy, mental health problems or high body mass index.

Most patients attended face to face pre-assessment clinic. The exceptions were patients requiring local anaesthetic procedures, such as back pain injections, who were pre-assessed over the telephone.

We observed patients had access to a consultant anaesthesiologist review for general anaesthetic cases, to determine ASA grade. ASA is the American society of anaesthesiologist's physical status classification system, for assessing the fitness of patients before surgery.

Staff used a nationally recognised tool called the national early warning score (NEWS2) to assess the health and wellbeing of patients. Staff used this to identify if the clinical condition of a patient was deteriorating and required early intervention and or escalation to keep the patient safe. We reviewed records audit data for quarters three and four 2019. This indicated compliance scores of 96% and 97% respectively.

The hospital had a management of sepsis policy on the intranet. Nursing staff we spoke had a clear understanding of the signs and symptoms of sepsis. They described signs and symptoms of a deteriorating patient and gave examples of when and how they would escalate a concern.

Staff knew about and dealt with any specific risk issues. We reviewed clinical risk assessments including pressure damage acquisition, malnutrition, falls, moving and handling and infection. We found these were completed appropriately. Where risk assessments identified patients at high-risk, staff had referred them to further services such

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as therapy services, to provide additional support, equipment or assistance. For example, there was a physiotherapist falls lead available to provide advice and support.

At our last inspection in 2018, we were concerned venous thromboembolism (VTE) risk assessments were not consistently completed. In addition, we found actions required for high risk patients were not always documented. At this inspection, we found improvement.

For example, we reviewed VTE risk assessment audit data provided, for the standard reporting period November 2018 to October 2019.. We found 100% compliance for the periods November 2018 to January 2019 and May to October 2019. However the compliance rate for the period February to April 2019 was 60%.

The service had recognised there was still improvement to be made and appointed a VTE lead nurse to drive up compliance. A VTE committee was newly formed, and the lead linked in to the Spire VTE network at quarterly national meetings. A VTE discharge information leaflet was introduced, to raise patients' awareness and new competency-based training was in draft version, awaiting approval. Staff we spoke with told us compliance was improving and explained application for VTE exemplar status was deferred until June 2020, in order to demonstrate sustained compliance.

We observed a robust process in place to manage and communicate changes to operating theatre lists, between theatre and the ward. The theatre manager introduced individual theatre lists rather than all day listing, to identify skill mix needs. Paediatric patients were usually first on the theatre list, unless the clinical priority was different.

The hospital conducted quarterly observational and documentation audits of compliance with world health organisation (WHO) safer surgery checks. We reviewed data for the period August to October 2019, and this indicated 99% compliance with completion of documentation and 100% compliance for observed practice.

After gaining patients' consent, we observed theatre team safety briefs for local anaesthetic and general anaesthetic patients. These were conducted robustly, in accordance with WHO safer surgery guidelines and checklist. The cases

we observed were conducted in accordance with national and local safety standards for invasive procedures (NatSSIPs) and local safety standards for invasive procedures (LocSSIPs).

The hospital operated a 24-hour on call service for unplanned transfers to theatre. A dedicated team was available to attend within thirty minutes.

The hospital had a major haemorrhage policy. Staff we spoke with told us this was tested by scenarios periodically but could not recall when the last test was held.

At our last inspection in 2018, we were concerned post-operative surgical patients were not always reviewed daily, or prior to discharge, by a consultant. At this inspection, we found improvement. For example, patient records we reviewed during inspection evidenced surgical patients were reviewed daily and on discharge. In addition, between July and November 2019, the service conducted random spot-checks, to monitor and maintain consultant daily visits. This showed 100% compliance across all cases.

Consultants at the service had access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health.

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

At discharge, patients were given contact details for the ward should they have any concerns.

Nursing and support 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 service had enough nursing staff of all grades to keep patients safe from avoidable harm and to provide the right care and treatment. Planned and actual staffing figures were displayed. Nursing staff worked day shifts between 7.30am to 8pm and rotated onto night duty. Night shift was 7.30pm to 8am.

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The service reported their qualified nursing staff numbers in surgery in terms of full-time equivalents (FTEs). The FTE for each person was based on their hours worked as a proportion of the contracted hours normally worked by a full-time employee in the post. As of 1 October 2019, the hospital employed 47.6 FTE registered nurses and 15.7 FTE operating department assistants/health care assistants, across the hospital.

At the time of our inspection, there were no registered nurse vacancies and two health care assistant vacancies on the ward. In theatre, there were five scrub practitioner vacancies, three anaesthetic nurse practitioner vacancies and 1.55 post anaesthetic care nurse vacancies. These were backfilled with regular agency staff. Sickness rates for the period January 2020 to the time of inspection were 10.68% for wards (including paediatrics) and 26.02% in theatres.

The hospital offered pre-booked elective services to patients which allowed for effective planning of staffing, to meet clinical needs.

Managers used an adapted Shelford staffing tool in conjunction with the red flag algorithm, following the National Institute for Health and Care Excellence (NICE) 2014 safe staffing for nursing in the adult inpatient ward. The ward manager adjusted staffing levels daily according to the needs of patients. For example, variances such as extended recovery or close observation needs were highlighted to the ward following pre-operative assessment. At times of unpredicted high workload, the ward manager was utilised as a supernumerary nurse.

The theatre department worked within the association for perioperative practice (AfPP) guidelines to ensure safe staffing of theatres.

During our inspection, the number of nurses and healthcare assistants on all shifts on ward two matched the planned numbers. When ward one day-case beds were occupied, this was staffed with two registered nurses. The rota was prepared a week in advance of admissions and circulated to staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. We saw copies of induction records on file.

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

The service had enough medical staff to keep patients safe.

The surgery service was consultant-led. All patients were admitted under a named consultant. As of 1 October 2019, the hospital had 284 validated consultants with practising privileges. The term 'practising privileges' means medical practitioners were not employed directly by the hospital, but were approved to practise there.

Consultants conducted daily ward rounds. This was confirmed by patients we spoke with. Consultants were contactable by telephone for advice in between ward rounds; we saw an up to date contact list at ward reception and in theatre. Nursing staff did not raise any concerns about the availability of medical staff.

There was always appropriate anaesthesiologist cover. Consultant surgeons arranged alternative anaesthetic cover if their usual anaesthetist was not available. Surgical and anaesthetic consultants remained responsible for their patients throughout their stay in hospital and were required to be available within 30 minutes or to arrange cross cover with another consultant if they were unable to provide the required level of availability. For example, during annual leave.

There were two RMO's covering the hospital. RMO handover was at midday every Monday. Each RMO covered the hospital 24 hours a day for seven days. They then had seven days off, to ensure appropriate rest periods were maintained. The hospital monitored any out of hours calls out, to ensure safe working hours. The RMO we spoke with confirmed they had adequate rest and sleep.

Consultants provided support for the RMOs remotely and on site, as required. The RMO we spoke with said they felt supported by the consultants and nursing staff.

Managers could access locums when they needed additional medical staff. For example, if the RMO became unwell. Managers made sure RMOs and locums had a full induction to the service before they started work.

Medical staffing

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If a radiologist was required, this was initiated by a consultant surgeon or on-call radiographer.

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.

The hospital had a patient records policy, which was referenced to general data protection regulations (GDPR) and data protection act 2018.

Records were predominantly on paper. The exception was diagnostic imaging and pathology reports which were held electronically.

At our last inspection in 2018, we had concerns staff and consultants did not consistently keep detailed records of patients' care and treatment. At this inspection we saw improvement. For example, the hospital contacted all consultants and reinforced the requirement for them to visit inpatients daily and ensure the visit was documented in the medical records, dated, timed and signed. This communication also provided consultants with the relevant general medical council (GMC) guidance.

We reviewed 12 sets of patient records and found consultant records were incorporated into the single patient hospital record. We saw consultants made detailed, contemporaneous entries. We saw post-operative instructions for the ward were recorded legibly in operation notes. However, we saw one operation note not signed by a consultant. In addition, consultants did not routinely document their GMC reference number, which did not reflect GMC best practice guidance.

The records we reviewed held appropriate nursing risk assessments and individualised care plans. For example, in relation to falls risk and pressure area care. Each record contained a sepsis pathway, ready for use if required. All nursing and RMO records we looked at were written legibly in black ink. Entries were dated, timed and signed. Designation was recorded as was the RMO's GMC reference number.

Records were audited quarterly to monitor compliance. Consultant record keeping compliance was 85% for the standard reporting period, August to October 2019, against a provider target of 80%.

At our last inspection in 2018, we had concerns some elements of WHO surgical safety checklist documentation were non-compliant. At this inspection, we found improvement. For example, in the 12 records we looked at, all sections of WHO check lists were complete. This concurred with audit data provided by the service, which showed 100% compliance for observed WHO checks and 99% for documentation of WHO checks, for the period August to October 2019.

Records were stored securely in a lockable trolley, in the ward office on ward two and in lockable cabinets in pre-assessment on ward one. We did not see any electronic records on view on unattended computer screens.

Medicines

Although the service had improved systems and processes to prescribe, administer, record and store medicines, we found some medicines governance processes were not yet fully embedded.

Surgery was the main service and medicines information also related to other services. The hospital had a medicines management policy which staff accessed on the intranet. In addition, in November 2019, the Spire group launched its use of the antimicrobial guidelines application (app), which replaced the previous antimicrobial prescribing policy.

At our last inspection in 2018, we found the service did not always follow best practice when prescribing, giving, recording and storing medicines. The service recognised this as a current amber risk on their February 2020 monthly risks bulletin.

At this inspection, we found the hospital was supported by a newly appointed, ward pharmacist, and a locum pharmacist, based in the dispensary. Although we saw improvements and some established good practice, we also found some medicines governance processes were not yet fully embedded.

For example, entries in the controlled drugs registers were now legible, and there was now clear marking of entries made in error. Medicines trolleys were now secured to the wall when not in use. We did not find any out of date intravenous fluids or medicines.

Medicines, including intravenous fluids, were stored securely and access was restricted to authorised staff. Storage and security audits were completed for all departments and we noted high compliance scores. We

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saw patients own controlled drugs were recorded in a separate register and the balance shown as zero when returned to patients on discharge. Balance checks of controlled drugs were completed at least once daily.

However, in one of the controlled drugs registers we reviewed on ward two, we saw several pages where patient details, doses and signatures had been entered but the medication was 'not given', crossed through, and recorded as 'written in error'. These entries were made after our previous inspection in 2018. Although compliance with correct recording of errors had improved, the high number of errors suggested staff may have completed the fields in the register in advance of administering the medication. This did not follow hospital policy. We also found one signature missing for an administered medication, and one time of administration not recorded. We brought this to the attention of the pharmacist at the time. They told us they would investigate further and continue to monitor through routine audit of the registers.

A medicine keys handover log had also been implemented in November 2019. However, there were several gaps in December 2019 when signatures were not recorded. We brought this to the attention of staff at the time.

On ward two, we found three pots containing denatured controlled drugs, in a locked cupboard. Staff we spoke with told us they should be removed after 24 hours, but the dated pots had been retained for longer. This was brought to the attention of a pharmacist at the time and they were removed.

The pharmacist we spoke with explained although there had been improvements since our last inspection, the focus now was on embedding governance processes. They described how they were working to achieve this. For example, a new electronic audit management and tracking system was being implemented, to improve the way audit data was collected, results cascaded and action plans monitored.

In addition, drug chart champions were now appointed on the ward. Champions and pharmacists provided practical training to nurses and medical staff following identification of prescription and medication errors. They promoted a team approach by attending ward meetings, discharge steering group meetings and departmental safety huddles.

Pharmacy operated 8.30am to 5pm Monday to Friday and 9am to 12 midday Saturday. In addition, there was 24 hours

a day, seven days per week on-call pharmacy service. If medicines were required from pharmacy out of hours, the RMO, accompanied by the senior registered nurse on duty accessed the dispensary. Out of hours access was recorded in a log book on the ward. However, this commenced in October 2019, and compliance had not been audited to monitor compliance.

There was diligent recording of medicine fridge temperatures and ambient room temperatures where medicines were stored, on ward one (when open) and theatres. However, on ward two, we found several gaps in ambient temperature checks for the fluid store room, in January and February 2020 and previous fridge and room temperature records for 2019 could not be located. Staff we spoke with told us they were archived but were unable to provide them during our inspection. We brought this to the attention of a manager at the time and they told us this would be reported formally as an incident. The service subsequently provided the incident report. Action taken was to ensure paper records were scanned electronically prior to archive.

The pharmacist or RMO checked (reconciled) patients' medicines on admission to hospital. Pharmacists conducted monthly audits of drug charts and medicine reconciliation. However, we found there were 13 gaps in the record since 21 February 2020.

Information provided by the hospital for the period July 2019 to September 2019, showed incorrect or incomplete prescribing by the RMO (35%) and consultants (63%). Interventions made by pharmacy where the prescription needed to be queried/amended accounted for nearly all of the interventions recorded (97%).

The pharmacist audited medicine administration records and this showed improvement. During our inspection, we looked at ten prescription records and all were completed legibly and correctly.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

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

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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.

The hospital had an incident reporting policy, which staff accessed on the intranet. The policy was in date and contained appropriate references to legislation and to relevant national best practice guidance.

At our last inspection in 2018, we found incidents were not identified, classified and investigated consistently well. In addition, we were concerned there was insufficient learning from incidents.

At this inspection we found improvement. Staff we spoke with were very clear about incident and near-miss reporting. They told us incident reporting had increased and the quality of reporting had improved. They gave specific examples of learning and changes in practice, which improved patient safety. For example, following near-miss reporting, the format of the safety brief in theatre was changed and staff attended further training to embed the changes. This new process was then rolled out to all other Spire hospitals by the national theatre lead.

Staff we spoke with told us learning was shared routinely in the departmental daily safety huddles, 'ten at ten' meetings, monthly sister's meetings and monthly ward meetings. The minutes of these were emailed afterwards to all appropriate staff.

At our last inspection in 2018, we were concerned the service did not meet duty of candour obligations consistently well. Regulation 20, 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 and other 'relevant persons' of certain 'notifiable safety incidents' and provide reasonable support, truthful information and a written apology. At this inspection, all staff we spoke with were aware of the duty of candour and provided specific examples of when they had used this.

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.

Data provided by the hospital showed there had been no never events in surgery within the reporting period October 2018 to September 2019. However, an incorrect lens implantation occurred in November 2019. As a result of learning from this, staff we spoke with explained national safety standards for invasive procedures (NatSSIPs), and a new process for ophthalmology were introduced. In addition, actions taken to improve safety were shared at a face to face meeting with the patient concerned.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance and safety quality data was displayed on wards for staff and patients to see. For example, the number of days since last patient fall with harm, VTE incidents, patient incidents that resulted in harm and infection rates.

We saw evidence of how the service used data to improve patient safety. For example, for the period August to October 2019, there was an increased number of patient's falls reported. In response, a falls prevention committee was set up to identify actions to prevent further falls. Risk assessment outcome posters and 'call don't fall' posters were developed and implemented in patient bedrooms. These communicated key messages to patients, including prompts to mobilise with walking aids and always use the call buzzer to summon assistance. Incident report feedback and shared learning was communicated hospital-wide, with a focus on falls prevention. In addition, patients identified as high risk were now given non-slip red socks.

Are surgery services effective?

Good 

Our rating of effective improved. 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.

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At our last inspection in 2018, we found the service had not adhered to national VTE prophylaxis guidance consistently well. At this inspection, we found improvement. For example, staff now followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Compliance was monitored through continuing audits.

All care records we inspected, showed patients had been prescribed prophylaxis (treatment given, or action taken to prevent blood clots) for VTE where this was indicated. In addition, we reviewed audit data for the standard reporting period November 2018 to October 2019 and found 100% compliance was achieved. However, there was an average compliance of 62.5% against a target of 80%, for prophylaxis given within the correct timescale. We saw an action plan in place to address non-compliance.

Incidents data for 2019 showed the hospital reported three hospital acquired VTE/pulmonary embolism for the period November 2018 to January 2019, two for the period February to April 2019 and one for the period May to July 2019. The most current VTE incidence rate for hip and knee surgery patients, shown on the clinical score card was 0.33%.

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.

There was a ward pantry and dedicated staff to serve meals and drinks for patients. Meal times were specified in the in-room information folders. However, meals were also available at times to suit patient needs. Carers and family were invited to eat with patients if they wished to and help with meals as appropriate.

Patients had a comprehensive menu to choose from. We saw regular morning and afternoon hot drinks rounds and drinking water jugs were replenished by pantry staff. There were 'think drink' posters in each bedroom to encourage patients to keep hydrated. In addition, there was a poster opposite each bed, which stated 'you are allowed to drink clear fluids up until ...' and a space where staff could specify a time.

Special dietary needs were catered for, for example, diabetic, gluten free and texture modified menus were

available for patients who required these. Patients we spoke with told us the food was 'excellent'. One patient said they had a poor appetite and the catering team provided whatever they wanted, even if it was not on the menu.

At our last inspection in 2018, we were concerned patients were often fasted for excessive periods prior to surgery. Current national guidance states patients should receive clear fluids up to two hours and food up to six hours prior to surgery. At this inspection we found improvement.

Patients we spoke with confirmed pre-operative fasting information was discussed with them at pre-assessment and they were given written information (fasting cards) in advance of admission. Patients were advised to have no food orally for six hours prior to admission and could have water up to one hour prior to admission.

Fasting audit results for the standard reporting period November 2018 to October 2019, showed improvement. Compliance rates for patients that were fasted in accordance with best practice guidance improved from 22% to 55% on average (ranging from 45% to 67), against a target of 65%. The associated action plan was reviewed by the fasting committee in February 2020.

Post-operative patients and those experiencing nausea and vomiting were routinely prescribed antiemetic (anti-sickness) medicine.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Staff could explain the process for referral to an on-call dietician for advice and support.

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. For example, on the ward, and in theatre recovery, we saw pain scores were monitored as part of the NEWS2 records, using a zero to three assessment.

Pain scores were audited quarterly. Information provided by the hospital indicated 100% compliance for the standard reporting period May to July 2019 and 98% for the period August to October 2019.

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Patients we spoke with who identified they had experienced pain, said this had been managed well during their stay and nursing staff had responded promptly when pain relief had been requested. This concurred with patient satisfaction survey results. Data for the period May to July 2019 84% of patients that had experienced pain, indicated their pain was managed well.

One nurse we spoke with was not aware of any formal tools to assess pain in patients unable to communicate. However, they explained how they used their clinical judgement. For example, vocalised sounds, facial expression, raised pulse and blood pressure, changes in behaviour and body movements.

There was no dedicated pain team however, if pain was not able to be managed well, staff and RMO we spoke with told us they escalated to an anaesthetist.

The most recent clinical score card data for pain audits, showed compliance of 98% against a target of 95%.

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 had been accredited under relevant clinical accreditation schemes.

The hospital collated local audit data to monitor patient outcomes and these were reported through the quality dashboard.

The hospital submitted data for national audit including:

- The private healthcare information network (PHIN).
- The national joint registry (NJR).
- The cosmetic and breast implant register.
- Patient reported outcome measures (PROMS), for hip and knee replacement,

Information was provided to the private healthcare information network (PHIN). This included information on length of stay, patient satisfaction and the number of patients seen. PHIN ensures robust information is received about private healthcare to improve quality data and transparency.

From October 2018 to September 2019 the hospital reported 11 unplanned returns to theatre, 18 unplanned transfers out of the hospital and 12 unplanned readmissions.

PROMS data we reviewed for the hospital showed patients had a higher than average pre-operative score for both private and NHS procedures than the NHS average. The hospital's post-operative scores were also higher than the NHS average for both groups. This showed their outcomes were better than the NHS average.

The service was accredited by;

- Centre sterile service certificate GB07/72672 valid from 7/06/2019 to 09/08/2022 EN ISO 13485:2016
- Endoscopy JAG accredited valid to 28/04/2022
- UKAS accredited Pathology 8964 surveillance visit 06/2019 passed.
- BUPA (breast and colorectal services)

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. For example, we reviewed three staff files which contained appropriate job descriptions and comprehensive records of core competencies. These included for example, induction programme, mobilisation of post-operative joint patients, care of people with dementia, oxygen administration, administration of medicines, acute illness management and immediate life support training. Managers and the clinical educator also had overview of staff competencies via an electronic tracker, organised by department.

The hospital had a policy for clinical supervision, which staff accessed on the intranet. This stated supervision should be offered two-monthly or quarterly at the discretion of head of clinical services and records kept. Managers spoke with told us clinical supervision was provided as needed. Three staff recently completed a clinical supervisor course, which would increase access to supervision once learning was embedded. Some staff we spoke confirmed they received supervision as required, while others told us they received weekly supervision sessions.

All consultants had an annual whole practice appraisal and were required to provide evidence of medical indemnity insurance, a nominated covering consultant, a disclosure

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and barring service (DBS) check, occupational health status regarding immunisations and the relevant training if they wished to treat children and young persons. Consultants we spoke with confirmed their appraisal process was very thorough.

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 appraisal year ran from January to December. Data provided by the hospital for the last completed appraisal year, indicated poor compliance with completion of appraisal across all staff groups. However, data for the current appraisal year showed between 97-100% compliance.

The RMOs were employed through a national agency. The agency was responsible for their ongoing training and provided continuing professional education sessions throughout the year. The chair of the medical advisory committee (MAC) provided clinical supervision when required.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, a staff member we spoke with was supported to complete a non-medical prescribing course and was allocated an appropriate clinical supervisor.

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 of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff held regular and effective multidisciplinary meetings. For example, we attended a daily bed meeting and observed discussion and decision making about specific patient care needs and plans to optimise their care. They also discussed staffing, safety flash alerts, equipment issues and incident reporting.

Patients had access to specialist nurses. For example, cosmetic surgery, cardiology, breast care, oncology/ gynaecology and urodynamics nurses.

The hospital employed a team of physiotherapists who supported patients pre and post-surgery to improve their surgical outcomes.

Seven-day services

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

Consultants led daily ward rounds including at weekends.

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

There was 24 hours a day seven days per week on-call pharmacy service.

Health promotion

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

Staff discussed patient health and wellbeing as part of their pre-operative assessment. The service held pre-operative education sessions for patients undergoing joint replacement. This facilitated informed consent and enhanced patient recovery by providing better understanding of what to expect and their role in their own recovery.

Patients we spoke with told us they received written health promotion information in the post prior to admission and written advice on discharge, as appropriate.

Staff referred patients to a dietitian if they required advice regarding diet and nutritional needs.

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.

The hospital had a deprivation of liberty safeguards policy, which staff accessed on the intranet. Staff we spoke with described and knew how to access policy and get accurate

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advice on mental capacity act and deprivation of liberty safeguards (DoLS). Staff we spoke with explained patients were individually risk assessed against specified admission criteria and the hospital rarely had patients subject to DoLS.

The hospital had a consent policy, which staff accessed on the intranet. The policy described consent as a two-stage process.

At our last inspection in 2018, we were concerned consent procedures had not been followed consistently well. At this inspection, we found improvement. For example, consent form audit data for the period August to October 2019 indicated 99% compliance.

In the records we reviewed during inspection, all but one consent form evidenced staff gained consent from patients for their care and treatment in line with legislation and guidance. The exception was where a consultant had signed but recorded the incorrect month. However, the patient had signed and indicated the correct month. This was brought to the attention of staff at the time.

Patients we spoke with told us they were provided with sufficient information to give informed consent.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. For example, staff we spoke with told us about a 'best interest' meeting held with the patient, their carer, consultant, matron and nurse in charge.

Most nursing staff (98%) completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

We observed 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 followed policy to keep patient care and treatment confidential.

We saw patients received compassionate care. For example, in theatres and ward, staff were seen to observe patient privacy and dignity by ensuring curtains were closed around them and bedroom doors were closed in accordance with their wishes. We also observed staff providing reassurance to patients undergoing local anaesthetic procedures in theatre and patients recovering from general anaesthetic in recovery.

Response time to answer call bells on the ward was recorded on the electronic monitor located opposite the nurse's station on the ward. We observed prompt responses to calls.

Patients we spoke with told us they were very happy with the care they received. One said 'it's as good as it gets'. The hospital gathered patient feedback through the friends and family test (FFT) and consistently received high satisfaction scores.

We saw thank-you cards and letters from patients, expressing their positive comments about the care they had received. We observed feedback from patients was shared with staff at the 'ten at ten' meetings

Emotional support

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

Staff provided emotional support to patients to minimise their distress.

Staff on the ward explained patient relatives could be accommodated overnight if required.

There was a quiet room available and this was also used as a prayer room. Specialist nursing staff we spoke with told us they received training in breaking bad news and this would be cascaded.

Understanding and involvement of patients and those close to them

Are surgery services 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.

Patients we spoke with told us staff were attentive and treated them well and with kindness.

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

At pre-assessment, physiotherapy-led patient education groups were provided for patients undergoing elective joint replacement procedures. This provided patients and those close to them the opportunity to learn about the treatment they were going to receive and allowed the opportunity to ask questions.

The ward had flexible visiting times that allowed greater time for friends and relatives to be part of patient care.

Staff involved patients and those close to them in decisions about their care and treatment. For example, patients we spoke with told us they felt fully informed about their treatment plans and arrangements for discharge.

The feedback from the friends and family test was positive. For example, data provided showed that from May 2019 to October 2019, 94.8% of patients were likely or extremely likely to recommend the hospital to friends and family.

Are surgery services responsive?

Good 

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

Service delivery to meet the needs of local people

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.

The hospital provided services for NHS, private-insured and self-funded patients. Patients were referred to the surgeon of their choice where possible and seen by the same consultant throughout their treatment ensuring continuity.

The hospital director had worked hard to promote a positive working relationship with other health providers in the area. For example, a range of services were available for NHS patients where commissioners had identified capacity shortfalls or for patients who wished to exercise their rights of flexibility and choice, under the e-referral system (previously known as choose and book).

Where possible, appointment and treatment times were undertaken at a time suitable to patients and carers. Staff we spoke with described attending capacity meetings, which defined patient needs. They gave specific examples of when theatre times and lists were flexed to meet the needs of patients living with disability or living with autism.

The facilities and premises were accessible to all patients. The hospital car park provided free parking spaces.

Pre-admission assessment appointments were provided to ensure effective planning of admissions.

The hospital provided care and treatment including diagnostic procedures at the same location.

Patients had a consultation and examination in their first visit. A subsequent pre-operative assessment appointment was provided to patients prior to their admission, conducted face to face or by telephone as appropriate.

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.

Equality, diversity and inclusion was a mandatory e-learning training course, which all staff completed. At the time of our inspection training compliance across all staff was 99.7%.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a named lead for dementia at the hospital, who provided advice and training for staff and to be involved in the care planning for all patients living with dementia and their families. There was a dementia awareness program and staff completed online training. Several staff were identified as 'dementia friends'. 'This is me' passports were available and used for patients living with dementia, and those living with learning disability. There was also a dementia friendly bedroom on the ward.

Staff we spoke with in pre-assessment clinic told us routine appointments were allocated an hour. However, they

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booked extended appointments of up to two hours, for people living with a disability, dementia and learning difficulties if required. One-stop clinics were available for breast care patients.

We reviewed PLACE audit reports for 2019 and noted 80.53% compliance for how well the needs of patients living with dementia were met. This was comparable with the national average of 80.70%. Compliance for how well the needs of patients living with disability were met was 86.21%; better than the national average of 82.5%.

Wards and departments were accessible for patients with limited mobility and people who used a wheelchair. Specialised equipment was available for bariatric patients, if needed. For example, moving and handling equipment.

Pre-assessment staff identified individual needs such as hearing, sight or language difficulties or disabilities. Translation services were available for patients where English was not their first language. British sign language interpreters were available and patient information could be provided in braille. Bedroom information folders contained a pictorial tool, so patients unable to speak could communicate their needs more easily.

Patients were provided with information leaflets regarding risks and benefits of surgery and could review these before their procedure. To comply with the accessible information standard, the provider had a contract for this information to be available in different formats, to ensure patients of all abilities had access to important clinical information. This was referred to in patient letters.

We saw staff cared for patients as individuals and strived to meet their individual needs. We saw patients being treated with dignity and respect by addressing them as they wished to be addressed and closing curtains and bedroom doors as necessary.

Beverage bays and toilet facilities were available throughout the hospital for patients, carers and relatives including those living with a disability.

The ward operated open visiting times for patient's relatives and friends. Overnight accommodation for family and carers was facilitated as required.

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.

Services were elective and the provider offered flexibility and choice to patients who were either referred or made a self-referral.

Patients were referred to the hospital by their GP, self-referral or NHS referral. For the period November 2018 to October 2019, activity was 34% NHS funded patients and 66% non-NHS funded patients. For the same period, activity consisted of 77% day case and 23% inpatient.

Appointment waiting times were based largely on patient convenience. For example, around plans for work and family holidays. However, the hospital was required to monitor waiting times for first outpatient appointment, diagnostic tests and commencement of surgical pathway, in accordance with the standard acute NHS contract and other locally agreed NHS contracts.

Data from the provider indicated the average wait time for NHS work from referral was two to three weeks, except for ENT which was eight weeks. For private patients, appointments were available on the next available clinic, sometimes same or next day.

Pre-assessment clinic was usually operational Monday to Friday between 9am and 5pm. However, staff we spoke with explained they offered an 8.30am appointment if required and were considering additional clinics at the weekend.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers and staff worked to make sure that they started discharge planning as early as possible, at pre-assessment. Staff we spoke with explained medicines to take home were prescribed and prepared the day before expected discharge.

Managers worked to keep the number of cancelled operations to a minimum. Data provided by the hospital showed in the last 12 months, there were 17 patient operations cancelled for non-clinical reasons. Of these, 88% were offered another appointment within 28 days of the cancellation.

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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 had a complaints policy, which staff accessed on the intranet.

The patient experience manager was responsible for overseeing the management of all complaints received by the hospital. This included ensuring complaints were uploaded onto the electronic reporting system, outcomes were shared with relevant staff involved with the investigation and timescales for responses were met.

Oversight was provided to the hospital director and senior management team via a weekly complaints meeting.

For the period November 2018 to October 2019, the hospital received 78 formal complaints. One complaint was referred to the ombudsman or Independent Sector Complaints Adjudication Service (ISCAS). Data provided by the hospital for the period November 2018 to July 2019, showed on average, 84% of complaints were closed within 20 working days.

Patients we spoke with told us they knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas.

At our last inspection in 2018, we saw limited evidence of discussions about learning from complaints, in meeting minutes we reviewed. However, at this inspection, we found improvement.

Learning was shared across the hospital in daily 'ten at ten meetings', monthly head of departments meeting, fortnightly clinical audit and effectiveness meetings, fortnightly process review, quarterly medical advisory committee and departmental team meetings.

Learning from feedback and complaints was shared with patients and visitors by using a 'you said, we did' format (posters and TV screen information), with examples of changes in response to concerns and complaints raised. For example, patients were concerned about privacy during check-in. Signage was improved to ask other patients to avoid approaching the desk until called.

Are surgery services well-led?

Good 

Our rating of well-led improved. 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 our last inspection in 2018, we were concerned leaders did not have the right skills and abilities to run a service providing high-quality sustainable care. At this inspection, there was a new leadership team in place and we saw improvement.

For example, staff we spoke with told us there was 'now a good management structure in place', and they felt very supported by their leaders. They told us the senior management team was very visible and promoted autonomy of departmental managers.

Staff we spoke with told us described how theatre manager introduced a 'going home checklist' for the team debrief in theatre. This had improved morale and improved team cohesion. Staff said this had 'helped them switch off' prior to going home.

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.

Following the last inspection report and the appointment of a new leadership team, the hospital paused activity for a week to regroup and launch a new purpose. The week involved a number of events, supported by local and national Spire leaders, including training and team building. The programme was also supported by a number of partners including the CCG.

Surgery

Staff we spoke with were clear about departmental strategies. For example, we saw the strategic objectives and engagement plan for theatre displayed clearly in the staff rest room. These were based upon feedback from staff and service users.

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.

To support career development, senior managers had introduced regular tea trolley teaching sessions, a new national idea for rapid practical training. The concept involved training materials sitting on the top of the trolley, with tea and cakes below to encourage people to gather. Examples of training delivered included VTE prevention and MCA/DOLS, with excellent feedback from staff.

The hospital had a whistleblowing policy, marked as 'under review', which staff accessed on the intranet. There was a freedom to speak up guardian for staff to raise concerns without fear.

Nursing, medical and non-clinical staff we spoke with described an open, supportive culture.

Staff we spoke with told us they now felt empowered. They said, 'work does not keep me awake at night' and described the team to be 'like a family'.

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 was an up to date policy in place for management of consultant practising privileges. Practising privileges were formally reviewed every two years and annually for wholly-privately practising consultants. The hospital medical advisory committee (MAC) met quarterly. The MAC

considered all applications and advised the hospital director regarding eligibility for practising privileges and for their continuation, withdrawal, suspension or restriction, with the final decision resting with the hospital director.

In the 12 months prior to 1 October 2019, 32 consultants had practising privileges removed; 11 retired, 17 requested to withdraw their practising privileges as they no longer wished to continue with private practice; four were removed for failure to provide mandatory documentation.

For the same period, 24 consultants had their practising privileges suspended; 23 due to expiry of mandatory documentation and one pending an internal investigation in relation to behaviours and prescribing concerns.

The hospital had 13 consultants with practising privileges for cosmetic surgery and all were on the specialist register.

Senior departmental managers attended clinical governance meetings.

Managing risks, issues and performance

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

The hospital had a risk management policy, which staff accessed on the intranet.

At our last inspection in 2018, we told the service it must ensure risk registers were managed properly. At this inspection, we found a comprehensive risk register was held within the electronic incident reporting system. Departments had overview of their own risks and reviewed them appropriately. The top risks each month were communicated to staff via a risk bulletin.

The hospital had a major incident and business continuity plan, with a hyperlink to a trust document, describing arrangements for patient transfers. The plan was up to date, however, the hyperlinked document within it had been due for review in October 2019.

Surgery

The plan advised annual table top tests to be completed. Staff we spoke with in theatre described an evacuation scenario and table top exercise, conducted in October 2019, led by the group fire officer.

The hospital tested the major incident alarm every Tuesday.

Managing information

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 provider produced 48-hour flash reports as an opportunity to learn from events on a wider scale. These were used to highlight either complaints or incidents that had led to a change of practice. The 48-hour flash reports were shared throughout every hospital within the group and each hospital had to acknowledge that they had been read and distributed throughout the local service. We saw these discussed at the daily 10@10 huddle, the daily update meeting held in each clinical area.

Important information such as policies and minutes of meetings were held electronically on the hospital intranet and all staff we spoke with could access the system.

Staff viewed pathology results electronically. Health records and nursing pathway records were on paper and amalgamated into a single record.

We observed good adherence to the principles of information governance. For example, computer screens were closed when unattended and records were secure and stored away from public areas.

Staff compliance with information governance training was 95.8%.

Engagement

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

The hospital's website provided a wide range of information about the clinical services available. It also provided information about how to leave feedback. For

example, by email, comment on the social media page, patient experience survey, and a search engine review. Managers were visible in the departments, which provided patients and visitors with opportunity to express their views and opinions face to face. We saw thank you cards and letters displayed on the ward.

Staff we spoke with told us management engaged with them well and were very supportive and visible. For example, they walked the departments daily and joined departmental huddles. Staff said they were encouraged to voice their opinions and speak with managers if they had any concerns. There was a staff 'Spire for You' system which included discounts, a free Employee Assist line for personal assistance and wellbeing, and regular reward and recognition events, which was valued by staff. Staff told us they felt appreciated by their clinical colleagues and hospital managers.

Staff used the 'ten at ten' meeting to share messages and good practice. Departments also held staff meetings monthly when possible, where issues, such as service configuration, governance and staffing, were discussed. Minutes of these were circulated afterwards.

Results of the last staff survey in October 2019 indicated a staff response rate of 60%. Spire Leeds had above average staff engagement results; 84% engagement index compared to average 81% across the Spire hospitals group.

Patients had access to the Spire patient discharge survey to inform the hospital of their experience and the hospital used this feedback to learn and improve. All patients identifying areas for improvement were contacted to ask them to be involved in the hospital's improvement plan.

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.

Staff we spoke with said they were supported to attend external training provided by a local trust, to develop their career.

The hospital had an agreement with the local university to take second and third-year student nurses on clinical

Surgery

placement. Students received a comprehensive induction and were always supernumerary. Named mentors worked closely with students and signed off their competencies when achieved.






The hospital had been part of NHS Improvement pilot for the independent sector 'Getting It Right First Time' (GIRFT). This had involved an onsite review of a number of key performance indicators selected for their overall contribution to quality of orthopaedic care.

In theatre, the manager designed and implemented a more structured five steps to safer surgery team briefing and debrief record. This was recognised as an exemplar by senior management and implemented across all Spire hospitals.

The hospital held 'Spire for You' awards; a member of the theatre staff received an award for breast care support.

There was a 'time to shine' staff nomination and awards at the 'ten at ten' meeting each day.

Services for children & young people

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

Information about the service

Spire Leeds Hospital is amongst Yorkshire's largest independent hospitals offering treatment across over 30 medical specialties which includes children's and young people's services. The children's and young people's service is led by a registered children's nurse who is supported by a team of children's trained registered nurses.

Children are seen and admitted onto a seven bedded paediatric ward, the outpatient's department and radiology departments.

Children up to 18 years of age attend the outpatient department across a range of specialities including paediatric medicine, orthopaedics, ear, nose and throat, plastic surgery, Urology, Ophthalmic and General Surgery.

Inpatient and day case surgery is provided to children from one year and a minimum weight of 10kgs.

During the inspection, we visited the children's ward, outpatients department and radiology and tracked one child from admission, through theatre to discharge home.

We spoke with 19 staff including registered nurses, play specialist, reception staff, medical staff, operating department practitioners, and senior managers.

We spoke with nine children and young people and eight parents. During our inspection, we reviewed 11 sets of patient records and five medicine prescription charts.

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

Activity (1 February 2019 to 1 February 2020)

From 1 February 2019 to 1 February 2020 paediatric activity for Spire Leeds Hospital was:

- NHS – Inpatient: 34% and Outpatient: 40%
- Private – Inpatient: 66% and Outpatient: 60%

Current staffing included:

- One lead paediatric nurse
- Four full time children's nurses
- Two children's nurses who worked 22.5 hours weekly
- One play leader who worked 22.5 hours weekly

Track record on safety

- Zero Never events
- Two serious incidents and nine incidents were identified in the February 2020 Paediatric Steering group report.
- Zero serious injuries
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- Zero complaints

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department - August 2022

Services for children & young people

- Joint Advisory Group on GI endoscopy (JAG) accreditation – April 2022
- Pathology received an inspection by UKAS 13th June 2019; confirmation of full accreditation was received in July 2019.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds maintenance
- Laser protection service
- Maintenance of medical equipment
- Pathology and histology
- Resident Medical Officer provision

Summary of findings

Spire Leeds Hospital is operated by Spire Healthcare Limited. The hospital itself is set in landscaped grounds on the outskirts of Leeds with good travel links and off-street parking. The building was wheelchair accessible. The older part of the hospital was a listed building where the administration services resided.

The children's and young people's service has seven beds. Children's and young people's facilities include seven bedrooms with en-suite facilities and a television. One playroom, a staff office and a small medicine cupboard was also present in the clinical area. Access to the children's ward was through an adult ward. In addition, the hospital has X-ray, outpatient and diagnostic facilities.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on the 3 and 4 March 2020.

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

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

Services we rate

Our rating of this service improved. We rated it as **Good** overall.

We found good practice in relation to children's and young people's care:

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

Services for children & young people

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 children and young people 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 children and young people, advised them and their families 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 children and young people 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 children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's 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 children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

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

Are services for children & young people safe?

Good 

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

Mandatory training

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

There was a system in place that was used to log clinical and mandatory training. Monthly training reports had kept the senior management team informed of the status of training compliance. Training information was discussed at the hospital clinical effectiveness committee and with heads of departments.

Mandatory and Role Specific Training:

The Spire mandatory training guide identified the mandatory training subjects' staff were to complete by the 31 December of each year. These subjects included; safeguarding adults and children at levels one and two, infection control, information governance, equality and diversity and health and safety awareness.

Whilst on site we reviewed paediatric staff mandatory training records for the ten mandatory training modules which were completed yearly through e-learning. All (100%) paediatric staff had completed mandatory training modules up to 3 March 2020.

Additional training was identified which was role specific, for example, incident reporting, paediatric immediate life support (PILS) and safeguarding children at level three.

Paediatric Critical Care Training:

The provider had obtained a corporate licence through the Manchester critical care skills institute to deliver the paediatric acute illness management one day course to its staff. We saw the paediatric acute illness management (AIM) timetable which confirmed the day included six workshops and four to five scenarios as well as staff completion of multiple-choice questions at the end of the day.

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We were told the last two simulations included the management of a child with croup and sepsis. Croup is a respiratory infection that is usually caused by a virus and can range from mild to severe in its presentation.

We reviewed the feedback provided about the multidisciplinary team's performance on the sepsis session and noted that team performance was recognised as effective. One recommendation resulted from this scenario.

Deteriorating child training and spotting the sick child updates were provided on alternate years.

In addition, two yearly updates in paediatric AIM was provided to staff. We reviewed one of the AIM sessions completed by staff in 2019/20 which confirmed that staff competences were satisfactory. Seven paediatric nurses and four recovery staff had completed the paediatric AIM training in 2019/20. In addition, three new paediatric staff completed the AIM training in January 2020.

Sepsis Training:

Sepsis guidance was available in the form of the paediatric septic six tool. Sepsis scenarios delivered included the management of a child with sepsis and the management of a child with leukaemia.

Sepsis training was part of the paediatric immediate life support (PILS) and European paediatric life support (EPLS) training sessions. The last sepsis training session took place on the 4 November 2019; feedback from this scenario identified no practice concerns. Another sepsis talk was planned for 27 March 2020.

Staff confirmed they had also received sepsis information in leaflet form to take away.

Paediatric Life Support Training:

We reviewed paediatric life support training figures against the training attendance register and noted that 89% of staff had completed paediatric basic life support training. The shortfall was because additional staff groups had been identified to attend this training recently following a training review of staff groups who would benefit from this training. We were told of the 126 staff identified to complete this training, 15 staff were to complete this training by the end of March 2020. Staff said some of these staff groups included administration, radiology and physiotherapy staff.

Paediatric immediate life support training attendance by staff from November 2019 to February 2020 confirmed attendance from 73% (46 staff) to 88% in February 2020. The shortfall in attendance was due to the employment of new staff who were due to complete this training. An additional eight staff had been booked onto the PILS course which meant that 100% compliance in attendance at this training would be achieved by the end of March 2020.

European paediatric life support (EPLS) training compliance was 88%. Staff informed us that this shortfall was because one nurse's EPLS training had just become out of date prior to the inspection. Following the inspection, the provider confirmed that EPLS training compliance was at 100%.

Training records confirmed that five children's nurses had completed EPLS training and two new children's nurses were about to attend the EPLS training. We tracked the children's ward rotas from August 2019 which confirmed that on each shift when the unit was operational at least one children's trained nurse with EPLS training was present.

The children's ward daily roster recorded the level of resuscitation competency for staff members on each shift. In addition, the resident medical officer (RMO) had the European paediatric advanced life support qualification and was experienced in this area. The RMO was on duty 24 hours.

Additional training had been put in place for March 2020 for paediatric basic life support and PILS.

The recovery team lead, and the training lead had also completed EPLS training. The recovery lead had also completed paediatric cannulation training.

Four recovery nurses had completed the paediatric immediate life support training; whilst, two recovery staff had completed the paediatric AIM study day.

Staff said that operating department practitioners (ODPs) had been encouraged to complete EPLS training. The EPLS training for ODPs was to commence from June 2020.

Consultants were offered opportunities to undertake paediatric and adult basic life support at Spire Leeds and level three safeguarding training as part of the educational requirements to maintain their practising privileges for children and young people.

Services for children & young people

Induction

Staff confirmed they had received an induction to the service. The induction comprised of hospital and local inductions. Study day one comprised mandatory training and staff were introduced to the Spire Hospitals 'Purpose' which was launched in the summer of 2019.

We reviewed one nurses training and induction folder. The folder confirmed the induction activities completed and ongoing training attendance. Examples of training attended included hand hygiene, nutrition, chaperoning, anaphylaxis, safeguarding adults and monitoring vital signs in patients.

A new starter folder was also in place which provided information about the hospital/service.

Each member of staff had an induction personalised to their needs and included a 12-week probation period. Staff told us that the length of probation periods were dependent on the experience of the new nurse/staff member. Staff said they also had an option to review/renew the probation period. When we spoke to staff, we were given examples to confirm this.

All children's nurses rotated between the ward and the outpatient's children's clinics.

Staff had follow-up one to one meetings at four, eight and 12 weeks where their progress was reviewed.

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.

At a corporate level the group clinical director was the designated children's safeguarding lead for the Spire hospitals group.

The children's safeguarding lead at Spire Leeds Hospital was the lead children's nurse.

The lead children's nurse attended the local clinical commissioning group (CCG) health advisory group and the Yorkshire and Humber named nurses forums.

The paediatric team had open access to the Leeds Front Door safeguarding hub. The front door service is where people can access children's social work services when they feel that a child or young person is at risk of harm.

Staff showed us the latest annual safeguarding report which fed into the local clinical commissioning groups safeguarding audit programme.

Safeguarding children and young people's policies were in date and available for staff to access via the hospital intranet. The policy/procedure was comprehensive. Guidance included child sexual exploitation, female genital mutilation, was not bought, treatment of children/consent, mental capacity and looked after children. The appendices included further guidance, for example, escalation process, PREVENT strategy and missing child flowchart.

When a girl under 13 years was sexually active, we saw guidance/protocols in place to guide staff.

- Children's nurses had access to the Royal College of Nursing restraint guidance for reference although restraints had never been utilised at the hospital for any patients.

Safeguarding incidents were identified as serious incidents and reviewed through the hospital incident process. The safeguarding team could also access Leeds care records, so they had accurate and up to date information in relation to the child's and/or young persons. Incidents were also discussed at the hospital's paediatric steering and clinical effectiveness groups.

There had not been any serious case reviews in the last 12 months.

The hospital were also involved in the multi-agency risk assessment conference (MARAC) which is a victim focused meeting attended by key agencies where high-risk cases were discussed. All paediatric staff completed domestic violence training.

Weekly environmental risk assessments were completed in all areas that children were present to maintain their security.

When a child or adolescent aged up to 18 years was assessed by the Spire hospital pre-assessment team or ward staff a 'Safeguarding Children Checklist' was completed and placed at the front of the admission notes. We saw this checklist completed within children's and young people's medical records.

Services for children & young people

Staff said that should an under-age mum or pregnant young person enter the service they would assess the young person's capacity and understanding and raise this as a safeguarding concern to the local children's safeguarding service.

Staff said where patients were considered high risk or had capacity issues weekly capacity meetings took place.

When children and/or young people were not brought to their hospital appointment this was followed up by the children's nurse, the GP would be contacted, and concerns would be raised through the local Front Door service. Information about children/young people not brought to their appointment was also raised at the daily 'ten at ten' multidisciplinary team meeting.

All paediatric staff had received quarterly supervision with the named nurse safeguarding lead from the local CCG. Staff could also request individual safeguarding supervision sessions. The level four safeguarding leads had monthly individual safeguarding supervision sessions.

All paediatric staff who had direct access and provided care to children and young people had completed level three children's safeguarding training.

All the staff we spoke with confirmed they knew how to identify, and report abuse and neglect. Where necessary staff said they would discuss individual cases with the local safeguarding board.

Staff said best interest meetings were held as required to ensure the safety of the child and/or young person. Two staff described the last best interest meeting and its outcome which had taken place in January 2020.

Staff said they received children's newsletters from the local safeguarding children's board.

Safeguarding Training:

Safeguarding children's training was completed by designated staff at level two to level four.

All consultants had level three safeguarding children's training.

Safeguarding level two adults and children's training was included within the identified mandatory training; 100% of staff had completed this training.

In addition, all paediatric staff received additional face to face level three training with the local safeguarding children's partnership.

Spire had a level three safeguarding online training module which was completed as a minimum every three years. All clinical staff involved in the direct care and planning of care of children completed level three safeguarding training. Training figures and discussions with staff confirmed that 99% of all but one staff member had completed this training.

The lead children's nurse, matron and governance lead had completed level four safeguarding training. The lead children's nurse had also completed a master's degree module in safeguarding and the Law.

A three yearly rolling programme was in place for PREVENT training with yearly top ups.

Staff had annual face to face updates. In 2018, child sexual exploitation and female genital mutilation. In 2019, contextual safeguarding updates were given and further sessions were booked completed in early 2020.

Autism training was completed in February 2020 as part of the paediatric nursing teams training.

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 environment was seen to be visibly clean.

Coronavirus information was displayed in the hospitals main entrance and people could access hand gel stations throughout the hospital.

Staff had received a Coronavirus briefing and staff said they were reviewing this situation daily.

Children's and young people's Methicillin-resistant Staphylococcus aureus and patient resistant coliforms infection status was determined at their preadmission assessment.

The Spire Leeds annual plan (2019) identified a strategic plan overseen by the Hospital Infection Prevention and Control Committee which ensured the hospital had in place, systems, competency and processes to achieve effective prevention, detection and control of healthcare

Services for children & young people

associated infections in place. The infection control committee (ICC) meeting minutes (21 June 2019) identified difficulties keeping up with the Leeds annual plan to date due to clinical demands.

The infection control committee (ICC) meeting minutes (21 June 2019) confirmed that the paediatric environmental audit scored 96% in May 2019; the outcome resulted in the removal of non-wipeable chairs from the paediatric area.

Paediatric cleaning and jobs rotas from 30 December 2019 to the week of 17 February 2020 confirmed daily and bi-weekly cleaning and jobs were completed.

Training records confirmed that 100% of paediatric staff had completed the annual infection prevention and control training session.

Hand hygiene audit results from July to December 2019 for the children's service confirmed 95% to 100% compliance against the three areas audited.

Antimicrobial stewardship identified no concerns within children's services.

A change in how children's toys were cleaned was agreed by the infection control committee in their meeting minutes dated the 21 June 2019 ; toys were to be cleaned with a recognised detergent. From October to December 2019 the paediatric infection prevention control audit score was 99%. Toys were cleaned daily following use. We saw 'Toys I have played with' boxes in every bedroom. The play leader had taken on responsibility for the cleaning and maintenance of the children's toys which were in use. Daily toy cleaning checklists from April to December 2019 confirmed that the toys were cleaned. Monthly deep cleans of toys took place, the last deep clean was on the 23 February 2020.

Handwashing advice was available in poster format in the child's folder by their bed and by sinks in clinical areas.

Staff were seen to have bare arms below the elbows and were observed to gel their hands appropriately.

No healthcare acquired infections were identified in children and young people in 2019/2020.

The paediatric service had identified an infection prevention control link champion who had protected time to carry out this role.

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

The paediatric ward was protected by electronic access-controlled doors.

Staff said external doors on the paediatric unit were alarmed; however, this was not demonstrated on inspection.

All children and young people were nursed in private, single rooms with en-suite bathrooms.

Child size toilets were not available in outpatient areas.

Children and young people in the theatre recovery area were nursed in the paediatric bay which was located in a recovery area shared with adult patients.

Environmental risk assessments were completed in all areas children and young people were seen in. We reviewed 16 completed environmental risk assessments and noted completion was mainly monthly within the outpatient areas. In addition, an individual risk assessment for the child's admission room was completed as part of their care pathway.

Staff said that children and young people who had mental health care needs were not cared for at Spire Leeds hospital. A ligature risk assessment and ligature point identification tool had been completed which identified potential ligature risks at Spire Leeds hospital. The completed ligature risk assessment was dated 5 February 2020 and the risk rating applied was very low. Some actions and progress made to date was identified against these actions which were identified for completion in April 2020.

We reviewed ten pieces of clinical equipment and noted they had all been either portable appliance tested (PAT) or had been serviced.

We also received service records for all the clinical equipment in use in the children's service which confirmed that all the equipment had been serviced in 2019.

From 15 July 2019 to November 2019 paediatric resuscitation trolley audits confirmed compliance from 97% (August 2019) to 100%. The audit also identified 100%

Environment and equipment

Services for children & young people

in relation to the correct paediatric defibrillator pads being with the defibrillator. Overall, the hospital's compliance in this area ranged from 96% (August), 99% (October 2019) to 100% for the remaining months.

We checked the paediatric resuscitation equipment in the theatre recovery, the children's ward and outpatients and noted that equipment was in date and daily and monthly checks of the equipment had taken place. Paediatric algorithm guidance was seen on the resuscitation trolleys and was also displayed in the children's ward office.

Resuscitation paediatric emergency care bags followed the child when required.

A paediatric resuscitation bag was located in the x-ray department which was next door to outpatients. We saw that staff undertook daily checks of the resuscitation equipment in this bag.

Control of substances hazardous to health substances were stored securely in a locked cupboard.

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.

Critical care advice and transfer was undertaken by the regional paediatric retrieval service.

If the hospital required further medical advice on paediatric issues, the consultant paediatrician and paediatric adviser to the group medical director, Spire hospitals was contacted.

An agreement dated 9 August 2019 for the provision of critical care transfer services for paediatric patients was in place with a local NHS trust. We reviewed the agreement with a staff member and saw it did not have a review date. The provider has since confirmed that the critical care transfer agreement was reviewed yearly.

Staff said that should a child collapse they were either taken into the theatre or anaesthetic room. Retrieval of inpatients was via Embrace. Embrace is a highly specialist, transport service for critically ill infants and children in Yorkshire and the Humber who require care in another hospital in the region or further afield. Should a child fall ill

in the outpatient's department, staff called 999 and kept the child where they were. Staff said there had been no instances where children had collapsed in the last 12 months.

Daily multidisciplinary team (MDT) briefings 'ten at ten', discussed issues associated with clinical safety, theatre and resuscitation huddles which provided assurance the hospital was safe.

We attended one briefing which was known in the service as a ten at ten MDT briefing which confirmed discussions of clinical issues, for example, return to theatre, did not arrive, incidents and paediatric activity throughout the hospital. On the 3 March 2020 four children and two young people were going to theatre. One young person had been risk assessed and was going to be admitted to the adult ward. Confirmation by the MDT that the hospital was ready for medical emergency, major incident and haemorrhage was given. The meeting was minuted and emailed to hospital staff.

The Spire resuscitation policy (clinical policy 12) for review June 2020 included paediatric resuscitation guidance and levels of training required for those who worked with children and young people. The resuscitation policy stated that children aged 12 and over were treated as an adult in the event of a cardiac arrest and anaphylaxis.

Children wore a colour coded wrist band which identified what size resuscitation equipment was appropriate for use on them should their condition deteriorate.

Weekly Thursday capacity meetings took place with theatre to look at planned admissions for the next week. An assessment criterion was in place to determine the child's/young person's fitness for admission to Spire Leeds Hospital.

Every child under 18 years of age underwent a clinical pre-assessment undertaken by a registered children's nurse to determine if they were clinically fit and suitable for treatment at Spire Leeds hospital.

Young people aged 16-18 years were risk assessed by a registered children's nurse before determining their suitability to be cared for under adult services.

Services for children & young people

Staff used paediatric early warning score (PEWS) charts to monitor children. The PEWS tool was utilised throughout the Spire hospital group and was age specific. Baseline observations were taken by staff whilst the child was in the pre-assessment clinic.

The age appropriate PEWS tool was used to capture information about a child's or young person's physiological status and as such alerted the practitioner should a deterioration in the child's health occur. We saw that PEWS recordings were taken where applicable and evidence of appropriate escalation was seen documented against two PEWS which had triggered.

In 2019/20 the PEWS audits confirmed 97% to 100% compliance against the Spire network average of 96%.

We observed that a log of parents names were kept in the ultrasound department/radiology when a parent accompanied their child into the diagnostic procedure so that staff were aware of which parents had accompanied their child when they underwent the procedure.

Local Safety Standards for Invasive Procedures were in place using the national Safety Standards for Invasive Procedures.

Leaders ensured that employees involved in the performance of invasive procedures developed a shared understanding and were educated in good safety practice, as set out in the national standards. Surgical safety guardians supported safety at the frontline. Staff received ongoing education through network learning and leadership of the specialist clinical director and were supported by the director of clinical services.

Performance of invasive procedures was monitored through clinical audit overseen by the surgical safety guardians and any associated actions for improvement were shared through the networks within Spire. The provider identified they did not complete surgical safety audits for children and young people specifically. During March 2019 – December 2019 (Q2, Q3, Q4) 45 patients' data was collected and four of these patients were under 18 years (8%). The overall compliance for this period, inclusive of adults and children was over 97%. Due to high compliance, an action plan was not required.

Staff had completed competencies in relation to specific procedures.

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 service was led by a designated senior nurse for children.

Staff said that staff and patient levels had allowed them to give the care required.

Staff said a staffing acuity tool was not used to determine staffing needs for the service. Instead, staffing levels were reviewed daily against the planned admissions.

The local paediatric policy for the Spire hospital identified that as a minimum nursing staff ratios must comply with Royal College of Nursing guidance, 'Defining staffing levels for children and young people's services (2011).

Staff said they did not have identified funded and actual staffing establishments for the children's service. Current staffing included:

- One lead paediatric nurse
- Four full time children's nurses
- Two children's nurses who worked 22.5 hours weekly
- One play leader who worked 22.5 hours weekly

Electronic rostering had been introduced.

Current vacancy factor was 0.75 whole time equivalent (wte.) registered children's nurse post. In addition, we were told that one wte. registered children's nurse was due to leave in 10 weeks' time.

The Spire group had a national specialist for children's services whose role was to educate the Spire Group in respect of children's services whose focus is on quality, and to further develop and improve services for children and young people across the network.

Daily agreed staffing requirements for the paediatric unit identified two children's nurses on duty at all times when there were inpatients at the hospital. Staff told us the pre-assessment clinic was supported by one registered nurse. The lead paediatric nurse worked Monday to Friday and was present on the ward to support staff clinically.

Services for children & young people

We reviewed staffing rotas from August 2019 and noted that there were a minimum of two children's trained nurses present on shift. We also noted that all shifts had at least one identified children's nurse with training in European paediatric life support. Staff told us that no staffing incidents were reported over the last 12 months.

The staffing board at the entrance to the unit provided safety information about the unit which included day and night shift staffing levels and the date of the last staffing issue which was identified as 14 August 2018. Staffing information for the 3 March 2020 confirmed day shift staffing levels as three registered children's nurses with European paediatric life support training and two registered children's nurses with paediatric immediate life support training, plus, one play leader. The ward was not open overnight on the day of our inspection, though overnight services were available as required and staffing arranged dependant on service needs.

All the children's trained nursing staff worked on the children's ward, in theatre recovery once they had obtained the relevant competencies and in children's clinics in the outpatient department.

Two bank children's nurses were used regularly. One was a paediatric intensive care nurse who worked in recovery. During the period February 2019 – February 2020 the following bank and agency shift cover was required:

- Agency nurse – Five
- Bank children's nurse for recovery – 64
- Bank children's nurse for the ward - 32

Sickness for the contracted children's team during the period February 2019 - February 2020 equated to 0.8% for the year. Bank staff usage was higher during this time period as children's nurse recruitment was ongoing. Staff said bank usage had decreased as more children's nurses were recruited into post.

Medical staffing

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

A paediatrician was not onsite whilst children were having surgery as they were managed by their surgical teams.

A named paediatrician provided support and advice to the Spire groups children's service and could be contacted as required.

All consultants caring for children and young people in either a surgical or anaesthetic context had provided evidence they had undertaken clinical paediatric activity within their scope of practice, and this was recorded on the consultant compliance register.

Every surgical paediatric patient was admitted under a named consultant with paediatric practicing privileges.

The surgical consultant reviewed and saw the child before surgery.

It was a requirement for the consultants to remain on call whilst they had a patient in the hospital and to attend on request. A hospital wide contact list was maintained for all doctors with practising privileges for staff to access if needed.

Cross cover arrangements were in place in the event consultants were unable to be contacted. This information was stored on their profile and reviewed biennially.

Children's records confirmed they were admitted under the care of a dedicated consultant and seen by the Consultant on admission prior to any treatment. Children's records confirmed they were seen by a consultant within 12 hours of admission.

The medical advisory committee considered all applications and advised the hospital director regarding eligibility for practising privileges and for their continuation, withdrawal, suspension or restriction; the hospital director made the final decision.

All consultants underwent an annual whole practice appraisal and provided copies of these. They also held and provided evidence of medical indemnity insurance, a nominated covering consultant, a disclosure and barring check, occupational health status regarding immunisations and the relevant children's and young person's training when they wished to treat children and young persons. Staff said that if any of these documents expired, practising privileges were suspended. Weekly monitoring and reporting took place to ensure that all the necessary documentation and checks had taken place.

Services for children & young people

Practising privileges were formally reviewed every two years and annually for wholly-privately practising consultants.

Surgical consultant staff were described as approachable and responded to any questions and support required.

The resident medical officer (RMO) communicated changes and updates at the daily multidisciplinary bed meeting. This was recorded on the senior nurse sheet and bed meeting minutes.

RMOs worked a seven-day rota. Ward rounding, and duties were coordinated with the ward staff to ensure that protected sleep time was facilitated. The RMO had a dedicated bedroom and living space within the hospital whilst they were on duty. Two RMOs were employed through an agency. Information provided by the provider confirmed that the RMOs curriculum vitae which included mandatory training modules completed with dates, was reviewed by both the agency and the director of clinical services / ward manager prior to their first shift, along with evidence of any additional practical training. The national contract set the quality standards for RMOs across the Spire network of hospitals which included European paediatric advanced life support. Additional training, such as Datix training was provided on site by the Spire e-learning system. Our discussions with the RMO confirmed they had completed an appraisal and training was completed through the agency provider they came from.

Staff told us that informal clinical supervision was provided to RMO staff by consultant staff.

Medical staff had completed level three safeguarding training and European paediatric life support (EPLS) training.

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.

Staff confirmed they had completed annual refresher training relating to records management.

Staff had recently received training on how to access children's and young people's safeguarding records through the local authority.

We reviewed 13 children's and young people's records and saw that they were all complete and seven records showed multidisciplinary team input into the child/young person's care.

The records contained the information needed to deliver safe care and treatment which were accessible to the multidisciplinary team.

Evidence of clinical review of care and treatment with senior clinicians was documented in children's and young people's records.

The records we reviewed included risk assessments; including safeguarding assessments. We also saw completed pre-operative assessments, patient observation checks, care plans and assessment of nutritional status.

The age appropriate paediatric early warning score (PEWS) tool was used to capture information about a child's or young person's physiological status and as such alerted the practitioner should a deterioration in the child's health occur. We saw that PEWS recordings were taken where applicable and evidence of appropriate escalation was seen documented against two PEWS which had triggered.

Children's records were paper based and kept securely in the ward office.

If parents and/or carers brought the child's national patient held records these were completed to inform children's community teams, health visitors and GPs of the treatment and care received by the child.

Records audits took place throughout 2019 where 10 records were audited. We reviewed four records audits and noted that compliance ranged from 83% to 100%, the lowest scoring area was the score for consultant documentation for two audits.

We also saw that 83% compliance was identified for intraoperative temperature recording in the December 2019 audit. We were aware of the actions in place to improve compliance against intraoperative temperature recording and the latest children's and young person's scorecard we received confirmed compliance at 93%. The target was 95% for intraoperative temperature recording.

- The October to December 2019 children's and young people's dashboard highlighted the following information captured within audits of records; PEWS

Services for children & young people

chart completion, pre-assessment documentation, temperature monitoring and the presence of a GP medical summary. The dashboard confirmed the following levels of compliance: PEWS - 100%

- Pre-assessment questionnaire – 100%
- Intraoperative temperature control - 83% - target above 95%

GP medical summary – 50% The action plan which resulted from the October to December 2019 audit identified actions to improve compliance against intraoperative temperature control and GP medical summaries presence in the child and/or young person's records. Staff told us that the application to Leeds Care Records had been accepted so staff could now access these records.

Medicines

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

Comprehensive medicines management policies and procedures (clinical policy 13) were in place.

Controlled drug audits dated 28 March 2019 and 27 June 2019 confirmed 100% compliance.

Due to the low usage of control drugs within the children's service a decision was made to withdraw these drugs from the unit. Access to control drugs for children and young people is made on a patient specific basis from Ward Two.

We undertook checks on emergency medicines and noted that they were in-date.

Medicines storage was noted to be secure, clean and tidy inside. Random checks of medicines confirmed they were in date.

The children's service shared a drug fridge with the adult ward which was next to them. One local anaesthetic cream was stored in this fridge. We reviewed the documented daily fridge checks which we saw were complete and no concerns were identified.

We reviewed five children's and young people's medicine charts and noted all relevant sections were completed. Each drug chart identified the child's and / or young person's weight, age and allergy status. All prescriptions within the medicine charts were signed and dated and writing was legible.

When we followed one child's patient journey, we reviewed their prescription chart and noted that all relevant sections were completed including reference to the child's weight and allergy status.

Patient group directions (PGDs) were in place for nursing staff to administer local anaesthetic cream. The PGDs were authorised in line with legislation and staff had signed to confirm they had received the relevant training and had read and understood the PGD.

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.

Incident reporting guidance was in place for staff. The key decisions and actions flowchart within the guidance directed staff as to whether the incident should progress down the serious incident investigation route.

Additional incident training was provided in July 2019 to staff on how to submit and manage incidents. The role of the investigator and further incident training was provided to staff during the hospitals 'Pause' week.

The staff we spoke with knew how to report incidents and understood 'duty of candour' and its role when investigating incidents and complaints.

Incidents were reported via the incident reporting system. Discussions of incidents took place daily at the morning 'ten at ten' daily safety briefing huddle and at the fortnightly rapid response panel meeting. A further review of incidents and shared learning took place at the quarterly clinical governance committee meeting and the medical advisory committee.

Learning from incidents were discussed and shared via the 'Datix Feedback / Shared lessons Outcomes' monthly newsletter, via root cause analysis (RCA) findings, learning summary briefs and at team meetings.

Services for children & young people

Two serious incidents had been identified during the February 2019 to February 2020 period. We reviewed the documentation associated with one of the serious incidents.

The root cause analysis (RCA) report named 'Patient transfer out' dated 6 June 2019; approved on the 26 September 2019 reinforced the paediatric early warning score escalation plan and the importance of accurate documentation and frequency of observations by the children's and young people's nursing team. Four recommendations resulted from this incident, all but one recommendation identified on the accompanying action plan were implemented. The outstanding action was to ensure the RCA was amended to include the recording of paediatric warning scores for children. A flowchart was produced which guided staff for children who required an unexpected extended stay.

We reviewed two incidents on inspection which confirmed a robust incident management process was in place and that learning had taken place.

Shared learning and lessons were identified from incidents.

Following the inspection, the provider asked for this information to be included in the report. The hospital had engaged with NHS Improvement's Learning from Deaths framework. Morbidity and Mortality was a key agenda item for the clinical governance committee and there was a quarterly national Spire learning from deaths report detailing learning from across the group. Spire has a very low level of patient mortality due to the nature of their elective service, but any surgical death would be subject to an independent full investigation.

Staff said the mortality and morbidity (M&M) committee met twice yearly to review trends and learning. We reviewed the M&M committee agenda dated 27 April 2020 and noted that quality and shared learning formed part of the April 2020 meeting.

Are services for children & young people 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.

Evidence based guidance was used to inform care. We reviewed five evidenced based guidelines, four algorithms and two good practice flash updates. The good practice flash updates related to chaperoning children and young people at Spire Leeds Hospital, and the new 'Was not brought' policy, which set out what staff should do if children were not brought to appointments.

All guidelines and algorithms were in date and demonstrated an ongoing review process had taken place. Monitoring and discussion of clinical guidelines and policy reviews were also documented in minutes of team meeting, clinical audit and governance meetings minutes.

Staff team meeting minutes confirmed that staff had received updates against new policies, guidelines, alerts and / or safety bulletins.

The 'was not brought policy' and the 'Was not brought' good practice flash summary document was added to local paediatric policy. Staff awareness in this area was updated through 'Was not brought' training sessions, videos and via the good practice flash route which identified the background, process and key actions to take in this area. This new policy was also discussed at the 27 February 2020 staff meeting.

The updated local paediatric policy for the Spire Leeds Hospital was issued in January 2020. This policy acted as a guide for staff and set out the criteria for admission to the hospital. The policy was written in line with evidence-based guidance from the Royal College of Anaesthetists and Royal College of Surgeons.

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.

Services for children & young people

Food choices were available which included special diets, for example diabetic, gluten free, renal, and textured and allergy diets.

A children's menu with freshly prepared meals was available and parents could also order a meal. We saw evidence of this during our inspection and there was a menu in the bedroom folders.

Tea and coffee facilities were available to parents and/or carers and were located throughout the hospital.

The hospital had introduced a fasting committee and identified champions to address non-compliance and provide training.

National guidance by the Royal College of Anaesthetists and Royal College of Nursing informed the service that patients should receive clear fluids up to two hours before surgery and food up to six hours. Fasting guidance approved by the paediatric anaesthetist (29 May 2018) was available to staff to access. The guidance identified up to three ml/kg of fluid should be encouraged up to one hour prior to surgery, for example, one to five-year-old children can have up to 55ml.

The paediatric nutrition assessment tool was completed for each child or young person as part of their pre-admission assessment. This determined whether they were at risk of nutritional deficiencies. Actions were identified against the treatment plans where children and young people presented as medium or high risk.

Patients were asked for feedback on the quality of food, with latest results October 2019 to December 2019 showed 91% positive feedback from patients.

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.

A pain assessment was performed at pre-assessment.

The faces and ruler pain tools were incorporated into the age specific paediatric early warning score (PEWS) chart.

We reviewed seven children's and young people's care records which confirmed that pain levels were assessed and recorded on an age specific PEWS chart.

Pain scores were audited quarterly, and 2019 results showed 100% compliance, against the Spire target of 95%.

The patient satisfaction survey asked the patient how well their pain was managed throughout their stay. Latest data October 2019 to December 2019 showed 84% of patients responded 'a great deal' to pain being managed (where the patient had pain to manage).

The December 2019 team meeting minutes identified that staff had received a paediatric pain update.

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 had been accredited under relevant clinical accreditation schemes.

Outcomes and audits were monitored and reported quarterly via the children's and young person's national dashboard which benchmarked results across the Spire group. A range of hospital specific audits and measurement tools were used, for example, percent of patients fasted with guidelines, percent of pain scores with every set of observations, complaints.

The Spire Leeds clinical audit report 2019 confirmed quarterly audits of the paediatric scorecard, paediatric early warning score, pain and children and young people's waiting times in the outpatients department took place. We reviewed some of these audits for 2019 to 2020 and noted high levels of compliance.

Two examples of improved outcomes during 2019/20 were:

1. Intra-operative temperature:

New processes were implemented to improve the outcome of measuring intra-operative temperature for children and young people and this was monitored through the children and young people's dashboard. Outcomes of this audit were reported through local and national governance processes.

Staff said since the introduction of a temperature management process an improvement had been observed in intraoperative temperature recording. The latest children and young people's dashboard confirmed compliance at 93% (target was 95%).

Services for children & young people

The children and young people's dashboard confirmed that the proportion of children and young people who were fasted within guidelines was 95% (target over 65%). Additional performance indicators showed very high compliance in the areas measured which contributed to positive patient outcomes.

Paediatric early warning scores were audited. In 2019/20 the PEWS audits confirmed 97% to 100% compliance against the Spire network average of 96%.

The hospital had a number of daily MDT safety huddles to ensure effective communication. This included a whole hospital huddle at 10am, a clinical safety huddle at 9.15am and other departmental huddles, for example, theatre and resuscitation.

Spire's monthly 'National Safety Update' highlighted new National Guidance (NICE) guidance, updated policies and internal and external safety alerts. These also included shared learning from other sites and were shared with all staff.

The children's service promoted health promotion activities via social media as well as onsite.

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.

The service had a children's services training plan and strategy in place.

All new staff completed an induction and went through a period of preceptorship.

Discussions with staff confirmed that throughout their induction period they had completed competency packs and been offered one to one support. We reviewed one nurse's training and induction folder. The folder confirmed the induction activities completed and ongoing training attendance. Examples of training attended included hand hygiene, nutrition, chaperoning, anaphylaxis, safeguarding adults and monitoring vital signs in patients.

The staff training schedule which identified individual staff members study days was displayed on the children's ward office wall.

Spire Leeds Hospital had identified pause days for staff when staff could attend training sessions. For 2020, four days were allocated to pause training sessions.

Staff said they had yearly appraisals. Appraisal data confirmed that all existing staff had an appraisal in 2019/20. Three new staff had joined the service, two staff had completed their probationary period and were due to have their first appraisal.

All paediatric staff rotated across the paediatric ward, children's clinics and theatre recovery. Staff said that they had completed additional training, for example, European Paediatric Life Support training to help equip them for these different environments.

Staff had completed the chaperone training pack prior to the rotation to outpatients commencement on the 27 January 2020.

Staff who cared for children in the operating theatre and recovery area had received additional training in caring for children. Please refer to mandatory training section.

Staff told us that they could access information about mental health guidance and had completed children's safeguarding training at level three.

Staff said they had completed training in the recognition of the distressed child.

The local children and adolescent mental health service (CAMHS) delivered autism awareness and a CAHMS update session to the children's team.

Outpatient staff completed paediatric competencies in anaphylaxis, child and young people, level three safeguarding and paediatric intermediate life support (PILS). All staff completed care of children and young people competencies. The level of competency was dependent on staff nurse level. The competency framework were updated centrally in the last year. We saw a completed competency document for a nurse in the children's ward.

Scenario training for outpatient staff had taken place. These training sessions were documented with action points and learning.

Multidisciplinary working

Services for children & young people

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

Discussions with staff throughout the service confirmed effective working between the multi-disciplinary teams. This was confirmed further by our observations of multi-disciplinary team interactions.

Staff said that consultants were always available for advice.

We saw discharge planning for babies, children or the young person involved members of the multidisciplinary team involved in their care.

We observed the discharge processes had been followed on the child we tracked.

The multi-disciplinary team provided clinical assessment and treatments using a child friendly approach, which utilised play and distraction therapies.

Staff could access the local CAMHS team 24 hours a day, seven days a week.

Seven-day services

Key services were available seven days a week to support timely care for children, young people and their families.

Consultant level staff provided out of hours cover. Ward nursing staff could ring the consultant surgeon directly if they were required out of hours.

If a radiologist was required, this would be initiated by the consultant surgeon or the on-call radiographer.

The hospital had a registered medical officer on site 24 hours, seven days a week, to provide medical assessment and treatment as required whilst the consultant was contacted.

Spire Leeds Hospital had a pathology service which operated 24 hours a day and included an on-call system to ensure continuation of services out of hours.

The out-patient department opened six days a week including evenings for flexible appointments for patients.

Radiology and pharmacy departments operated six days a week. Pharmacy services closed earlier on Saturdays. An on-call pharmacist could be contacted out of hours and at weekends.

Physiotherapy operated from Monday to Saturday including evenings (weekdays only).

The hospital also had a histology service that provided histopathological dissection and reporting of tissue samples for routine investigation and cancer diagnostic services. All other specialist testing that was not performed within the pathology department was referred to Spire Manchester.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Health promotion leaflets were displayed throughout the children's ward area.

Leaflets on bed wetting, daytime wetting, bowel problems and potty training were available for parents to take away.

A 'Signpost to local services' folder was available to children, young people and their families. The type of information provided included wellbeing information, for example, how to care for your wellbeing.

Mental health support was available to children, young people and their families when it was needed.

Leeds lets change cards were available to take away. Contact details were identified so parents and young people could contact them for advice on how to eat healthier and be active.

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.

All clinical staff participated in mental capacity training via Spire's mandatory training portal and additional further training, which included awareness of the deprivation of liberty safeguards, dementia awareness and PREVENT anti radicalisation awareness training.

Services for children & young people

Discussions with staff confirmed their awareness of consent processes, mental capacity and deprivation of liberty safeguards and best interests assessments.

Staff assessed young people's capacity to consent to care and treatment in line with Gillick competency guidance. Gillick competence is concerned with determining a child's capacity to consent. Staff said young people's Gillick competencies were assessed to support the choice of young people aged 16-17 years to be cared for within the adult services if appropriate. Young people aged 16 or 17 could consent to their own treatment if they were able to demonstrate a true understanding of their surgery.

We observed two children's consent processes. In one observation we observed the clinician take a medical history, explain the treatment choices, procedure and risks associated with surgery. The mother signed the consent form prior to the procedure taking place.

Consent audits were undertaken in 2019. One consent audit confirmed 92% compliance during the period October 2019 to December 2019 however, the remaining three audits confirmed 100% compliance.

Are services for children & young people caring?

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, and took account of their individual needs.

We spoke with nine children and young people and nine parents some of which had scored the service 10/10. Everybody we spoke with described positive experiences had with all the staff involved in their care. Special mention was made of the children's nurses and play leader.

Patients were cared for in en-suite rooms to maintain privacy and dignity. This also allowed for open visiting times for relatives and friends. Overnight stays for family and carers was also facilitated as required.

Patients had access to the Spire patient discharge survey (PDS) to describe their experiences.

Patient forums were established to review areas of concern and to give patients a voice. Recently a forum for young people was held in the hospital attended by nine young people who undertook the 15 steps challenge.

A quiet room was allocated daily in the hospital for patients and staff to utilise if required.

Volunteers were available to support clinical teams to deliver a compassionate and caring service. A dedicated patient experience lead could also be contacted.

The hospital's children and young people's team regularly linked in with local schools for health awareness and promotion and with the local high school to encourage students to consider careers in healthcare. They also involved local schools in fun activities such as a 'design a Christmas card' competition.

We saw the outcome of the patient on line survey for December 2019. This was a child specific survey which comprised of seven questions. The questions asked about food, staff, explanation, facilities, toys and rooms. The score achieved by this survey was 100%.

Emotional support

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

A play leader supported children and their families through their hospital journey. A dedicated playroom had been developed for use by children and young people.

A range of age appropriate toys, books and videos was provided. Children could also bring their favourite toys or comforters into hospital.

No toys or distraction aids were available in the radiology department or ultrasound room. Following our inspection, the provider told us waiting times in radiology were minimal. Staff said they would call the play leader to assist them if this was needed.

Free WIFI was available for children, young people and visitors.

The play leader used a character from a children's television programme to demonstrate the patient pathway

Services for children & young people

from pre-admission to discharge and/or follow-up. The play leader had developed a photo book with a play character to demonstrate the pathway the child would travel whilst at the hospital.

Bravery certificates and gifts were provided through an external provider. We saw that staff gave a bravery certificate and soft toy to a child prior to their discharge home.

Chaplaincy support was available for spiritual support.

A 'Signpost to local services' folder was available to children, young people and their families. The type of information provided included the bereavement support service for 0-19-year olds, strengthening family ties project through a local Yorkshire trust and wellbeing information, for example, how to care for your wellbeing.

Mental health support was available to children, young people and their families when it was needed.

We noted that age appropriate colouring/activity packs were located in areas where children and / or young people were seen and cared for.

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.

We saw evidence of discussion with family documented in eight of the 11 children's records we reviewed. Discussions held with children, young people and their parents confirmed their involvement in discussions about their condition/treatment plan and that explanations given were understood.

We observed one preoperative assessment which involved staff, parents and children. We noted that parents and children were involved and informed throughout these processes. Clarification was sought, for example, who was allowed to visit, allergies and medicines status were checked, and the child's temperature recording was taken. The second half of the assessment involved the play leader who checked the child's understanding, noted their favourite programme and explained what they should bring into hospital with them through the use of a picture book.

Feedback was encouraged through various means with responses publicised on 'You Said We Did' displays.

'Tops and Pants' was also used to capture information from parents, carers and .

'We are here to listen – tell us how you are feeling' poster was displayed on an information board.

Parents received an information pack about their child's treatment, hospital stay and aftercare to help them and their child prepare. If parents had any questions or special requirements, staff were identified by parents as being approachable.

We saw information specifically aimed at about how to prepare and what to expect during their stay. Two booklets were available; one had more pictorial information in.

'Rees Bear has an anaesthetic' is a story which could be read to children by their parents. It allowed children to ask questions and explore any worries they may have about what is going to happen during their admission. This information was from the Royal College of Anaesthetists (UK) and included a leaflet for parents.

Leeds safeguarding board and chaplaincy information was also displayed on an information board.

Child friendly information leaflets were available in the children's ward, outpatients/radiology. We saw that some leaflets were pictorial in content so that they could be explained to children.

A staff photo board identified the nursing staff who worked within the children's service.

The patient information board identified information about staffing levels, complaints information in five languages, who to contact following discharge and photos of the children's nursing team.

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

Services for children & young 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.

A children's and young people's inpatient and day care service was offered.

Staff said the children's and young people's service operated intermittently 24 hours a day/seven days a week. Mostly, the service operated Monday to Friday from 7am to 5pm. Weekend working only took place where there was planned surgery. In addition, an allergy clinic took place on Saturday mornings. For this quarter three additional allergy clinics were planned.

Free car parking was available for patients and visitors

The paediatric unit was a child friendly environment. The unit was decorated with murals and games which all children could access. A playroom was available in the children's unit.

The unit comprised of seven side rooms all with en-suite facilities and a television. The room was specially prepared for the child's or young person's admission to make the room feel as homely as possible. Beds were made up with colourful bedding and quilt covers, and a range of age appropriate toys were made available for children and young people to occupy themselves with whilst in hospital.

Parents could stay overnight; an additional bed was provided in the child's room for the parents use.

Toys and electronic entertainment were available for children and young people to access. We saw that interactive toys were available.

Two toy cars were available for children to go to theatre in if they wanted to use them.

Flexible visiting was available 24 hours for parents of children who were in-patients.

The service had undertaken a '15 step challenge' with the help of previous young people who had used the service. The challenge looked at all areas children and young people either visited or were cared for during their visit to the hospital. Following the 15 steps challenge the following initiatives were implemented:

- Colourful staff name badges
- Teenager activity packs were introduced

- Bean bags have been purchased for the play room
- Child friendly toilet door pictorial signs are now in place on the children's ward.

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 patients access services. They coordinated care with other services and providers.

Children and young people who required surgery were invited to a pre-admission visit. The pre-assessment appointment allowed the parent, child or young person to ask questions about the operation and hospital stay. It was at this stage that any questions were answered, and special requirements identified.

Adolescents aged 16-18 were pre-assessed by the paediatric team. At this pre-assessment the option was given to the child regarding his/her choice of care within the paediatric setting or adult setting. We saw that a paediatric risk assessment was carried out to support this decision when we reviewed young people's notes.

A play leader supported children and young people through the hospital journey. The playleader worked 22.5 hours per week and was involved in preadmission processes, admission and outpatient clinic activities. At pre-assessment all the equipment to be used during the child's/young person's stay was introduced to the child and family.

Where children and young people were needle phobic the play leader worked with them to reduce anxieties associated with these phobias. The play leader was honest about how the procedure felt, described the needle as a straw and spoke about the magic cream which was used to numb the area where the magic straw would be placed.

The lead paediatric nurse had taken the lead for children and young people with learning disabilities. Staff said these children were assessed through a best interest meeting so that the right support was put in place prior to their admission/visit to the hospital.

Staff described how they had accommodated a young person with learning disabilities. They used the learning disability passport to capture information about the young person. The same two staff saw the young person when they visited the hospital and appointments for the young

Services for children & young people

person at quieter times of the day were considered so that they felt comfortable in the hospital environment. Protected parking was arranged for days the young person attended the hospital.

Translation services were provided for patients where English was not their first language.

Hospital passports were available and used with patients who had additional needs.

Chaperones were available for those young people who requested them.

Staff used communication aids to ensure effective communication took place where children and young people/parents have difficulties communicating.

Patient information was provided in a variety of formats, including large print, pictorial and audio versions.

There was a lot of child friendly information seen on the children's ward and in areas within the outpatient areas, for example, 'My visit to x-ray' was explained in pictures and 'Looking inside you – explained by Mr Mole'.

A 'spot the animal' game had been introduced to occupy children's minds as they travelled to theatre. We tracked one child from admission to discharge and saw that they participated in the 'spot the animal' game as they went to theatre in the toy car.

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 children's service breakdown of activity by age groups from November 2018 to October 2019 (Source - RPIR) identified that the majority of activity fell within the three to 15-year age group. Children's activity statistics confirmed inpatient and day-case discharges and outpatient attendances. In total within the three to 15-year age group activity was identified as 3858 or 4% of activity.

Referral to treatment figures from August 2019 to January 2020 confirmed that 97.5% to 100% of children and young people were seen within the 18-week performance target

timescale. Eight children and / or young people were seen after 18 weeks. The provider has confirmed that those children seen outside of the 18-week window was due to patients 'choice'.

People were supported to access the service. The access information was displayed in the main hospital reception area and advised patients and families what access tools were available, for example, a hearing loop and how to request the equipment.

The 'Local Paediatric Policy for Spire Leeds Hospital' (v19) with an issue date of January 2020 identified criteria for admission to the Spire children's service. The hospital accepted children over 10 kg in weight for admission. Every child had a clinical pre-assessment by a registered sick children's nurse two weeks prior to admission.

Pre-assessment clinics took place.

The online booking service improved control and access to patients for booking appointments

The private GP who saw children for a private GP appointment could refer the child or young person on to a specialist consultant where it is appropriate.

Patients were offered a choice of consultant and appointment times to suit them.

The lead children's nurse and children's nursing team oversaw children's outpatient clinics.

In outpatients, children's clinics were predominately ear, nose and throat (ENT) clinics. Two clinics took place weekly run by paediatric ENT surgeons. Children and their families were given the option of when to be seen in clinic. A children's nurse was present at this clinic.

Children from the age of five years had scans in the magnetic resonance imaging department. Should a young person be pregnant the scan would not take place until discussions had taken place with the radiologist and paediatrician. In radiology pregnancy checks start from 12 years of age.

Children's waiting times in the outpatients department were monitored quarterly. The October 2019 to December 2019 audit of 15 children's experiences confirmed that five children waited five minutes longer than their appointment time. The remaining 10 children were either seen on time or before their appointment time.

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A wide selection of paediatric clinics took place at the hospital, for example, paediatric medicine, dermatology, general surgery, urology, orthopaedics, private GP, ear, nose and throat, cardiology, plastics and ophthalmology.

Friday allergy and immunology clinics which were led by paediatricians took place.

There were no dedicated children's theatre lists; children's surgery took precedent on all lists.

We followed one patient through this surgical pathway and saw that the parent accompanied their child to the operating theatre and stayed with them until they were asleep. The nurse and the parent then collected the child from theatre recovery and took them back to the ward.

To reduce the length of inpatient stays, children with catheters were discharged home and returned to hospital one week later for catheter removal. Staff said if parents had concerns they could ring the paediatric ward or access the consultant for support.

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 patient experience manager was responsible for overseeing the management of complaints. Oversight of complaints are shared with the hospital director and senior leadership team at the weekly complaints meeting.

The staff we spoke with knew how to manage complaints and understood 'duty of candour' and its role when investigating complaints.

A complaints policy was in place.

Complaints information could be accessed in a variety of languages on request.

'Please talk to us' and 'We're here to help' hospital leaflets were available for children and families to access. They informed people of the complaints process, stages of the complaints review and introduced the private patient advisor team.

Comments and suggestions could be posted in the comments box which was located just inside the entrance to the paediatric ward.

During 2019/20 the service had no complaints. In 2019, three complaints were received which related to young people in the wider hospital service. The three complaints related to outpatients and the adult ward.

We reviewed two complaints and noted that both were fully investigated, had met investigation timescales and had resulted in actions.

Staff received feedback about complaints at their team meeting sessions. We reviewed three team meeting minutes for December 2019 to February 2020 and noted that no complaints were made in respect of the children's service.

Are services for children & young people well-led?

Good 

Our rating of well-led improved. 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.

Following the previous CQC inspection on the 11 December 2018, in July 2019 an internal review of paediatric services took place managed through the Spire Group. A new hospital director was appointed to post in 2019.

The re-evaluation of the organisational structure resulted in the creation of a head of governance role. The head of clinical governance was appointed in April 2019 to ensure consistency in safe service delivery, support for staff and governance standards. The existing clinical governance team was to be strengthened with the appointment of a further clinical governance nurse in 2020. The leadership

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team ensured that clinical governance and patient safety was of the highest priority within the hospital, by promoting the Head of Governance into the senior management team structure.

The paediatric steering group reviewed and guided the implementation of national and local paediatric policy. This body managed clinical governance for the paediatric service in line with regulatory guidance, promoting best practice in all aspects of paediatric patient care.

The Spire group appointed a corporate lead children's nurse in September 2019 whose role was to educate the Spire group in respect of children's services and whose focus was on quality. Discussions held with this nurse confirmed their awareness around what previous issues were identified following the last CQC inspection. This staff member said they had worked closely with the children's team and management teams at the Spire Leeds hospital to improve the culture, children's strategy, key performance indicators and ways of working within the service. Discussions with different staff groups confirmed they felt supported by the corporate lead for children's services.

A senior manager was on-call 24 hours a day, seven days a week.

The paediatric nursing lead reported to the director of clinical services.

The lead for children's services was a member of the Spire Healthcare national children's and young people's steering group, supporting the development of services, policies and improvements.

A paediatrician who was not based at the hospital provided clinical support for the paediatric service.

The senior management team (SMT) had an open-door policy and were visible and approachable. Visibility of the SMT across the hospital enabled an open culture of soft intelligence reporting by staff.

Monthly hospital leadership team meetings, weekly senior management team action plan meetings and monthly formal SMT meetings were in place.

A staff recognition and reward programme "Spire for you" was in place. We saw discussions take place at the 'ten at ten' meeting when staff were asked whether they had staff members they wanted to recognise and the reasons why.

Staff were encouraged to develop their leadership skills; one staff member was being supported to complete the NHS Leadership Academy course.

Staff said they felt supported by the heads of department and the senior management team, for example the director of clinical services was visible and visited the children's ward daily.

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 Spire Hospitals 'Purpose' was launched in the summer of 2019. The purpose stated, 'Making a positive difference to our patients' lives through outstanding personalised care.' Staff said the introduction had been supported through staff attendance at training and the use of DVDs.

Staff said an overarching group strategy for children and young people was in place. Staff were involved in its development through regional service specific cluster groups where children's and young people's services were discussed and learning and ideas for improvement shared. Comments were received through email and team calls.

A paediatric philosophy of care was in place and displayed in the paediatric ward.

The children and young people services strategy 2020 was in place. The strategy identified the Spire's children's services purpose, values, and the three strategic objectives which formed the basis of a national approach for children and young people during 2020.

The children and young people strategy 'Fix, Build, Grow' was launched in February 2020 and documented in the minutes of the February 2020 paediatric steering group.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The

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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.

Spire Leeds Hospital introduced a 'Pause week' which involved all staff to bring everyone together to launch Spire's Purpose and provide time to regroup as a team to lay the foundations for improved future working relationships with the regulators. This has provided the platform to embed the new purpose into everyday practice.

Staff described and we saw a culture of recognition, reward and celebration through the implementation of 'Inspiring People' awards. We observed discussions of 'Inspiring People' at the 'ten at ten' safety meetings where two staff were identified to receive them from the multidisciplinary team. A third staff member from the children's ward was also recognised as they had received a 'love heart' from a patient they had cared for.

Staff we spoke with said they felt supported and 'it was a really nice team'.

Staff commented on how the culture had changed for the better and described management as very approachable.

Staff said they had received really good feedback about the care they provided which made them proud to work within the children's service.

A whistleblowing policy guided staff on how and why they should speak up. At Spire Leeds staff told us that there were no recent whistle blowing events.

The name and photo of the freedom to speak up guardian was displayed on the children's ward so that staff were aware of who to approach.

Staff we spoke with were aware of who to approach should they have any concerns.

The hospital confirmed there was a robust governance process for soft intelligence reporting and challenging consultant behaviours and performance.

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.

The hospital's clinical governance structure chart confirmed direct reporting from committees, forums and groups to the senior leadership team and hospital director. The paediatric steering committee and the medical advisory committees were identified within this structure.

The head of governance also had a background as a children's nurse. The existing clinical governance team was to be strengthened with the appointment of a further clinical governance nurse in 2020. Spire Leeds Hospital had identified a clinical governance improvement plan (2020) which identified improvements against four key areas. These key areas included: improve audit structure for 2020, continue to build and promote a prominent safety culture and utilise national documents on patient safety to improve patient care.

The national resuscitation working group was chaired by a national clinical specialist for resuscitation who reported to the specialist clinical services director for acute services. We observed that children and young people were identified as a standing agenda item within meeting agendas. For example, infection prevention and control committee, clinical audit and effectiveness committee and clinical governance committee meetings.

Paediatric service representation in the hospital governance forums included the daily leadership safety briefing, clinical effectiveness and audit committee, and all relevant clinical speciality committees.

The 5 August 2019 governance committee meeting minutes identified that children must be nursed on the paediatric unit at all times with no exceptions and that children must be first on the list for theatres. The hospital had a clear policy that all children under 16 must be nursed on a paediatric ward and this was fully implemented. Young people aged 16-17 had the option to be treated on an adult pathway and cared for in the adult ward. This was only facilitated following a positive risk assessment completed by a children's nurse. The paediatric steering group met three times a year to review and develop the provision of paediatric services within Spire Leeds Hospital. Membership included the paediatric lead nurse, paediatric surgeon, paediatric anaesthetist, paediatrician, director of

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clinical services, a safeguarding representative and a member of the Medical Advisory Committee. The paediatric steering group reported into the hospital clinical governance committee and medical advisory committee governance.

The paediatric steering group reviewed and guided the implementation of national and local paediatric policy. This body managed clinical governance for the paediatric service in line with regulatory guidance, promoting best practice in all aspects of paediatric patient care.

The group provided a forum to discuss the complexity of cases being admitted ensuring the most up to date appropriate care was available for all children at Spire Leeds Hospital. The group monitored the paediatric service and explored new paediatric initiatives. A paediatric governance report was presented to this group. One paediatric governance report which reported on staff whistleblowing concerns within the children's service was reported at the 29 April 2019 clinical governance committee meeting.

We reviewed the two governance and quality reports whose reporting period was from October 2019 to March 2020. Both included a children's and young person's section which reported on the children's dashboard, progress made against the clinical scorecard action plan, summary of incidents and lessons learnt, recruitment, training, complaints, family feedback and achievements since the last CQC inspection.

Managing risks, 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.

A dedicated risk lead was in place. The risk lead worked closely with the group head of risk to ensure the register and assessments were well managed.

The heads of department had completed a new health and safety programme in November 2019. The training took place over three days with an exam at the end. Staff said this was a new training programme and it was going to be circulated to all staff groups.

Quarterly health and safety monitoring of departments took place. The children's service last monitoring session took place on 26 November 2019 and identified all was satisfactory. One action identified that a no smoking sign was required for a cupboard where hazardous materials were stored. Following the inspection, the provider confirmed this had been implemented.

Learning from incidents were discussed and shared via the 'Datix Feedback / Shared lessons Outcomes' monthly newsletter, via root cause analysis (RCA) findings, learning summary briefs and at team meetings.

Good safety practice and incidents for learning in relation to surgical safety were shared centrally through the distribution of 'Good Practice Flash reports' (posters) and disseminated to teams locally at the morning safety huddle 'ten at ten'. Safety information was also discussed at governance and the medical advisory group meetings and via safety bulletins to all staff groups.

Benchmarking of key performance indicators was demonstrated on a quarterly basis in the national children's and young person's dashboard. The children's services dashboard identified whether indicators were green, amber or red and how these compared against the Spire national network. Action plans were generated when performance indicators fell below their targets.

The children's clinical dashboard for quarter four 2019 measured 24 indicators. The indicators were identified against the CQC key lines of enquiry: safe, effective, caring, responsive and well led. Fifteen indicators were measured using a green, amber and red rating criteria. Fourteen of these indicators were rated green. Targets were identified against each area, for example to achieve the pain target the audit rating was to be over 95%; Spire Leeds children's service scored 100% against the pain indicator.

Spire Leeds children's service had one red rating scored 83% for intraoperative temperature control. In response, additional training for theatre staff was put in place alongside ongoing monitoring. The latest dashboard rating for this area was 93% and rated amber. The Spire network average for this area was 89% against a target of over 95%.

The GP summaries indicator scored 50% against the Spire network score of 83% as GP summaries were only present

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in 50% of the notes following this audit. In response application to Leeds Care Records took place and staff could now access this facility. The October to December 2019 dashboard data was reported at 50%.

The clinical scorecard benchmarked the hospital against Spire comparators for key performance indicators. Performance was reviewed at the clinical audit and effectiveness committee, clinical governance committee and at the medical advisory committee with actions taken to reflect outcomes and performance.

Risk was a monthly agenda item at key hospital meetings.

Each department has their own relevant risks that are reviewed regularly and updated based on controls, assurance, gaps and actions.

The hospitals risk register identified the top five risks and associated risk ratings; none of the risks related directly to paediatrics. Spire Leeds top five risk ratings ranged from 12 to 20 in February 2020.

The children's service had a local risk register in place. We saw a copy of the February 2020 children's top risks. The children's risk register mirrored in part the corporate risk register in respect of prescription errors. The children's top risk ratings in February 2020 ranged from three to six which amounted to a green rating.

The service followed the Spire Leeds hospital business continuity plan in the event of a disaster / if the hospitals services were compromised. Clear guidance and accountabilities were identified as part of this business continuity plan.

Mandatory training reports were collated for the senior management team. The report we saw was dated from November 2019 to February 2020. Individual training attendance figures were not identified for the children's service as the figures had been captured as part of the ward mandatory training figures. We discussed this with staff and asked whether the children's training information could be filtered to show whether there was full compliance in this area. The information was filtered and confirmed 100% completion of mandatory training within the children's service up to 3 March 2020.

Scenario training attendance and outcome reports were sent to the senior management team monthly.

Managing information

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 group medical director for Spire Healthcare was the overall Caldicott Guardian to oversee the use and sharing of clinical information.

The director of clinical services was the identified Caldicott Guardian at Spire Leeds Hospital who oversaw the use and sharing of clinical information.

All staff had completed information governance training annually.

An information management information poster, 'How to transport confidential data' was seen on the wall of the children's ward office.

Staff said that all information was encrypted, and email traffic was secured through the use of information technology systems.

Staff were assigned nhs.net email addresses so that confidential information could be sent.

To comply with the Accessible Information Standard, Spire had a contract for information to be available in different formats to ensure patients of all abilities had access to important clinical information and this was referenced in patient letters.

The hospital used either the my hospital passport or the coming into hospital information booklets. Both booklets included a mix of pictorial and written information which informed staff about the child and / or young person.

The my hospital passport booklet was specifically aimed at people with learning disabilities coming into hospital and included information about the Mental Capacity Act – five key principles.

Staff said arrangements to meet with the child or young person and their family took place prior to admission to the hospital. This meeting acted as an introduction to the staff and enabled the child or young person to actively participate in the planning for their forthcoming admission. Where necessary other members of the multidisciplinary

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team were also involved in this initial meeting. Staff said they would ensure that the staff present at the initial meeting would be present on the day of the child's admission.

Staff said the child or young person and their parent or carer were given the hospital passport to take away to complete whilst at home. This passport or coming into hospital booklet informed staff of the child or young person's specific needs, likes and dislikes.

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.

Staff communication methods took the format of primary care and consultant newsletters, information boards, shared learning summaries and daily huddle briefs.

Staff said staff meetings usually took place when no children and young people were present on the ward. We reviewed three team meeting minutes from December 2019 to February 2020 and noted that permanent and bank staff attended these meetings.

A mini staff survey took place in October 2019.

The children's service responses were not reported separately so we were unable to determine any changes from the previous survey. The response rate identified 45/60 (75%) staff responses. The provider noted some significant improvements from the January 2019 survey. For example, 91% of staff felt the top priority in Spire Healthcare was the delivery of the highest quality patient care (up 15% from the last survey and 9% above the Spire network average), 89% of staff felt fully engaged at work (up 10% and 8% above the network average) and 100% staff reported they believed what they did at work made a positive difference to Spire Healthcare, 14% above the network average.

Children's and young people's newsletters kept staff informed of issues and learning within the service. We saw two newsletters displayed on the children's ward, the latest newsletter was dated February 2020.

Quarterly medical advisory committee meetings were held with consultant representatives across specialities to seek advice, escalate issues and share learning.

Recently a young person's forum was held in the hospital. The forum was attended by nine young people who undertook the 15 steps challenge.

A quiet room was allocated daily for the use of staff and/or patients if required.

Three patient satisfaction pods were situated in the main reception area, outpatients and the ambulatory ward which allowed real time feedback from patients and hospital visitors. The patient experience manager had given immediate responses to any negative responses and dealt with any departmental issues arising. This had allowed those children and young people and their families the opportunity to feedback, rather than be sent an electronic version which may not be accessible to all.

Children's and young people's feedback cards were available to take away so feedback could be given when time allowed.

Tops and pants patient feedback was displayed on the children's ward.

Children's and young people's feedback given in December 2019 scored 100% in all areas. These areas included: 'The people who looked after me were nice', the doctors and nurses explained things in a way I could understand', 'I like the room', 'I liked the food,' 'I had enough to play with and the doctors and nurses explained what was going to happen'.

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.

Inspiring peoples awards were identified for individual staff. We saw this in practice at the services ten at ten multidisciplinary team meeting we attended where two staff members were identified for this award.

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Staff said they were proud that the Spire Leeds hospital held the licences to provide training at instructor level for European paediatric advanced life support, adult life support and immediate life support. The adult life support training license was awarded in December 2019.

A playroom had been developed in the children's ward. Staff said that they were waiting for funding to be confirmed so that they could develop the outside area immediately outside the play area into an outdoor play area.

Children and young people under the age of 18 years had safeguarding risk assessments.

Access to Leeds Care Records (LCR). Staff had been trained in how to access the LCR and were now able to access additional information which related to children and young people using the service.

Increased staff awareness of when children were not brought to hospital had been communicated hospital wide through 'was not brought' training sessions.

We saw additional improvements were adopted through ways of working and communication updates. These improvements included:





- Rotation of registered children's nurses to outpatients, radiology and physiotherapy.
- Increased paediatric team attendance at the ten at ten daily multidisciplinary hospital meeting.

To capture feedback and improve the child's experience the service had introduced an electronic survey for children and young people to complete.

To make the trip to theatre a positive experience children could ride in an electronic car and follow a game which followed the route to theatre during their journey to theatre.

A patient safety board was introduced and located in the children's ward corridor which provided information on when the services last complaint, last unsafe staffing episode and last incident took place. Additional information also identified current staffing levels and staffing resuscitation qualification levels.

Outpatients

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Information about the service

The outpatient department provided a variety of clinics such as orthopaedics, ear, nose and throat, ophthalmology and cardiology amongst others.

Between March 2019 and February 2020 there had been 55,392 new and follow up appointments across the outpatient services. Of these, there were 4059 children and young person's appointments.

During the inspection we spoke with twelve staff, reviewed fourteen patient records and spoke with ten patients.

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

Summary of findings

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

We do not rate effective in outpatients.

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

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

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.

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.

Outpatients

Are outpatients services safe?

Good 

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

We rated it as **good**.

Mandatory training

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

The hospital set a target of 95% for mandatory training for staff. Compliance with mandatory training was 100% for all staff across the outpatient department.

Staff received and kept up to date with their mandatory training. Mandatory training was provided as a mixture of e-learning and face to face training depending on the training course. Where staff were not up to date with training, leaders told us they were booked on to complete the training.

The department management had oversight of mandatory training compliance and leaders had access to electronic systems which enabled them to monitor training compliance levels across the services.

The mandatory training included training modules such as safeguarding, information governance and infection control amongst other modules.

Compliance for nurses in the department for immediate life support and paediatric immediate life support was 100%. The information highlighted where the renewal was due this was booked in for March 2020. Compliance for healthcare assistants with basic life support and paediatric basic life support was 100%.

The service had an up to date training policy.

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.

The hospital had safeguarding policies in place which staff could access and these policies were in date.

The hospital had safeguarding leads in place. Staff we spoke with could describe the action they would take if they had safeguarding concerns for patients across outpatients.

Safeguarding posters were on display in the department.

Safeguarding training compliance was 100% for safeguarding adults' level one and two, safeguarding children and young person's level one and two. Safeguarding level three compliance in outpatients was 100%.

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.

Areas visited were visibly clean and tidy. During the inspection we saw staff adhering to 'bare arms below the elbow'. We saw hand washing guidance posters on display in the department. Hand sanitiser was available and there were washing sinks available in the areas visited. Personal protective equipment was available in the department, for example gloves and aprons. Hand wash was available in the areas visited.

Consulting and treatment rooms had paper on each of the trolley beds to help prevent infection and we were told this was replaced after each patient.

There was an infection, prevention and control lead at the hospital for advice and support. There had been no infections in outpatients between January 2019 and September 2019. Staff told us patients with a communicable disease would be allocated to the end of a clinic list and there would be a deep clean afterwards as required.

There was daily cleaning in the outpatient department and waste disposal available for various types of waste across the outpatient services. Cleaning logs we saw in the consulting rooms and the department were completed as required.

Outpatients

We also saw 'I am clean' stickers attached to equipment in the department. Toys were cleaned daily and there were cleaning logs on display in the toy areas highlighting the daily cleaning.

The ear, nose and throat outpatient clinics used endoscopes for procedures. The department used a green bag and red bag system to ensure staff knew which endoscopes were clean or used.

There were infection prevention and control posters on display around the department. There was also an infection control newsletter for January 2020 on the notice board in the department with information for staff.

Seating in waiting areas and consulting rooms were in good condition and without rips or tears.

The departments completed hand hygiene environment audits, for example the November 2019 showed hand hygiene posters were available.

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 outpatient department had consulting and treatment rooms and a reception at the entrance to the main outpatient department. There was a cardiology and ear, nose and throat department in a separate area of the hospital. There was a nursing station in the outpatient corridor and the reception was staffed during opening hours in the department. Patients checked in at the main reception and would be directed to the waiting areas in the department. There were three waiting areas in the outpatient departments. Toilets were available in the outpatient department.

There was seating available in the waiting rooms for patients waiting for appointments. There was a quiet room available for patient and visitor use and this room was identified each day by staff at the daily 10 at 10 meeting.

There was waste disposal available in the department for clinical and non-clinical waste.

Consulting and treatment rooms had doors with keypad locks attached which enhanced the security of the rooms.

The outpatient department had access to a resuscitation trolley which was shared with the diagnostic imaging department which was next to the outpatient corridor. There was an adult resuscitation trolley. We checked recent dates, and these were checked as required. The resuscitation trolleys were checked daily and the trolleys were secured. There was an adult anaphylactic kit. These were sealed and in date. They contained items such as adrenaline.

We saw equipment had portable appliance testing stickers attached to equipment and these were in date.

There was signage directing patients and visitors to the various parts of the department. Wheelchairs were available for patient use across the hospital.

Staff had access to personal protective equipment such as gloves and aprons. These were available in each of the consulting or treatment rooms. We asked if there was enough equipment in the department and were told there was enough equipment, however the department had requested additional computers for staff use in the department, and this had been considered as part of the strategy. The hospital had a maintenance team which staff could contact if required. There was access to an information technology team for advice and support as required.

Leaders and staff had identified the challenge of the available space around the outpatient nursing station. This was being considered as part of the ongoing strategy in the department.

The service provided the outpatient planned preventative maintenance schedule which included the last date serviced.

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.

Safety checklists were in use in the outpatient department for example, when injections were provided or there were more invasive procedures being done. During the inspection we saw four safety checklists and found these to be completed as required. Staff described the completion and use of safety checklists, for example

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for eye injections which were done in the ophthalmology clinics. These safety checklists included information such as the step one sign in, step two time out and step three signature.

Where patients were clinically unwell or deteriorated during their visit to outpatients, staff would contact the resuscitation team quickly. There was medical and nursing staff available in the outpatient department during the day when outpatients were open.

There was a resident medical officer on site at the hospital.

There was a department risk assessment folder with risk assessments for the department.

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.

We were told there were no concerns with staffing levels across the department, although there had been challenges with staffing levels previously. We were told this had improved and during the inspection, the planned number of staff matched the actual number of staff. The rota for February 2020 showed the actual number of staff matched the planned number of staff on all occasions, except for two occasions where the hospital provided information stating numbers were made up by the supernumerary nurse on duty due to sickness. The service had plans to appoint a deputy senior nurse to the department to support the nurse managers.

There were eight registered nursing staff and five healthcare assistants with no vacancies across the department.

Staffing rotas were planned two weeks in advance and considered the type and number of clinics the service had booked, and department leaders used a recognised acuity tool which assisted in planning for staffing levels. Leaders told us safety assurance was provided by using the safe staffing tool to assist in managing staffing requirements. Leaders used a daily planner which

detailed which staff were working. This planner was used to schedule and then deploy staff. There were three shifts each day to ensure the outpatient department opening hours were staffed.

Oversight of staffing was maintained by the leadership team and where required if there were vacancies, the service would recruit. Where needed to ensure staffing levels were as required, bank staff would be utilised.

Medical staffing

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

Medical staff were not managed directly by the outpatient department.

Medical staff worked at the hospital under practising privileges and held outpatient appointment clinics as required in the department. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice or within the provision of community services.

Records

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

Records were mainly paper records across the outpatient's department. Records were stored securely, there was a secure storage facility in the department for patient records and the clinic room doors had key pad locks to enhance the security of records. Patient records were brought to the clinic rooms as required. Records were transferred to the department in a locked trolley.

We reviewed fourteen patient records during the inspection and found these were mostly completed as required, although we did find six records which were not always legible. There was evidence of consent in records.

Where required, there was evidence of surgical safety checklists in records. We saw eight surgical safety checklists, and these were completed as required.

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Where notes were not available for the clinic, staff would create a temporary set of records. The service worked with the medical records team and administration teams to ensure patient records were available for the clinics which were on.

In the previous three months, only one percent of patients were seen in the department without all records being available.

The department audited the surgical safety checklist. The most recent results showed out of ten surgical safety checklists audited, there was 100% compliance and between October 2019 and December 2019 compliance was at 97% compliance out of ten records audited.

Medicines

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

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

Medicines seen during the inspection were stored securely and the medicine cupboard keys were kept by a registered nurse or locked away in a cupboard. Medicines seen during the inspection were found to be in date. The service did not keep any controlled drugs and did not have any patient group directives in place.

There was a pharmacy department with dedicated pharmacy staff available where support and advice could be sought. The team ordered weekly items from the pharmacy department for stock in the department.

Medicines refrigerator checks were completed as required on the temperature logs.

The outpatient team had a document which they completed to indicate short dated pharmacy items stored in the department to contribute to managing stock in the department. There was also a short dated consumable log which staff completed to manage short dated consumables stored in the department. Short dated consumable logs for January 2020, February 2020 and March 2020 were completed as required.

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.

The service had an up to date incident reporting policy.

There had been no never events or serious incidents across outpatients in the previous 12 months.

The department staff had access to an electronic incident reporting system in outpatients and staff we spoke with were aware of this system and could describe how they would report an incident. Staff received feedback from incidents at the daily huddle or team meetings. There were also regular newsletters which included information on incidents as needed. Learning was discussed where required at the clinical effectiveness meetings and information from other departments was shared at these meetings.

Leaders in the department would investigate incidents and the clinical governance lead also had oversight of incidents across the service. There was feedback on display in the department with the shared learning outcomes from January 2020 which had information on incident feedback.

Staff we spoke with could describe the duty of candour. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Are outpatients services effective?

We do not rate effective in outpatients, however we found:

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

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guidance. Policies and procedures were available and accessible through the hospital systems. Policies viewed as part of our inspection were found to be in date. Staff in the service had access to policies such as incident reporting, mental capacity act and deprivation of liberty safeguards and the chaperone policy amongst others.

Evidence based care and treatment was used across the outpatient department. The department used the surgical safety checklists when required for invasive procedures in the department, there was awareness of aseptic technique and hand hygiene and there was information on display regarding sepsis in the department.

Nutrition and hydration

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

There were drinks available for patients attending the outpatient department. Staff told us they could provide patients with food and drink if required and for example, if a patient was a diabetic patient.

Pain relief

Pain relief was not generally provided in outpatients, although there were medical staff available for advice if required and where needed the service could provide prescribed pain relief.

Patient outcomes

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

The services at the hospital participated in audits. The department did participate in some internal audits, however many of the clinical audits were completed by the specialties, for example the surgical speciality. The previous inspection found improvements could be made to the audit programme in outpatients and at this inspection we found staff had implemented more audits across the department. For example, the staff had started to audit the surgical safety checklist across outpatients which was used for invasive procedures, department managers were doing a daily spot check consultation documentation audit which was to check records were completed properly.

The department had also completed a waiting time audit for when patients arrived in the department until they were seen. Staff told us the October 2019 to December 2019 waiting time audit highlighted no patient waited more than 15 minutes to be seen for their appointment once in the department.

The hospital provided information stating the outpatient service contributed to the hospital monitoring of patient outcome data.

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 received appraisals and these were overseen and managed by the leaders of the department. Appraisals were an opportunity to discuss objectives for the year. Information provided by the service highlighted all staff had received an appraisal in 2019 and for 2020 nine staff had objectives set and four staff were booked in to complete this in March 2020.

Staff received an induction programme to the hospital when they started working at the service. There was an up to date induction for new starters policy.

The department had a dementia lead and they had completed additional training to carry out this role. There was also other training available to staff, for example aseptic non touch technique training. There were staff who had taken on link roles in the department such as the tissue viability link nurse and there were specialist nursing staff in various departments, for example in urology.

Staff were supported to develop and complete further training. Additional training for staff where required or relevant, that had been completed, included enhanced communication training and dementia training. There were also competency packs which staff were required to complete to undertake certain roles.

Staff could attend conferences where relevant to their role and there had been updates on wound care provided to staff.

There was an up to date clinical supervision policy.

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Multidisciplinary working

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

The department staff worked closely with the admissions team and the wards if required when a patient required admission to the hospital.

Leaders described the work the multidisciplinary team were part of with other parts of the hospital such as the finance team.

The hospital held daily huddles which different teams and staff across the hospital attended to work together to plan and discuss the services for the day and this included outpatients.

Seven-day services

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

The outpatient department was open Monday to Friday between 8am and 9pm. The department was open on a Saturday morning between 8:30am and 12pm. The department was closed on Sundays.

Health promotion

The service had relevant information promoting healthy lifestyles and support in departments which were available for patients.

Consent and Mental Capacity Act

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Staff could describe gaining verbal consent and written consent.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We saw information on display regarding the deprivation of liberty standards and the mental capacity act.

The hospital had an up to date deprivation of liberty safeguards policy and there was an up to date consent to investigation or treatment policy.

Are outpatients services caring?

Good 

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

We rated it as **good**.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff followed policy to keep patient care and treatment confidential. Staff were friendly, approachable and introduced themselves to patients. A value of the hospital was 'Caring is our passion'.

Privacy and dignity were maintained in the areas we visited through ensuring doors were closed as required. There were keypad locks attached to the clinic room and treatment room doors to enhance privacy and dignity. The reception had a sign displayed asking patients to wait at the sign at reception to ensure patients could speak without being overheard at the reception desk.

There were signs on display in various areas of the department regarding chaperones being available. There was an up to date chaperone guidelines policy.

Patient feedback regarding compassionate care during the inspection was positive. Patient survey results we saw on display during the inspection was generally positive. For example, patient survey results from October 2019 to December 2019 showed 95% of respondents stated the services at the hospital met or exceeded expectations. In the recent hospital patient experience survey, which included outpatients, 78% of respondents were extremely likely to recommend the service and 16% were likely to recommend the service.

Emotional support

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

There were specialist nursing staff available in the various departments providing additional care and support to patients.

Staff could provide contact details for the specialist services so patients could contact the service after their visit if required.

Recent patient feedback from October 2019 to December 2019 on display in the outpatient department showed 96% of respondents received excellent care from nurses.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients were involved in their care and treatment and patients told us they were provided with treatment options.

Patients and their families could give feedback on the service and their treatment, staff supported them to do this. Patient survey results from October 2019 to December 2019 showed 93% of respondents stated they felt fully informed.

There was a dementia folder available for patients and visitors with information on local dementia services and social groups available to them.

When required, contact details of the outpatient's service were provided to patients so they could contact the department with any queries after their visit.

Are outpatients services responsive?

Good 

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

We rated it as **good**.

Service delivery to meet the needs of local people

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

Leaders described the way they planned and managed services across outpatients. Staff across the department worked with other services and departments across the hospital to meet the needs of people attending the service. Capacity and demand were managed by the department leadership team and the leaders attended the hospital capacity and demand meeting. The outpatient daily planner was considered as part of capacity and demand and they linked this to the inpatient capacity and demand information. Outpatients could accommodate additional clinics and appointments if required to meet demand.

Facilities and premises were appropriate for the services being delivered.

There was a choice of appointments available to patients and appointment times varied depending on the needs of the patients.

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.

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 could fast track patients through the department if needed and to meet their needs. The service also tried to minimise the need for additional appointments and would refer patients on the day for other treatments or procedures if appropriate and required, for example for scans. Staff told us they considered staffing levels when offering further treatment, procedures or consultations on the same day.

The service worked closely with other departments to meet people's individual needs such as the administrative teams and the diagnostic imaging

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department. There were dementia leads available for advice and support. A quiet room was identified at the daily huddle could be provided as needed to patients and visitors.

Staff were aware of care passports and would use these as required.

There were various leaflets on display and available throughout the department. There were patient information leaflets for example, for asthma.

Interpreter services were available and accessible as required.

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.

Information we saw and what staff told us during the inspection evidenced there were no issues with waiting lists across any of the specialties and patients would receive their appointment when needed. We were told if the medical staff had a clinic on the day a patient was referred, they could appoint a patient to the same day clinic if required and there was capacity.

Information provided by the provider highlighted the average waiting times for a national health service referral was between two to three weeks, although waiting times for ear, nose and throat were eight weeks.

A choice of appointment dates and time were available for patients. We were told patient received their follow up appointment date when it was requested by the medical staff and there were no backlogs of patients waiting for first or follow up appointments. Where requested, appointments were available on the next available clinic which could be the same day or next day. Information provided by the service highlighted urgent appointments were usually seen within 48 hours or at the patient's earliest convenience.

We were told NHS patients would be seen within 18 weeks of being referred to the hospital outpatient services, unless this was due to patient preference.

The service would offer the soonest appointment available for urgent and priority referrals for appointments. There were some specialties such as the breast care service which held urgent slots for appointments.

Where a patient required a follow up appointment, they could book their follow up appointment at the reception after their appointment or could contact the service by telephone to book their appointment. We were told the breach report would show patients who had no appointment allocated as there had been no activity with that patient.

Where appointments were delayed whilst in the clinic, staff informed patients verbally to inform them of the appointment delay.

Staff described what they would do when a patient 'did not attend' their appointment and this included passing the information over to the patient experience manager who was doing more work on 'did not attend' appointments.

The 'did not attend' rate for outpatients in January 2020 for National Health Service patients was 0.61% and in February 2020 was 0.57% and for all other patients was 0.58% in January 2020 and 0.55% in February 2020.

The service provided information highlighting the number of cancelled clinics was low, although the service did not audit the number of clinics or appointments cancelled in the outpatient department.

Outpatient clinic utilisation in January 2020 was 68.4% and in February 2020 it was 63.9%.

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 service clearly displayed information about how to raise a concern in patient areas. There were posters for what to do if you have a complaint. The department had processes in place such as suggestion boxes and feedback cards to encourage patients and visitors to provide feedback or provide suggestions to the service.

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Leaders told us they would try and resolve complaints informally if appropriate, however the complaint would be addressed formally if required. Managers investigated complaints. Managers shared feedback from complaints with staff and learning was used to improve the service.

There had been a small number of complaints in the department, these were mainly about waiting times. Between January 2019 and December 2019 there had been eight complaints in outpatients. The department leadership team were considering clinic utilisation in further detail in response to the patient satisfaction survey and in clinic waiting times.

The hospital had a patient experience manager who oversaw complaints to the services and there was a hospital weekly complaint meeting. There were various ways people could provide feedback to the service, for example by telephone and patient surveys.

Learning from complaints was completed through sharing learning with staff at the team meetings and daily huddles. The clinical governance committee meeting minutes from February 2020 included patient experience and feedback as an agenda item.

There was a hospital wide patient experience manager to support the complaints process.

The hospital had an up to date complaints policy.

Are outpatients services well-led?

Good 

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

We rated it as **good**.

Leadership

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

For our main findings please refer to the surgery report.

There was a clear leadership structure in place across the department. There was an outpatient nursing manager and deputy outpatient nursing manager who had direct reports including the registered nursing team and the healthcare assistant nursing teams. The outpatient manager reported to a senior manager at the hospital.

Leaders had an open-door policy and were visible in the department. Staff told us leaders were approachable and supportive. Leaders told us they had completed additional leadership training.

Leaders described the challenges and planned improvements regarding outpatients which included additional computers being required in the department and requiring additional administrative support for outpatients.

Business cases were used across the department and leaders told us quality was considered when completing business cases.

Leaders we spoke with could describe the duty of candour.

Vision and strategy

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

For our main findings please refer to the surgery report.

There was a clear strategy in place for the outpatient department and this could be described by the leadership team. This was documented and on display in the department. There was also a hospital strategy and leaders told us the local strategy aligned with the overall hospital strategy. Leaders told us they had considered service development, the environment and the patient satisfaction survey as part of the local strategy and contributed to the equipment plans as required.

The need for additional staffing resource in the administration team had been identified and this work was ongoing. Improvement of the utilisation of clinic rooms was being considered, for example improving the

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use of the colposcopy room. Leaders also told us the strategy included other work such as effectively communicating delays to patients in the department and to review the clinical space.

The three outpatient department objectives for 2020 were to review the clinical work station and treatment space, continue to work with medical records on records management in the department and to work with the paediatric team and other specialties at the hospital to improve the patient journey and development opportunities.

Culture

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

For our main findings please refer to the surgery report.

Morale was positive across the department and staff described good team work.

There were opportunities to develop further and complete additional courses and staff were supported to do these.

Morale was monitored through the staff survey, regular meetings with staff and leaders were visible in the department.

There was a hospital recognition programme to recognise and reward staff for their work. The hospital had recently recruited a patient experience manager to support work across the hospital including outpatients, for example on 'did not attend' rates and the complaints process.

The communication folder was used in the department to share information with staff. The January 2020 information included information for example, on policy updates, safety updates and staff development.

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.

For our main findings please refer to the surgery report.

There were governance processes in place across the outpatient department and leaders could describe these processes. Leaders in the department attended meetings to contribute to managing governance in the department.

There were three governance meetings the senior staff across the department attended. These were the rapid response meeting and the clinical effectiveness meeting which met on alternate weeks and there was a quarterly clinical governance meeting.

There was also a monthly senior nurse meeting which staff from the department attended. Escalation of issues and risks could be done through these regular meetings at the hospital.

There was a clinical governance organisational structure chart which applied to the hospital which included outpatients. This highlighted the various committees which were in place across the hospital and included, for example, the clinical governance committee and the health and safety/risk committee. The medical advisory committee was also included on this clinical governance organisation structure chart.

The clinical governance committee meeting minutes from February 2020 included agenda items such as detailed incident review, patient safety, clinical effectiveness, governance and compliance.

There was a governance calendar with meetings identified for staff to attend, for example, the cardiology services team meetings.

Incidents were reported through the incident reporting system and would be reviewed by the department leaders.

Managing risks, issues and performance

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

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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.

For our main findings please refer to the surgery report.

The hospital had an up to date risk management policy.

There was a department risk register which was reviewed regularly. Leaders could describe the risks attached to the risk register and the mitigation around the risk. There was one risk attached regarding security of doors and the team had acted to address this by putting alarms on the external doors. Risks were reviewed by department managers and the health and safety manager.

Clinical performance information was on display on notice boards for staff to review. There were issues identified in audits, the team used action plans to address the challenges.

There were electronic incident reporting systems used to report incidents across outpatients.

The teams used information such as incidents which had been reported to assess risk, performance and issues in further detail. The service also used information from patient feedback and complaints to the department to assess the performance of the service further.

The service participated in audits to monitor the services, for example through patient satisfaction surveys and hand hygiene audits.

Managing information

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

For our main findings please refer to the surgery report.

Leaders had access to the required information such as performance information regarding mandatory training compliance levels and patient survey results. There was access to electronic information systems such as the incident reporting systems.

We saw the accessible information standard information posters on display in various areas of the department including the reception area.

There were notice boards and information boards on display in the outpatient department to provide information to staff, patients and visitors.

Policies and procedures seen during the inspection were in date.

Engagement

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

For our main findings please refer to the surgery report.

There were daily huddles and regular meetings in outpatients. Relevant information was shared with the teams at these huddles and team meetings. The daily huddle boards included morning and afternoon information and key messages.

We also saw notice boards with information displayed for staff to review, for example the patient survey feedback results and the risk register information was on display.

Suggestion boxes were available for patients to provide feedback to the services. There were also 'you said, we did' information on display about what the service had changed in response to patient feedback.

The service completed annual staff surveys to enable staff feedback and the department completed patient satisfaction surveys to enable patients and visitors to provide feedback on the services.

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.

For our main findings please refer to the surgery report.

The department had considered improvements to the service and department as part of the departmental strategy.

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The department used audits to assess and monitor the performance of the department and to make improvements where required. Since the previous inspection, the department had completed more audits to monitor performance of the service.

The department senior staff attended the hospital process review meetings where the teams considered new services and improvements across the departments.

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Information about the service

The diagnostic imaging department provided general x-ray services, magnetic resonance imaging (MRI) scanning, computed tomography (CT) scanning, fluoroscopy services, ultrasound scanning, angiography services, mammography services and there was an image intensifier in theatres.

As at March 2020 and in the previous twelve months, there had been 3368 MRI scans of which 106 were paediatric scans, there had been 1521 CT scans of which 22 were paediatric scans, there had been 7686 x-rays of which 240 were paediatric scans and there were 3936 ultrasound scans of which 174 were paediatric scans.

During the inspection we spoke with fourteen staff, reviewed twelve patient records and spoke with five patients.

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

Summary of findings

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

We do not rate effective in diagnostic imaging.

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

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

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.

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.

Diagnostic imaging

Are diagnostic imaging services safe?

Good 

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

We rated it as **good**.

Mandatory training

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

The hospital set a target of 95% for mandatory training for staff. Compliance with mandatory training was 100% compliance for all staff across the diagnostic imaging department, except for one module which was 85%, although information provided by the service highlighted the training was due to be completed over the next few months. Information provided by the service stated as at 18 March 2020, 29 staff had received basic life support training and 25 staff had completed the paediatric basic life support training.

Staff received and kept up to date with their mandatory training. Mandatory training was provided as a mixture of e-learning and face to face training depending on the training course. Where staff were not up to date with training, leaders told us they were booked on to complete the training.

The department management had oversight of mandatory training compliance and leaders had access to electronic systems which enabled them to monitor training compliance levels across the services.

The mandatory training included training modules such as safeguarding, information governance and infection control amongst other modules.

The department had three trained radiation protection supervisors who had completed additional training to do this role. Radiographer staff completed radiation safety training each year.

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.

The hospital had safeguarding policies in place which staff could access and these policies were in date.

The hospital had safeguarding leads in place. Staff we spoke with could describe the action they would take if they had safeguarding concerns for adults or children across diagnostic imaging. Staff had access to a children's nurse at the hospital for advice and support.

Staff could describe using the 'pause and check' checklist. The 'pause and check' checklist was on display in departments during the inspection. The 'pause and check' poster is a clinical imaging operator checklist used in radiology departments for procedures. The pause part of the checklist indicates patient, anatomy, user checks, systems and settings checks, exposure and draw to a close.

The three-point identification check was used in the department. The three-point identification check included name, date of birth and address. We saw evidence of the identification checks being done and in records seen.

Safeguarding training compliance with safeguarding adults' level two was 100%, with safeguarding children and young person's level two training was 100% and compliance with safeguarding children and young person's level three training was 100%. There were 29 staff who were required to complete level three safeguarding children and young person's training.

Safeguarding posters were on display in the department.

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.

Areas visited were visibly clean and tidy. During the inspection we saw staff adhering to 'bare arms below the elbow'. We saw hand washing guidance posters on display in the department. Hand sanitiser was available

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and there were washing sinks available in the areas visited. Personal protective equipment was available in the department, for example gloves and aprons. Hand wash was available in the areas visited.

Scanning rooms had paper on each of the trolley beds and we were told this was replaced after each patient.

There was an infection, prevention and control lead at the hospital for advice and support. There had been no infections reported in diagnostic imaging between January 2019 and September 2019. Staff told us patients with a communicable disease would be allocated to the end of a scanning list and there would be a deep clean afterwards as required.

There was daily cleaning in the department and waste disposal available for various types of waste across the diagnostic imaging services.

Cleaning logs seen during the inspection were completed as required.

Patient led assessment of the care environment were completed. The information was for the hospital, although diagnostic imaging was included in the overall hospital audit information. This audit showed cleanliness was 99.79% compliant.

The service completed hand hygiene environment audits. Between October 2019 and December 2019, the hand hygiene environment audit showed areas checked were compliant. For example, this audit showed hand hygiene posters were available in the area.

Environment and equipment

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

The department was located next to the outpatient department in the hospital. There was a reception which was shared with outpatients. Patients were then directed to the relevant waiting area where there was seating and drinks available. Toilets were available in the department.

The department had a variety of scanning rooms such as ultrasound, x-ray, MRI and CT, changing rooms for patients, three reporting rooms where scans were reported by the medical staff and offices with computers.

There was seating available in the waiting rooms for patients waiting for scans. There was a quiet room available for patient and visitor use and this room was identified each day by staff at the daily hospital meeting.

The various departments within the diagnostic imaging unit had relevant warning signage on display to highlight restricted areas to staff, patients and visitors. The x-ray areas had lights warning of x-rays. There was also warning signage such as 'authorised persons only' on display.

We visited the magnetic resonance imaging unit (MRI) and equipment had the relevant MRI safe stickers attached as required.

The MRI unit had warning signage on display to highlight the risks to staff and patients. Patients, carers, staff and visitors had to complete a safety questionnaire before they could enter the MRI unit with staff.

Equipment such as lead aprons had annual audits to check for the lead apron integrity. There had been a lead apron audit completed in January 2020 which included screening checks and visual checks of the lead aprons.

We saw a board in x-ray with quality assurance information displayed, for example, there were yearly audit checks on this board, monthly quality assurance and cleaning logs. Checks we saw during the inspection were up to date.

There was waste disposal available in the department for clinical and non-clinical waste.

Rooms had doors with keypad locks attached which enhanced the security of the rooms.

The department had access to an adult resuscitation trolley. We checked recent dates, and these were checked as required. The resuscitation trolleys were checked daily and the trolleys were secured. There was an adult anaphylactic kit. These were sealed and in date. They contained items such as adrenaline.

We saw equipment had portable appliance testing stickers attached to equipment.

There was signage directing patients and visitors to the various parts of the department. Wheelchairs were available for patient use across the hospital.

Staff had access to personal protective equipment such as gloves and aprons. The hospital had a maintenance

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team which staff could contact if required. There was access to an information technology team for advice and support as required. There was enough equipment in the department for use.

There was an audit for the observation of staff working in a controlled area. This was done over a four-week period. The audit considered questions, for example, only essential staff present in controlled areas. The results from the December 2019 audit stated staff were fully compliant.

The service provided the equipment schedule for the diagnostic imaging department. This document included information such as the last service date.

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.

The department had access to an external medical physics expert, radiation protection advisor and the department had two radiation protection supervisors for advice. The radiation protection supervisors worked across the various areas of the department. Staff told us they had access to a radiologist for advice as needed. Radiation scenarios had been run to ensure that operators practised how to quickly terminate an exposure in an emergency if needed.

Where patients were clinically unwell or deteriorated in the department, staff would call the hospital resuscitation team and had access to a resuscitation trolley. Where a patient was clinically unwell or deteriorated in the MR imaging room, staff would transfer the patients to a trolley and remove the patient from the room. There was a procedure in place to remove patients from the scanner and into a trolley bay. The hospital provided additional information highlighting they had completed a simulation scenario and the latest had been completed in August 2019.

The service had local rules in place for staff to follow for their speciality area. These were on display in the various areas of the department. Patients attending the MR department had to complete a safety form prior to entering the scanning area.

The World Health Organisation (WHO) checklist was used for invasive procedures, for example injections. The surgical safety checklist audit from February 2020 showed 99% compliance for diagnostic imaging.

Staff in the department wore dosimeters and these were changed every three months. These were worn to monitor the staff exposure to radiation in the department. The department received a dose report for the dosimeters which enabled the department leaders to monitor exposure to radiation in the department. A dosimeter (TLD) audit from January 2020 showed 100% compliance. There were ten people audited. The audit was to ensure issued TLD's were worn by all staff working in areas where it was required.

Staff told us patients receiving contrast in the CT department stayed in the department for around 30 minutes after the procedure as a safety precaution. Staff completed basic life support training as part of mandatory training.

There were diagnostic reference levels on display in the various areas of the department. There was a procedure in the reporting room for significant findings on scans.

The safety forms used in the MRI department included questions, for example regarding pregnancy. This form was completed prior to patients going in for a scan and these were then scanned onto the electronic system for record keeping.

Staff used the 'pause and check' checklist in the department to check the correct patient was receiving the correct scan. We were told this was audited and we saw audits completed by the service, a previous month had not shown 100% compliance and the department leaders had put actions in place to address this and checked the documents for a week to ensure staff were completing the checks. The CT audit of information on the referral card from September 2019 showed 97.5% compliance. The general x-ray six-point check audit from September 2019 showed 95% compliance. The service completed an audit on the justification of referral in the MRI department and this highlighted there was 100% compliance with the three-point id check in line with pause and check guidance.

Risk assessments had been completed for various risks across the department. These were stored in a folder in

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the department and accessible to staff. Risk assessments seen during the inspection were in date, for example the radiology department risk assessment had been reviewed in June 2019.

There was a resident medical officer on site at the hospital.

Diagnostic Imaging 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.

There were no concerns with staffing levels across the specialties within diagnostic imaging during our inspection and the department had recently recruited additional radiographers to CT and MRI. There were eight senior radiographers and four health care assistants in the department. Information seen for January 2020 showed the actual staffing levels for the department met the planned staffing levels on all shifts.

All radiographers in the department were senior radiographers and there was a diagnostic imaging manager. There were assistant staff working in the department and a reception team facilitating bookings and directing patients to the appropriate waiting areas.

Staff worked in their speciality areas and as part of the ongoing strategy, leaders had included skill mix in the strategy as part of the service development to ensure skill mix was appropriate.

The staff in the department worked to set hours and therefore all shifts were covered as required. Rotas were done in advance to take into consideration factors such as annual leave. To assist in staffing challenges, the department used bank staff to ensure all shifts were covered.

A member of staff from the diagnostic imaging department attended the weekly theatre utilisation meeting to assist with planning staffing across the department.

Medical staffing

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

Medical staff were not managed directly by the diagnostic imaging department. The radiologists were not always on site, although staff told us they could contact radiologists by telephone if required.

Medical staff worked at the hospital under practising privileges and attended the diagnostic imaging at their set times. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice or within the provision of community services.

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.

Records were a mixture of electronic records and paper records. The department used a computer system to record details of examinations and where paper records were used, for example when surgical safety checklists or MR safety forms were used, these were scanned on the systems. Records during the inspection were securely stored. Staff had access to the required computer systems to deliver the care and examinations required.

During the inspection we reviewed twelve patient records. These were completed as required. There was evidence in patient records of surgical safety checklists being completed when required, identification checks and information and magnetic resonance imaging safety forms being completed.

Medicines

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

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

Medicines seen during the inspection were stored securely and the medicine cupboard keys were kept by a radiographer or locked away in a cupboard. Medicines

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seen during the inspection were in date. Medicines refrigerator checks were completed as required on the temperature logs. The service did not keep any controlled drugs.

The results from a medicine expiry date check for January 2020 and February 2020 were on display in one of the offices and this showed 100% compliance for January 2020 and February 2020 for medicine expiry checks in the department.

We looked at patient group directions (legal framework which allows registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber) in the department. These were up to date and signed by the appropriate individuals.

There was a pharmacy department with dedicated pharmacy staff available where support and advice could be sought.

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.

There had been no never events or serious incidents in the department. There had been two radiation incidents in the previous two years, although only one of these incidents was a reportable incident. Learning had been considered and the work to address it was ongoing. There had been 46 incidents between 7 January 2019 and 3 March 2020 and 34 of these were no harm, eleven were low harm and one was moderate harm.

The department staff had access to an electronic incident reporting system in the diagnostic imaging department and staff we spoke with were aware of this system and could describe how they would report an incident.

Staff received feedback from incidents at the daily huddle or team meetings. There were also regular newsletters

which included information on incidents as needed. Learning was discussed where required at the clinical effectiveness meetings and information from other departments was shared at these meetings.

There was evidence of lessons learnt in a folder which staff had access to and included information on lessons learnt from incidents which had occurred in the department. This folder included the January 2020 feedback information, and this included incident feedback and shared outcomes for the department team, and this was shared with the team every month.

Leaders in the department would investigate the incidents or would ask the relevant person to investigate the incident and we were told the clinical governance lead also had oversight of incidents across the service. The service completed the root cause analysis where needed for serious incidents.

Staff we spoke with could describe the duty of candour. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Are diagnostic imaging services effective?

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

We do not rate effective in diagnostic imaging, however we found:

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. Policies and procedures were available and accessible through the hospital systems. Policies viewed

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as part of our inspection were found to be in date. Staff in the service had access to policies such as incident reporting, mental capacity act and deprivation of liberty safeguards and the chaperone policy amongst others.

Evidence based care and treatment was used across the diagnostic imaging department. The department used the safety surgical checklists when required for invasive procedures in the department. The department had relevant safety information on display in the waiting areas and signage on display outside the scanning rooms as required. There was national guidance referenced in some of the audits for staff reference seen during the inspection.

Staff had access to ionising radiation (medical exposure) regulations (IRMER) policies in the department which were up to date.

The department displayed the diagnostic reference levels in the rooms and there were local rules as required in each of the rooms.

Nutrition and hydration

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

There was drinks available for patients attending the diagnostic imaging department. Staff told us they could provide patients with food and drink if required.

Pain relief

Pain relief was not generally provided in diagnostic imaging department, although there were medical staff available for advice if required.

Patient outcomes

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

The department participated in various audits and had implemented audits to monitor and assess the services, for example there were audits for the observation of staff working in controlled areas and an audit for the surgical safety checklist.

Other audits the department completed to monitor performance and the services included a medicines

management audit and monthly local rules audit. There was an audit for the justification of referral and the purpose of this audit was to ensure compliance with justification process and to ensure x-ray referrals are completed with information. Each year, the audit considered 25 referrals. The results of the most recent audit in September 2019 for CT showed 95% compliance against a target of 90%. The same audit for the MRI service showed 81% compliance in September 2019, 83.3% compliance in October 2019 and 96.7% compliance in November 2019.

The surgical safety checklist audit audited ten checklists. The most recent results which we saw during the inspection showed that for February 2020 compliance with the safety surgical checklist was 99%. This audit considered the sign in, time out and sign out checklist.

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 received appraisals and these were overseen and managed by the leaders of the department. Appraisals were an opportunity to discuss objectives for the year. Information showed all staff had received an appraisal in the previous twelve months.

Staff received an induction programme to the hospital when they started working at the service.

Staff had access to additional courses and training. There was also access to courses to support leadership development, for example, leaders had access to a managing performance course and root cause analysis training. The department had radiation protection supervisors who had completed additional training to do this role. Leaders in the department could attend radiology learning meetings.

Staff completed reflective work and there were study days on a regular basis which staff attended. Staff were encouraged to complete continued professional development. Radiographer staff received a radiation safety training session annually and there were MRI safety training sessions for the MRI team annually. There was also a presentation for new starters to the service on radiation protection and MRI safety.

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There was a continuing professional development calendar on display in one of the offices in the department for 2020 which showed what was offered for continuing professional development each month. For example, in September 2020, the calendar highlighted there was a planned group presentation on the role of the radiation protection supervisors and feedback from the radiation protection meetings.

Multidisciplinary working

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

For our main findings please refer to the surgery report.

The department staff worked closely with other hospital teams and the outpatient's team to provide the service to patients.

Leaders described the multidisciplinary team working they were part of with other parts of the hospital such as the finance team.

The hospital held daily huddles which different teams and staff across the hospital attended to work together to plan and discuss the services for the day and this included diagnostic imaging.

Seven-day services

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

The department was open between 8am and 9pm Monday to Friday, although on a Thursday there were extended opening hours until 9:30pm. The department opened on a Saturday morning until 12:30pm.

There were on-call radiographers 24 hours a day for general x-ray.

Health promotion

The service had relevant information promoting healthy lifestyles and support in the diagnostic imaging department.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Staff could describe gaining verbal consent and written consent and the use of the consent forms in the department.

The department had completed a consent to examination audit in January 2020. This showed MRI had 100% compliance from a sample of 20 patients, CT had 90% compliance from a sample of 20 patients, screening and ultrasound had 100% compliance from a sample of 20 patients and mammography had 95% compliance from a sample of 20 patients.

The hospital had an up to date deprivation of liberty safeguards policy.

Are diagnostic imaging services caring?

Good 

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

We rated it as **good**.

Compassionate care

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

The reception was in a separate room to the waiting area so patients could speak with reception staff without being overhead to contribute to privacy and dignity in the department.

Chaperones were available in the department and there were posters on display regarding this in the department and the waiting areas. We saw two electronic records which showed chaperones had been requested by patients.

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Privacy and dignity were maintained in the department by ensuring doors were closed where required and there were changing rooms in the department. Staff were discreet and responsive when caring for patients. The magnetic resonance unit had privacy blinds in the room to ensure the privacy and dignity for patients receiving a scan.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff introduced themselves to patients.

We spoke with five patients during our inspection and patient feedback was positive.

Emotional support

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

Staff spoke with patients during their procedure and scan and talked patients through what the process was and patients were able to take their own time and go through the procedure at a pace which suited them. Staff described having enough time to spend with patients during their visit to the department.

Staff responded to patients where they may be anxious or claustrophobic and could offer visits to the department before appointments to address patient concerns.

Additional appointment and scanning time could be provided to patients if additional support and care was required.

Understanding and involvement of patients and those close to them

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

Families and carers could stay in the scanning room with patients if this was requested and appropriate to assist in supporting the patient during their scan. There was information regarding x-ray's available and on display in the waiting room to provide further information on x-ray safety to patients.

The department had access to a play specialist at the hospital who could provide additional support and utilise distraction techniques as required for children visiting the department.

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

Where there were delays in appointments, staff would inform patients and visitors of this delay.

Are diagnostic imaging services responsive?

Good 

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

We rated it as **good**.

Service delivery to meet the needs of local people

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

For our main findings please refer to the surgery report.

The diagnostic imaging department provided a variety of scans to meet the needs of patients.

Leaders described the way they planned and managed services across diagnostic imaging. Staff across the department worked with other services and departments across the hospital to meet the needs of people attending the service. Leaders attended the process review meetings when there were service developments planned.

The services received referrals from local NHS healthcare providers. Waiting list information showed waiting times were less than six weeks across all services.

The hospital had introduced one stop breast clinics. These clinics enabled patients to attend to visit a doctor

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and a mammogram or ultrasound could be performed along with results. The one stop clinic included the diagnostic imaging department and scans would be reported during the one stop clinics.

Facilities and premises were appropriate for the services being delivered.

There was a choice of appointments available to patients and appointment times varied depending on the needs of the patients.

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.

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 could fast track patients through the department if needed and to meet their needs. There were appointment slots kept open for urgent patients who require a scan.

The service worked closely with other departments to meet people's individual needs such as the administrative teams and the outpatient's department. The quiet room which was identified at the daily huddle could be provided as needed to patients and visitors.

Interpreter services were available and accessible as required. Information was on display in various areas of the department in different languages regarding access to interpreters. There were a range of patient information leaflets available throughout the department. The department had a booklet with information on having an x-ray which could be read by patients and visitors and included pictures alongside the writing. This had been recognised as an outstanding piece of work by Spire's national team and had been shared as a national good practice flash across all Spire sites for implementation.

There was a 'x-rays and you, a brief explanation' poster on display in the waiting area providing further information on x-rays to patients and visitors, for example, information such as what x-rays are.

There were posters on display asking whether a patient may be pregnant, and these were in different languages.

Appointment scanning times varied depending on the type of scan and needs of the patient. Depending on the procedure, there was a letter sent with the appointment to provide information about the procedure. There was access to an information pack with information about the scan and what to do before and during a scan.

Staff were aware of the needs of patients and would support patients as needed. Staff made adjustments as required to meet people's individual needs. Staff had access to online dementia training and staff we spoke with had completed dementia training. There was information posters on display regarding dementia in the department.

Patients were offered a choice of appointments and provided with information prior to the scan where required.

The diagnostic imaging department did not monitor 'did not attend' information, although information provided by the service stated there were generally less than two 'did not attend' appointments each week. The service provided information on the process to manage the 'did not attend' process.

There was access to bariatric equipment from other departments across the hospital.

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.

Requests for scans were protocolled and screened by a radiologist prior to the scan. Appointment times were allocated depending on what the patient was having done. The number of patients attending for the day in the diagnostic imaging department was discussed at the hospital morning meeting.

During the inspection we asked the bookings team about access to appointments for scans and were told that for

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most scans, the appointment could be provided the next day if required. We asked about the six week waiting times and were told the waiting time for a scan across the various specialties would be up to one week.

Reporting from scans was completed the next time the radiologist was on site. Electronic patient records seen during the inspection showed the scans were reported within five days of being done. We saw nine records where this was applicable.

An audit of radiology reporting turnaround times for the department showed the target for reporting scans was five days from the examination to the report being completed. The audit sample was 100 examinations in April 2019, May 2019 and June 2019. In April 2019, there was 99% compliance, In May 2019 there was 100% compliance and in June 2019 there was 98% compliance.

Between October 2019 and December 2019 reporting turnaround audits showed the average working days for report turnaround for CT was 0.61 days, for MRI it was 1.01. days and for x-ray it was 0.88 days.

Information provided by the department for CT waiting times for February 2020 showed an average waiting time for the scan of 15.1 days and an average report time of 0.8 days. This included amended appointments through patient choice. Waiting times without amended appointments through patient choice showed an average waiting time for the scan of 4.3 days and an average report time of 0.9 days.

Information provided by the department for MRI waiting times for February 2020 showed an average waiting time for the scan of 3.6 days and an average report time of 1.1 days. This included amended appointments through patient choice. Waiting times without amended appointments through patient choice showed an average waiting time for the scan of 2.2 days and an average report time of 0.7 days.

Appointment slots were kept available daily in MRI and CT to accommodate urgent bookings.

Urgent ultrasound scans could be done on the same day if there was a radiologist on site. If a radiologist was not on site, they would be completed within 48 hours.

Information provided by the service stated patients could book an appointment at a convenient time for them and there were no waiting times to access the services in

diagnostic imaging. This information highlighted there were no cancellations of appointments more than six weeks in advance and no cancellations in the specialties in diagnostic imaging in February 2020.

The services did not actively monitor the waiting times of patients when waiting for their scan in clinic; however, they did provide examples of recent waiting times. For example, for x-ray services the information provided showed an average waiting times to be seen once in the department was 9.5 minutes and this included a number of patients being seen before their allotted time if they arrived early.

Reports were returned to general practitioners electronically.

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.

There had been two complaints in 2019.

The service clearly displayed information about how to raise a concern in patient areas. There were posters for what to do if you have a complaint. The department had processes in place such as suggestion boxes and feedback cards to encourage patients and visitors to provide feedback or provide suggestions to the service.

Leaders investigated complaints and shared feedback from complaints with staff. Feedback was provided at team meetings.

The hospital had a patient experience manager who oversaw complaints to the services and there was a hospital weekly complaint meeting. There were various ways people could provide feedback to the service, for example by telephone and patient surveys.

The hospital had an up to date complaints policy.

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Are diagnostic imaging services well-led?

Good 

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

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.

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

There was a clear leadership structure in place across the department. There was a diagnostic imaging department manager who had direct reports from the senior radiographers. The diagnostic imaging manager reported to a senior manager at the hospital.

Leaders had an open-door policy and were visible in the department. Staff told us leaders were approachable and supportive.

Leaders described the challenges and planned improvements regarding diagnostic imaging.

Business cases were used across the department and leaders told us quality was considered when completing business cases. There was a weekly capacity meeting which the diagnostic imaging department leaders attended to assist in planning and managing services.

Leaders we spoke with could describe the duty of candour.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision

and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

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

There was a clear strategy and vision for the service which leaders could describe. This included staff recruitment, utilising people's skills further and review of the point of care for patients. Leaders described the vision of achieving a good skill mix across the department and the department leadership had introduced additional staff meetings for the different staff groups which could then provide information into the overall department meeting. The strategy and vision were aligned to the overall hospital strategy and vision.

Staff had been involved in the development of the strategy and vision and attended a meeting to discuss where they wanted to be. Leaders told us they had also considered where there were challenges in the department to consider this as part of the strategy.

There was a radiology department organisational structure chart. The structure had recently been reviewed and each team member had been allocated a specific role to encourage staff engagement such as equipment lead, dementia lead and infection control link.

Culture

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

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

Morale was positive across the department and staff described good team work. Staff told us they felt valued and respected. There were regular team meetings in the department.

There were opportunities to develop further and complete additional courses and staff were supported to do these.

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Morale was monitored through the staff survey, regular meetings with staff and leaders were visible in the department.

There was a hospital recognition programme to recognise and reward staff for their work. The hospital had recently recruited a patient experience manager to support work across the hospital including diagnostic imaging, for example on 'did not attend' rates and the complaints process.

The service provided wellbeing services as part of the Spire benefits available to staff and there was a helpline which staff could use if required.

The radiology team meeting minutes from January 2020 included agenda items such as business updates, quality and shared learning, recent audits including the scorecard, actions and outcomes, risk management, new policies, training and development and service user feedback. There was also a section for learning from incidents and complaints.

We saw the imaging team had developed a 'Going for gold' folder. This included information for example, on lessons learnt and reflection on incidents.

There was a hospital freedom to speak up guardian.

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.

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

There were governance processes in place across the diagnostic imaging department and leaders could describe these processes. These governance processes included attendance at radiation protection committee meetings annually. The most recent radiation meeting had taken place in February 2020 and there were four of these meetings annually. The department manager managed governance across the department and

attended the monthly governance meeting at the hospital. There was also a clinical effectiveness meeting which contributed to the governance management across the service.

There was a daily hospital meeting which staff from all areas of the hospital attended and this meeting was used to communicate information with staff and leaders across the services. This meeting also communicated to staff what was going on across the various services during the day.

There were external discrepancy meetings which the medical staff could attend to discuss report discrepancies. Although, these meetings were not held at the hospital.

We saw daily quality assurance information displayed on the walls in the x-ray rooms.

Incidents were reported through the incident reporting system and would be reviewed by the department leaders. Incidents and actions were reviewed by senior leaders in the hospital before the incident was closed on the system. Incidents that were reported were discussed at the rapid response meeting and the health and safety meeting which alternated every two weeks.

The service provided the radiation protection meeting minutes from February 2020. We saw, this included agenda items such as recent inspection reports, procedures, protocols and guidelines, clinical audit, radiation incidents, equipment and training.

The department had plans to develop a business continuity plan to address challenges the department could have, for example, leaders told us this would include issues such as staffing, equipment breakdown and radiation incidents. This was planned to be developed over the next three months.

The service had a service level agreement in place with a local hospital provider which was up to date.

Managing risks, issues and performance

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

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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.

For our detailed findings on managing risks, issues and performance please see the well led section in the surgery report.

The hospital had an up to date risk management policy.

There was a department risk register which was reviewed regularly at the governance meetings and health and safety meetings. The risk register was also reviewed if there were any significant changes. Leaders told us they reviewed trends in risk through the incident reports. The rapid response meeting also considered risks in the diagnostic imaging department. Leaders could describe the risks attached to the risk register and the mitigation around the risk. The risk register, for example, included the risk description, key controls, key assurance and the actions taken.

Leaders could describe the risks there were in the department, for example, these included equipment breakdowns and the risk of radiation incidents. There was equipment which was due to be replaced in June 2020 to mitigate the equipment risk and to address the radiation incident risk, the service had done a radiation incident scenario and held radiation protection meetings as required.

Another risk identified and documented was regarding discrepancy meetings which was documented on the risk register and had actions attached. The risk document identified skill mix as a potential risk and this was being addressed through additional staff in the specialty areas, for example, the service had two new computed tomography (CT) radiographers and two new magnetic resonance imaging radiographers being recruited.

The department completed risk assessments as needed, for example, there was a risk assessment completed for 'any area where x-rays are used' which had been done in July 2019.

The teams used information such as incidents which had been reported to assess risk, performance and issues in further detail. The service also used information from patient feedback and complaints to the department to assess the performance of the service further.

Staff had access to radiation protection supervisors and external radiation protection advisors for advice and support. Staff told us they worked well with the external teams.

Local rules were on display in the areas visited. The MRI local rules folder included information such as the authorised persons, MRI safety quality standards and the emergency procedures. These were updated every two years or when something changed.

Leaders could describe the quality assurance programme to ensure equipment was serviced and maintained as required. A staff member in the department had taken on the role of managing this system and it enabled oversight of equipment maintenance and servicing. The department had an external team come in and complete some of the quality assurance.

The service had an annual radiation protection meeting and from this received a report and recommendations or actions if required.

Reject analysis was completed in the department to analyse how many scans were rejected. Leaders had oversight of these audits.

Leaders used performance reports and information to monitor and manage the risks, issues and performance across diagnostic imaging. Leaders attended a daily meeting which was in place to ensure the departments could plan for the day's work and ensure staff were aware of any safety information.

The department had access to a backup generator at the hospital.

Managing information

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

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

Diagnostic imaging

Leaders had access to the required information such as performance information regarding mandatory training compliance levels and patient survey results. There was access to electronic information systems such as the incident reporting systems.

Staff had access to the required information systems. Staff could access the intranet for information and news about the hospital. Policies and procedures were available on the hospital intranet and there were folders available in the department with relevant policies and procedures available for staff to access. Staff had access to an information technology team for support as required.

We saw the accessible information standard information posters on display in various areas of the department including the reception area. There were notice boards and information boards on display in the department to provide information to staff, patients and visitors. The service provided the dates for the service level agreement the service had for radiation protection services, which showed these were in date.

There had been no recent information governance breaches in the diagnostic imaging department.

Policies and procedures seen during the inspection were in date.

Engagement

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

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

Suggestion boxes were available for patients to provide feedback to the services. There were also 'you said, we did' information on display about what the service had changed in response to patient feedback. The service utilised friends and family tests to gather feedback and enable improvements to be made if required.

There was an annual staff survey to enable staff to provide feedback to the leadership team. There had been no concern highlighted from the recent staff survey results.

The hospital produced staff and consultant newsletters, held monthly staff forums and staff told us there were monthly team meetings across the department. There was a communication file in the department which contributed to communicating information to staff across the diagnostic imaging department.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

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

The department had implemented a system for monitoring the equipment maintenance and schedule and this was documented electronically. This enabled staff to see a full equipment history of breakdown, repairs, service and QA in one place for each individual piece of equipment. A nominated equipment facilitator had also been appointed.

The department used audits to monitor the service provided and utilised actions plans as required to address challenges with audit findings.

The department management was part of the daily hospital meeting and information provided by the hospital highlighted these meetings ensured the departments could plan for the day's activity and be aware of key safety information.

The department had a 'My visit to X-Ray' booklet to provide information on an x-ray to patients and visitors. This included pictures alongside the wording.

Outstanding practice and areas for improvement

Outstanding practice

Overall Hospital

- The provider produced 48-hour flash reports as an opportunity to learn from events on a wider scale. These were used to highlight either complaints or incidents that had led to a change of practice. The

48-hour flash reports were shared throughout every hospital within the group and each hospital had to acknowledge that they had been read and distributed throughout the local service. We saw these discussed at the daily 10@10 huddle.

Areas for improvement

Action the provider **SHOULD** take to improve Overall Hospital

- The hospital should consider equalising the response time to complaints between NHS patients and private patients so that both types of patients are treated equally.
- The provider should ensure medicines governance processes are embedded and demonstrate this is sustained, through periodic audit.

Medical care (including older people's care)

- The hospital should consider how it can improve the environment (including where relevant, the equipment) for the endoscopy service and the environment for the oncology service.
- For patients wanting an endoscopic procedure, the hospital should consider using endoscopic nurse specialists to do the pre-assessment.
- For patients undergoing an endoscopic procedure that had CJD, who because of their disease, required special care with, amongst other things, de-contamination of endoscopes, the hospital should consider re-training of staff because on inspection, they were not aware of the written policy in place for management of CJD.
- The hospital should consider whether sedation and oxygen used during an endoscopic procedure should be written up on the patient's drug chart as opposed to the patient care pathway.
- The hospital should consider how the access and flow through the endoscopy service could be improved.
- The hospital should consider ensuring that, when the MAC is advising on a consultant's practising privileges, they consider non-attendance at meetings the

consultant is meant to attend and also review reporting mechanisms to ensure staff report consultant non-attendance at meetings, where appropriate.

Surgery

- The provider should ensure the dirty utility room floor on ward two, is refurbished to enable effective cleaning.
- The provider should ensure they risk assess and consider fitting a lock to the dirty utility room door on ward two, to reduce the risk of unauthorised access.
- The provider should ensure processes to improve VTE risk assessment and prophylaxis prescribing compliance are embedded and demonstrate this is sustained, through periodic audit.

Services for Children& Young People

- The provider should consider child size toilet facilities in the outpatients areas.
- The provider should continue to monitor and improve GP summary presence in children's and young people's notes.

Outpatients

- The outpatient department should consider ways to ensure patients records are legible as required.
- The outpatient department should consider auditing the number of cancelled clinics or appointments to monitor performance.

Diagnostic imaging

- The provider should consider monitoring the 'did not attend' rates.