Spire Healthcare Limited

Spire Little Aston Hospital

Quality Report

Little Aston Hall Drive, Little Aston
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This report describes our judgement of the quality of care at this hospital. 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 hospital	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Little Aston Hospital, part of Spire Healthcare, offers comprehensive private hospital treatments, procedures, tests and scans to patients from Sutton Coldfield and surrounding areas. The hospital offers a range of surgical procedures, cancer care, rapid access to assessment and investigation and a physiotherapy service. The hospital did not provide children's in patient or day case surgery

Patients are admitted for elective surgery, attend as a day case or for outpatient care. There are no emergency admissions.

Services are available to people who held private insurance or to those paying for one-off private treatment. Fixed prices, agreed in advance, are available. The hospital also offers services to NHS patients on behalf of the NHS through local contractual agreements and 39% of its activity was NHS funded care.

Facilities include an Inpatient ward with 24 private rooms with ensuite facilities, a Day Care Ward with 8 private rooms with ensuite facilities, a two bedded High Dependency Unit, a Chemotherapy Suite consisting of a 4 chair day care room and two private rooms with ensuite facilities and a Endoscopy Suite consisting of a 4 bay recovery area. There are 3 theatres all with laminar flow, 2 minor procedure theatres and an Endoscopy procedure.

Prior to the CQC on-site inspection, the CQC considered a range of quality indicators captured through our monitoring processes. In addition, we sought the views of a range partners and stakeholders. A key element of this comprised the focus groups with healthcare professionals and feedback from the public.

The inspection team make an evidence based judgment on five domains to ascertain if services were:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

Our key findings were as follows:

Spire Little Aston Hospital was selected for a comprehensive inspection as part of the independent healthcare inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

The inspection team included CQC inspectors, doctors, nurses, experts by experience and senior managers with experience of working in the Independent Healthcare sector. The inspection took place on 22 July 2015, with an unannounced visit on 5 August 2015.

The inspection team looked at the following core services: Surgery, High Dependency unit, outpatient and diagnostic imaging services.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- There was an open culture and learning environment for reporting incidents. The staff reported incidents using an electronic reporting system. Outcomes and learning from incidents were cascaded to staff.An increase in reported incidents was believed to be due to an improvement in culture within the hospital. Staff were aware of the duty of candour and a robust Duty of Candour Policy was in place.
- We were not assured the World Health Organisation (WHO) surgical safety checklist was being used consistently. Monthly figures did not demonstrate that the WHO checklist was being completed fully. Information sent to us in post inspection in September 2015 suggested a significant improvement month on month.
- There was no for Interventional Radiology in operation at the hospital during our inspection. This is a recommendation from the Royal College of Radiologists. The checklist
- Staff were aware of their responsibility to safeguard adults and children and the action to take if there was a concern and both training courses in 2014 were well attended.
- The hospital had a resident medical officer (RMO) who provided cover on an on call basis for the hospital 24 hours a day. The RMOs worked for seven days and then had seven days off and were supplied by an agency.
- There was sufficient staff to meet people's needs across outpatients and diagnostic and surgery. A recruitment campaign was underway to meet vacancies within ward and theatre areas and many staff worked overtime and as part of a bank to ensure safe staffing levels. Agency staff usage was RAG rated red on the hospital clinical score card and Spire Little Aston was one of the highest agency users in the Spire group.
- There were good infection control surveillance procedures to identify and manage infections. However, hand hygiene procedures for infection prevention and control needed to be improved in OPD. We saw the hospital identified that from 1 April 2014 to 31 March 2015 there had been no cases of MRSA, C. difficile, E. coli or MSSA infections. There were three post-operative wound infections during this time frame. Investigations into the causes had been carried out with action plans implemented.
- Medicines were stored and managed in safe way and the pharmacy department had good governance systems to

Summary of findings

monitor new drugs, off licence drugs, safety and drug alerts and incidents. There was a medicines reconciliation service on admission and audits on prescribing on the wards. Local medicines policies were up to date and the medication error rate was low.

- Mandatory training attendance figures showed at the end of June 2015 48% of staff had completed their mandatory e-learning / training which was the expected training compliance for half way through the year.

Are services effective?

Good

- Local policies and care pathways to treat patients followed national guidance. Governance and research for the introduction of new technologies had been followed.
- We saw that the hospital had systems in place to provide care and treatment in line with best practice guidelines such as National Institute for Health and Care Excellence (NICE)
- There was some participation with National audits, however majority of benchmarking clinical practice was measured and compared across the 39 Spire Healthcare Hospitals. A clinical scorecard was updated monthly and performance and quality was monitored and measured using a RAG rated system which fed up to the central governance team. Any area rated red was escalated automatically and a remedial action plan was required to address concerns.
- Patients had appropriate pain relief and their nutrition and hydration needs were well managed. They were offered a choice of meals and alternative meals could be provided if required and special diets were catered for.
- Staff understood their responsibilities in relation to gaining consent.

Are services caring?

Good

- Staff were caring and compassionate and treated patients with dignity and respect. Staff in the OPD went 'the extra mile' to ensure patients received their care and treatment and carers well fully supported.
- Patients were positive about services and told us they felt well-cared for and were involved in their care plans and were able to make informed decisions and choices.
- The hospital had recorded high for the NHS equivalent Friends and Family Tests scores for both privately funded and NHS

Summary of findings

funded patients who had responded to the survey, from April 2015 to June 2015 the hospital scored 99 %. Patients reported excellent, professional and caring staff and good information about their care and treatment.

- The needs of patients living with dementia or who had a learning disability were identified at pre-assessment and were supported by staff throughout their stay.

Are services responsive?

Good

- Patient operations and procedures were rarely cancelled. The hospital undertook NHS funded care. There was no differentiation between NHS or private patients, although theatre staff told us that if cancellations were required this would more likely be for NHS patients.
- Patients were positive about the information they received to help them in making decisions. Written information was available to support verbal information, however this was only available in standard English text.We were told by the hospital information could be translated in advance into other languages on request by the contracted translation service.
- Appraisal rates for both surgery and OPD and diagnostic services staff during 2013-2014 were 98%.

Are services well-led?

Good

- During the inspection we reviewed the 15 recommendations made by Verita, who is anindependent consultancy who carry out reviews and investigations of complex, sensitive issues to regulated organisations.The Verita review was commissioned by Spire Healthcare and was completed in March 2014. The aim of the review was to understand the circumstances that enabled a former breast care surgeon to practice as they did At Sire Parkway and Little Aston Hospitals, which led to the consultant's ultimate dismissal in 2013 and the recall of more than 600 patients at Spire Parkway Hospital.The consultant had practicing privileges at both hospital sites but Spire Little Aston Hospital to a much lesser extent. The report looked specifically at governance arrangements within both hospitals. We saw evidence to demonstrate that the majority of recommendations made by Verita had been implemented at Spire Little Aston Hospital. Corporate Spire had adopted a further eight actions across the Spire hospital network to improve governance and monitoring arrangements. We were assured all eight had been completed at Spire Little Aston.

Summary of findings

- The hospital's vision and values were well embedded across hospital services and staff were aware how this aligned to the Spire Corporate vision and strategy, which was to be recognised as a world class healthcare business.
- There were consultants from each speciality represented at the hospital's medical advisory committee (MAC). There were regular meetings held with the hospital management team and there was liaison with other consultants via email, meeting, minutes and newsletters.
- Governance arrangements were in place for teams and departments to discuss complaints, incidents and audits, share lessons learned and minimise clinical risks. However, the senior management team were working through a backlog of consultant biennial reviews which had not been carried out in a timely manner. 16% had been completed (49/300) at the time of the inspection. Post inspection, 30 September 2015, this figure had increased to 90%, with rationale and action plans for the outstanding 10%.
- The Hospital risk register did not include all risks across services. For example there was no reference made to the challenge related to the consultant biennial review backlog and the absence of the theatre WHO checklist had not been included as an identified risk.
- Staff were positive about the hospital as a place of work. There was a supportive and open culture and staff felt that ward and department managers were approachable as were the hospital management team. The hospital was described and felt like a "friendly" place to work. The culture in the theatre department was said to be improving following previous concerns about management arrangements.
- The senior management team used innovative ways to communicate with staff to glean feedback to improve services for patients and improve staff's working environment. This included employees' forum, team talks and a staff newsletter, a "reward drop-in session" and tea with the hospital director.
- The hospital actively monitored social media for any content involving them so that they could investigate any issues raised and respond appropriately.

Professor Sir Mike Richards

Chief Inspector of Hospitals.

Summary of findings

Our judgements about each of the main services

Service	Rating
Surgery	Good

Why have we given this rating?

We rated Surgical services at Spire Little Aston Hospital as good overall. However, we saw World Health Organisation (WHO) surgical safety checklist was not used consistently and monthly figures did not demonstrate that the WHO checklist was being completed fully. Evidence received three months after the inspection demonstrated significant improvement. Services followed procedures to provide safe care and incident reporting and dissemination of lessons learned was well in-bedded throughout. All staff were aware of the Duty of Candour and the complaints process was robust. Patient's nutrition and hydration needs were met and patient's pain levels were monitored and managed effectively. Some national audits were carried out together with local audits supported by action plans and regular review dates to measure progress to improve patient outcomes. Cases of unplanned returns to theatre, readmissions to hospital and transfers of patients to other hospitals were all 'similar to expected' compared to the other independent acute hospitals we hold this type of data for. The nursing handover required more structure as it did not include all details relevant to patients care and treatment. During the unannounced visit on 5 August 2015 we saw improvements had been made to the nursing handover. A staff induction programme was in place for new clinicians and consultants and staff competencies were assessed and signed off as competent within a timely manner. We were not assured there were robust on call arrangements for consultants. There were appropriate systems in place to respond to deteriorating patients and medicines were managed safely. Staff supported people with complex needs such as those with learning disabilities or people living with dementia appropriately. Staff were kind and caring, and treated patients and relatives with dignity and respect. Staff were supported with internal and external training and appraisal figures were good for staff across the hospital. The governance structure was in place with regular reviews of consultant's practising privileges. However, the newly appointed senior management team had inherited a backlog of consultant biennial reviews with only 16% completed at the time of the inspection. Post inspection

Summary of findings

30 September 2015 we saw this had increased to 90%. The hospital risk register did not include all risks across surgery services. Staff described local and senior managers as nurturing, excellent role models, with an 'open door' policy.We rated Surgical services at Spire Little Aston Hospital as good overall. However, we saw World Health Organisation (WHO) surgical safety checklist was not used consistently and monthly figures did not demonstrate that the WHO checklist was being completed fully. Evidence received three months after the inspection demonstrated significant improvement. Services followed procedures to provide safe care and incident reporting and dissemination of lessons learned was well in-bedded throughout. All staff were aware of the Duty of Candour and the complaints process was robust. Patient's nutrition and hydration needs were met and patient's pain levels were monitored and managed effectively. Some national audits were carried out together with local audits supported by action plans and regular review dates to measure progress to improve patient outcomes. Cases of unplanned returns to theatre, readmissions to hospital and transfers of patients to other hospitals were all 'similar to expected' compared to the other independent acute hospitals we hold this type of data for. The nursing handover required more structure as it did not include all details relevant to patients care and treatment. During the unannounced visit on 5 August 2015 we saw improvements had been made to the nursing handover. A staff induction programme was in place for new clinicians and consultants and staff competencies were assessed and signed off as competent within a timely manner. We were not assured there were robust on call arrangements for consultants. There were appropriate systems in place to respond to deteriorating patients and medicines were managed safely. Staff supported people with complex needs such as those with learning disabilities or people living with dementia appropriately. Staff were kind and caring, and treated patients and relatives with dignity and respect. Staff were supported with internal and external training and appraisal figures were good for staff across the hospital. The governance structure was in place with regular reviews of consultant's practising privileges. However, the newly appointed senior management team had inherited a backlog of consultant biennial reviews with only 16% completed at the time of the inspection. Post inspection

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Outpatients and diagnostic imaging

Good

The outpatient and diagnostic service department at Spire Little Aston was rated good overall. Incident reporting was well in-bedded and staff were aware of their responsibility towards Duty of Candour. Record management was well managed through outpatients and diagnostic services, however, Infection control practices in the OPD needed to be improved. Staffing levels met the needs of patients' and an ongoing recruitment drive was in place to fill vacancies. Patient's nutrition and hydration needs were met and patient's pain levels were monitored and managed well. Clinical practice across all areas was underpinned by National guidelines and imaging regulations were followed appropriately. There was a collaborative approach to care and treatment with evidence of strong MDT working across OPD and diagnostic services. Staff were supported to attend mandatory training and attendance at Safeguarding and Mental Capacity Act training was good. Facilities in the outpatients was under review to replace the reception desk, there was no dedicated administration or rest room for nurses in outpatients to use and inadequate car parking for patients and staff. Staff were caring and compassionate and treated patients with dignity and respect. Staff supported people with complex needs such as those with learning disabilities or people living with dementia appropriately. We saw numerous examples of how OPD staff went above and beyond to ensure patients received their care and treatment by often overcoming obstacles. Governance arrangements were effective to review risks and included, monitoring the performance of consultants, in areas such as lateness for clinics, unauthorised removal of medical records and clinic overruns. However there was no WHO safety check list for interventional radiology in operation. This had been introduced by the time we carried out an unannounced visit on 5 August 2015. The culture was open and transparent and staff said their departments were well led. Staff reported that the managers ensured they felt

Summary of findings

respected, valued, and engaged. The OPD and diagnostic service were proactive in obtaining feedback from patients and staff at regular intervals to improve care and treatment within the department.

Good

Spire Little Aston Hospital

Detailed findings

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Spire Little Aston Hospital

Spire Little Aston Hospital, part of Spire Healthcare, offered comprehensive private hospital treatments, procedures, tests and scans to patients from Sutton Coldfield and the surrounding areas. Facilities included 24 private rooms with en-suite facilities, 17 day-case facilities, two bedded high dependency unit. There were three theatres with laminar flow (a specialist system of circulated filtered air filtered to reduce the risk of airborne infection), two theatres provided treatment for minor procedures and one also provided endoscopy procedures. Outpatient facilities included 15 private consulting rooms, and a range of services including minor surgical procedures, cancer treatment, health assessments (including those for Australian and New Zealand visa applications) and cosmetic surgery. Diagnostic imaging was provided on site. Services offered included computerised tomography (CT) and magnetic resonance imaging (MRI) scans, mammography, x-rays, fluoroscopy and ultrasounds. Sport and general injury rehabilitation, health screening and occupational health facilities are provided through a Spire 'Perform' clinic on site.

There were 301 consultants with practising privileges to work at the hospital. Services included

cardiology; cosmetic surgery;; gynaecology; ophthalmology; orthopaedics; refractive eye surgery; speech and language therapy; urology and vascular surgery. cancer care, cardiac surgery and cardiology investigations, cosmetic and plastic surgery, dermatology, ear nose and throat conditions, gastroenterology, general surgery (eg hernia repair, haemorrhoids and varicose veins), gynaecology, neurology, neurosurgery, ophthalmology, oral and maxillofacial, orthopaedics (e.g. hip and knee replacements), spinal surgery, urology, and weight loss (bariatric) surgery. The diagnostic imaging department offered rapid access to MRI scans, CT scans, X-rays, ultrasounds and mammograms. The physiotherapy team provided a service for neck pain, back pain, upper and lower limb problems and post-operative orthopaedics as well as a Women's Health Service Services were available to people who held private insurance or to those paying for one-off private treatment. Fixed prices, agreed in advance, were available. The hospital also offered services to NHS patients on behalf of the NHS through local contractual agreements and 39% of its activity was NHS funded care.

Spire Little Aston Hospital was selected for a comprehensive inspection as part of the independent healthcare inspections programme. The inspection was conducted using the care quality commissions new methodology. The inspection team inspected the following core services:

- Surgery and HDU
- Outpatients and Diagnostics.

Detailed findings

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper Care Quality Commission (CQC)

The team included inspection managers; inspectors; a policy lead, consultant surgeon, professor in gynaecological research, senior nurse manager, theatre nurse specialist, managers in radiology and outpatients and an expert by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commission group and Healthwatch. We carried out an announced inspection visit on 22 July 2015 and an unannounced inspection on 5 August 2015. We held a focus group with a range of staff in the hospital, including theatre nurses, ward staff, therapists, pharmacists and other healthcare professionals and administrative and clerical staff. We also spoke with staff individually as requested. We talked with patients and staff from all the wards areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Spire Little Aston Hospital.

Facts and data about Spire Little Aston Hospital

The Hospital contains the following

34 beds including 24 inpatient, 8 day care and 2 HDU beds

15 consulting rooms

3 theatres (with laminar flow),

2 minor procedure theatres

Endoscopy Suite including 4 bay recovery area.

Chemotherapy suite including 4 chair day room and 2 beds.

Physiotherapy department

Imaging Department

Top five most common medical procedures.

462 Oncology/Chemotherapy

236 Haematology

188 Diagnostic Colonoscopy

155 Facet joint injection

145 Diagnostic Cystoscopy

Top five most common surgical procedures:

476 Injection of therapeutic substance into joint

334 Phacoemulsification of lens with implant

319 Primary total knee replacement

282 Multiple arthroscopic operation on knee

253 Endoscopic resection of semilunar cartilage

Staff (Doctors & dentists headcount, all other staff groups FTE):

Doctors & dentists working under rules or privileges

Detailed findings

301

Nurses:

47.6

Inpatient departments

22.3

Theatre departments

18.4

Outpatient departments

16.9

Operating department practitioners (theatre)

10.0

Care assistants:

15.2

Inpatient departments

4.6

Theatre departments

7.0

Outpatient departments

3.7

Other hospital wide staff:

Allied health professional

31.9

Administrative and clerical staff

68.3

Other support staff

36.3

Core private services provided by Spire Little Aston

Critical care

Diagnostic imaging

Endoscopy

Oncology

Refractive eye surgery.

Services accredited or recognised by a national body

BUPA Breast Cancer Accreditation

BUPA Bowel Cancer Accreditation

BUPA MRI and CT Accreditation

BUPA Prostate Screening Accreditation

Clinical Pathology Accreditation for Pathology Services

Macmillan Quality Environment Mark for oncology / Lakeside Unit

SGS Accreditation for Sterile Services.

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Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Spire Little Aston Hospital provided both day surgery and inpatient treatment for patients across a range of specialties. Surgical specialities were: orthopaedics, general surgery, breast surgery, ear, nose and throat surgery, gynaecology, urology, cosmetic surgery, ophthalmology and gastroenterology.

There were 1,803 overnight patients (762 NHS funded and 1,041 provided by other funding) and 5,239 day case patients (1,738 NHS funded and 3,501 provided by other funding) admitted to the hospital between March 2014 and April 2015. There were 6,123 visits to theatre recorded in that time. There were 580 endoscopy procedures undertaken at the hospital within the same time frame. The hospital prominently provide care and treatment for adults over 18 years. No children under 16 years receive in patient care.

The Hospital has 36 beds in total including 24 inpatient single rooms with ensuite facilities, 8 day care single rooms with ensuite facilities and 2 HDU beds, although the HDU was not in use at the time of our inspection, and was rarely used. The endoscopy unit consisted of a four bedded recovery area, endoscopy theatre and patients' waiting room. Three theatres at Spire Little Aston had laminar flow (a specialist system of circulated air filtered to reduce the risk of airborne infection), two theatres provided treatment for minor procedures and one also provided endoscopy procedures and did not have laminar flow. Theatres were used Monday to Saturday for surgery specialities.

We visited theatres, endoscopy, and the recovery (post anaesthetic) area during our announced inspection on 22 July 2015 and also visited the ward during our unannounced inspection on 5 August 2015. We spoke with the managers for both theatres and the ward area during both our announced and unannounced inspection. We spoke with 14 staff and six patients and looked at 16 patients' records.

Good

Surgery

Summary of findings

Surgery services were found to be caring, effective, responsive and well led, safety required improvement. Patients were treated kindly and with compassion and felt involved in decisions about their care and treatment. Services were responsive to meet the needs of the patients. The admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs.

Patients were largely protected from abuse and avoidable harm. Openness and transparency about safety was encouraged and staff reported incidents and near misses appropriately. When things went wrong there were appropriate systems in place to review and address these concerns.

Levels of staffing including medical, nursing, therapy and support staff were safe and met patients' needs. The hospital was visibly clean and there were appropriate systems in place to prevent and control healthcare associated infections. Medicines were managed safely.

The hospital monitored patient outcomes to provide assurance of the effectiveness of the service. Patients were well cared for on the ward and in theatres. Pain control was well managed. There was evidence of good multidisciplinary working and out-of-hours services were provided when needed. Staff had access to training and development and had received annual appraisals which supported their development needs. There was no differentiation between private and NHS patients in terms of provision of care. However although there were very few cancelled operations , staff told us cancellations were more likely for NHS patients.

Are surgery services safe?

Requires improvement

Surgical services required improvement, compliance with the WHO surgical checklist was between 62% and 78%. Surgical safety checklists were in place, however it was not used consistently and monthly results did not reflect that the WHO checklist was completed fully.

There was not a robust system of 'buddy' arrangement cover amongst clinicians.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. When things went wrong there were appropriate systems in place to review or investigate and when needed lessons were learnt. There were appropriate systems in place to respond to a deteriorating patient.

The hospital was visibly clean and there were appropriate systems in place to prevent and control healthcare associated infections. Medicines were managed safely and record keeping in all surgical areas was completed and audited, with any shortfalls addressed.

Levels of staff including medical, nursing, and therapy and support staff were safe and met patient's needs. Agency staff were used when necessary to maintain safe staffing levels. Mandatory training was ongoing and there were appropriate systems in place to ensure that staff attended required training.

Incidents

- Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The hospital had reported one never event on the Strategic Executive Information System (StEIS) from 1 April 2014 to 31 March 2015. This was reported as a surgical error and classed as wrong site surgery. However, there was documented evidence in the patient's records to support a discussion had taken place between the patient and the consultant and verbal consent obtained.

We saw that an investigation or root cause analysis (RCA) had been undertaken to identify actions to minimise the risk of similar incidents occurring in the future.

- The hospital had an embedded electronic system for reporting incidents and near misses. Between 1 April 2014 and 31 March 2015 there had been 13 serious incidents reported that required investigation.
- Staff felt supported to report incidents and told us they had reported cancelled operations and patient falls. Staff told us and we saw that incidents were investigated and learning was shared with them individually and in ward meetings
- The clinical governance report identified that there had been a 22% increase in incident reporting from 2013 to 2014 which was believed to be due to an improvement in culture within the hospital. Generally, staff had a good understanding of the different levels of harm from low to seriousincidents, but would always discuss incidents with their line managers for clarity.
- Categories of the highest rates of incidents reported were:

  Cancellation of operations on the day of service

  Clinical documentation incident

  Medication/drug incident

  Post-operative complication
- These incidents had been analysed and reported in the annual governance report which also detailed positive actions taken such as 89% of adverse events being reported within four days of incident in 2014 and that there were no surgical site infections for hip or knee procedures in 2014. Figures for quarter 2 Clinical dashboard dated July 2015 showed there were 3 medication incidents and one surgical site infection. Information had been disseminated to staff.
- We saw minutes that showed that reported incidents were reviewed and discussed during clinical governance meetings, heads of departments meetings and Medical Advisory Committee (MAC) meetings depending upon the nature of the incident.
- There was a quarterly report of the number of deaths during each three month period and the year to date. From 1 April 2014 to 31 May 2015 there had been five expected deaths and one unexpected death, all were not at the hospital. Staff told us and we saw minutes of meetings that confirmed that any deaths were discussed in the clinical governance and senior management meetings and when appropriate any learning would be shared with other staff.

Duty of Candour

- Duty of Candour information had been shared with staff both electronically and as a paper report.
- Staff we spoke with were aware of the Duty of Candour; they told us it was about being honest if things went wrong. One staff member said: “It’s about apologising if we get it wrong or make a mistake”. We saw examples of when both face to face apologies were made and a letter explaining the error which included an apology was sent to the patient. One incident related to a wrong site anaesthetic block and one patient was readmitted to hospital with a wound infection.
- The theatre manager told us that they would always go and speak to a patient if their operation had to be cancelled due to a non-clinical reason. They said they would apologise and promise that their operation would be rebooked within seven days.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The hospital used a ‘scorecard’ as a management tool, containing information about its performance against agreed targets such as use of agency staff, incidence of pressure ulcers, slips, trips and falls and patient feedback. Staff were made aware of the hospital’s performance and when improvements were needed action plans were in place and when needed actions were implemented.
- Contracts for NHS funded care have a target of 95% for venous thromboembolism (VTE) screening. For the time period July 2014 to September 2014 Spire Little Aston had achieved 100%.
- There had been three cases of a ‘hospital acquired’ VTE or pulmonary embolism between 1 April 2014 and 31 March 2015. An investigation had been undertaken for each case.

- Information was displayed within surgical areas so that patients, visitors and staff were aware of the hospital's safety performance. Staff told us that the availability of this information had been requested following the local clinical commissioning group monitoring visit.
- The hospital had identified an increased rate of patient falls. As part of the action plan to reduce patient falls new anti-embolism stockings were introduced that had a 'grip' sole. These stockings had been effective in the reduction of falls and were also identified as effective to prevent embolisms and complied with British Standard 7672 and NICE Guidelines CG092 2010.

Cleanliness, infection control and hygiene

- The hospital had appropriate policies and procedures in place to manage infection control. A policies and procedure file was accessible on the ward and in theatres. Staff we spoke were aware and showed us the location of these policies.
- We saw that adequate hand-washing facilities and hand sanitising gel were available. We observed staff washing their hands between seeing patients and using sanitising gel. The 'bare below the elbows' policy was observed by staff during clinical interventions.
- We saw that hand hygiene audits were undertaken and included observation of staff hand washing. Additionally, the hospital equated the quantity of hand gel used within a given time frame to how many times the gel being used on the assumption that there was a link between gel used and appropriate hand hygiene. The hospital target was for the hand sanitizer to be used more than 18 times per day, they had not met this target and an action plan was in place.
- We saw that infection control audits had been undertaken of the ward, theatres and recovery in June 2015. An action plan was in place to address any identified shortfalls.
- The hospitals 2014 Patient Led Assessment of the Care Environment (PLACE) identified a score of 96.2% for cleanliness.
- Information provided by the hospital identified that from 1 April 2014 to 31 March 2015 there had been no cases of MRSA, C. difficile, E. coli or MSSA infections. There were three post-operative wound infections during this time frame. We saw that investigations into the causes of these infections had been undertaken and when needed actions were implemented.
- During the surgical pre-assessment appointment all patients due to be admitted for surgery were swabbed for potential infections such as MRSA. Patients were only admitted for surgery if no infection was identified.
- We observed that staff complied with the hospital's policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- We observed that the ward areas including patients' rooms were visibly clean. We saw and domestic staff confirmed that there cleaning schedules were in place and cleanliness audits were undertaken. The cleanliness audits we saw identified if improvements were needed and confirmed that this was addressed.
- The hospital had a sterile services department on site There were suitable arrangements in place to ensure that the flow of dirty to clean equipment was in place and reduce the risk of contamination.

Environment and equipment

- Resuscitation equipment was available on the ward so that patients could be immediately resuscitated.
- Equipment was visibly clean, regularly checked and ready for use.
- We saw that patient moving and handling equipment was available and had been appropriately maintained and serviced. Staff told us and we saw there was suitable and sufficient equipment available to support the type of surgical procedures undertaken.

Medicines

- All arrangements for medicines were checked by our specialist pharmacist inspector.
- We found that medicines were stored, administered and managed safely. Medicines administration records were well maintained and clear about the medicines prescribed and administered.
- The hospital had an on-site pharmacy and pharmacists visited the ward five days a week to check and re-stock the medicine supply.

- There were appropriate arrangements in place to store and administer controlled drugs. Controlled drugs are medicines that need extra checks and special storage arrangements because of their potential for misuse. Stock levels were appropriately limited and monitored regularly.
- Patients' medicines were stored in locked cupboards. Where a patient had their own controlled drugs, they were stored in the controlled drug cupboard and returned to the patient on discharge.
- Emergency medicines were available for

Records

- The hospital used a paper-based records system for recording patients' care pathways. These were documents that covered the patient's journey from admission through surgery to discharge. There were different care pathways available for the different types of surgery undertaken at the hospital, for example gynaecology, and hip and knee replacement.
- NHS medical records were available for patients whose treatment was funded by the NHS.
- We looked at the pre-assessment information in eight patient records and saw that any tests and investigations undertaken were clearly documented and patients' medical and social history was recorded prior to them being admitted for surgery.
- Spire had a target that 90% of all patients' records should by fully signed and dated by their consultant daily, Spire Little Aston had achieved 95%. Records we looked at were all appropriately completed.
- The records gave an easily accessible record of the patient's journey through the hospital including the procedures undertaken and clearly showed the input of the various specialisms including anaesthetists and physiotherapists.
- Risk assessments were completed during pre-assessment appointments and then followed up on the ward. Post inspection we were sent July 2015 Clinical dashboard comparing June 2015 to July 2015 for Ward Spot Checks. The audit demonstrated 100% achieved for both months. We saw an increase from June 2015, 87% to 100% in July 2015 for falls assessments. There was an increase from June 2015, 67% to 76% in July 2015 for hourly ward rounds and an increase from June 2015 to July 2015 from 87% to 94% with temperature recording and early warning signs (EWS) recording.

Safeguarding

- The hospital had identified members of staff (one for adults and one for children) who were the lead for safeguarding adults and children. Staff could identify the safeguarding leads.
- The hospital safeguarding policies and procedures were readily available. Staff were aware of their responsibilities to protect vulnerable adults and children and the actions required to do so.
- Information we received from the hospital identified that all members of staff completed level one child protection and level one vulnerable adults e-learning training modules within their first three months of appointment and then had an annual update (refresher e learning module which included both safeguarding children and adults.
- Child Protection and safeguarding adults level one e-learning module: 94.1%
- Refresher e-learning module: 74% of staff had completed the 2015 safeguarding refresher training online (with a deadline of the end of the calendar year), 85% of staff completed this training in 2014. This was set against a target of 95%".
- The Matron/Head of Clinical Services and the Hospital Paediatric Lead had both undertaken and completed level three adult and paediatric safeguarding training.

Mandatory training

- The hospital used electronic learning to provide much of their mandatory training.
- At the end of 2014, 83% of staff had completed all mandatory training (health and safety, infection control, fire safety and safeguarding vulnerable adults and children). This was below Spire average, short of the required 95% target. We saw that that there was an action plan to improve the uptake of mandatory training.

- At the end of June 2015, 48% of staff had completed all mandatory training required for the year which is line with Spire average. The Head of Clinical Services has taken the lead in driving this target towards being reached before the end of the year.
- All clinical staff with direct patient contact completed basic life support training as part of their annual two day mandatory training programme (each calendar year). Annual mandatory training programme compliance for 2015 in July 2015 was 72%, this was based on percentage of staff who had completed training to date. The hospital had confirmed that the remaining clinical staff were booked onto an annual two day mandatory training programme before the end of 2015.
- All ward staff nurses, senior staff nurses and sisters/ charge nurses completed immediate life support (ILS) training annually. Compliance in 2014 was 97%. Information we received from the hospital identified that the 3% non-compliance was related to bank staff and all contracted staff had completed this training. Compliance for July 2015 was 67%. Information we received from the hospital was that all remaining ward staff were booked onto an ILS course before the end of 2015.
- All anaesthetics and recovery staff (registered nurses and operating department practitioners (ODP) completed ILS training annually. Compliance in 2014 was 94%. Information we received from the hospital identified that the 6% non-compliance was related to bank staff and all contracted staff had completed this training. Compliance for 2015 as at July 2015 was 65%. All remaining theatre staff were booked onto an ILS course before the end of 2015.
- Staff we spoke with said they were reminded to undertaken mandatory training when required by their managers.
- Compassion in practice training was introduced in October 2014, and became mandatory for staff from January 2015. To date (end of April 15), 69% of staff were compliant which is above average compared to other Spire hospitals.

Assessing and responding to patient risk

- Risks to patients were assessed at their pre-admission assessments and should there be any concerns surgery would not take place.100% of required and identified clinical staff had completed an acute illness management course.
- The hospital used an early warning score to assist staff to identify any deterioration in patients. We looked at six patients' records and found that early warning scores were regularly reviewed and reflected the patients' conditions.
- Should a patient need to return to theatre unexpectedly out of hours, there was a theatre team on call, supported by senior nursing staff, x-ray and physiotherapists.
- There have been five cases of unplanned transfers of an inpatient to other hospitals in the reporting period (Apr 14 to Mar 15). CQC assessed the proportion of unplanned transfers to be 'Similar to expected' compared to the other independent acute hospitals. (per 100 inpatient discharges) over the same period.
- There was a formal agreement in place for patients to be transferred to the local NHS hospital if they required high dependency or critical care (level three).
- We observed that within theatres each day a 'morning brief' took place; staff confirmed that this happened before each theatre session. We observed that each planned procedure was discussed and notes made. These notes were stored for future reference, should any issues be raised about planning and procedure. We observed and staff told us that the World Health Organization (WHO) surgical safety checklist was adhered to. This is a process recommended by the National Patient Safety Agency to be used for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors.
- We discussed this with senior managers who told us that since the appointment of the new theatre manager in April 2015 audits of the WHO checklist demonstrated improved compliance. We saw hospital audits of WHO checklist compliance identified: April 2015 62%, May 2015 73% and June 2015 78%. We were not assured these figures demonstrated that patients were adequatelyprotected against the risks of avoidable harm. We saw that although staff had completed the first stage of the WHO checklist which checked and confirmed the right patient, right procedure and that the patient had given their consent to the procedures the second stage checking the use of swabs etc was not always fully completed. A review of findings and shortfalls had resulted in a new process was introduced

in July 2015 where all WHO checklist documentation was checked before the patient left the Post Anaesthetic Care Unit to ensure their safety. The head of clinical governance told us that audit findings and any gaps were shared with the theatre manager and this was discussed and addressed with the staff through the performance management process.

- Three months following the inspection we were sent information to demonstrate significant improvements with WHO documentation audits; July WHO Documentation Audit was 94%, August WHO Documentation Audit achieved 95% and September WHO Documentation Audit met 100%.
- Since July 2015 a senior member of the hospital management team have visited different theatres at Spire Little Aston hospital, to carry out observation audits with different consultants.This consists of observing 5 WHO Checklists per month. We saw evidence to support this, the audit results showed 100% in July 2015, August 2015 and September 2015.
- The resident medical officer (RMO) provided the first response in an emergency situation. Staff told us that the RMO would review the patient quickly.
- There were service level agreements in place for the hospital should a patient's condition deteriorate and require additional care. The service level agreement provided assurance that patients requiring additional care such as intensive care would be admitted to a local hospital.

Nursing staffing

- The hospital had used a dependency tool that was based on the Shelford Safe Staffing Tool since January 2015, which is an It was completed daily by the nurse in charge and recorded patient numbers including admissions and discharges with each patient's dependency scored against set criteria. The number of both trained and untrained staff required was identified as a result of this score. We saw that that the required numbers of qualified nurses were available to care for patients. Planned and actual staffing levels were not displayed at the time of our inspection.
- The ratio of qualified to unqualified nurses working on the ward at Spire Little Aston was 75% qualified nurses to 25% unqualified nurses. The NHS ratio for skill mix is 65%:35% qualified to non-qualified staff. Spite Little Aston had a higher ratio of qualified staff than NHS hospitals.
- The hospital only undertook elective surgery which meant the number of nursing and care staff hours needed on any particular day could be calculated and booked in advance. Employed staff worked their contracted hours flexibly to cover the rota and any gaps were filled by bank or agency nursing staff or overtime.
- The 2014 agency hours spend as a percentage of total staff cost for ward and theatres was 22.4%, which was a red indicator on the hospital's scorecard and one of the highest in the Spire group. Recruitment was ongoing to address the need to use agency staff although managers told us that this remained a challenge.

Surgical staffing

- During the inspection we reviewed 15 recommendations made by Verita, who is an ndependent consultancy who carry out reviews and investigations to regulated organisations.The Verita review was commissioned by Spire Healthcare and was completed in March 2014. The aim of the review was to understand the circumstances that enabled a former breast care surgeon to practice as they did at Spire Parkway and Little Aston Hospitals, which led to the consultant's, suspension of practicing privileges and ultimate dismissal from practice in 2013.The consultant had practicing privileges at both hospital sites but Spire Little Aston Hospital to a much lesser extent. The report looked specifically at governance arrangements within both hospitals. We saw evidence to demonstrate that the majority of recommendations made by Verita had been implemented at Spire Little Aston Hospital.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. They also arranged alternative cover from another consultant with practising privileges at the hospital, in the event that they were not available.
- Surgical consultants' and anaesthetists' workload varied dependant on patient demand and operation sessions were scheduled accordingly. A wide range of surgical staff were available which included suitably skilled nurses and operation department practitioners.

Good

Surgery

- Consultants were required to be available on site within 45 minutes.
- We saw there was no formal arrangements for anaesthetist 'on call' cover, although anaesthetist remain responsible for patients for 24 hours post operatively as stipulated in the Spire Consultants handbook. The anaesthetist must be available to attend the hospital should the need arise within 24 hours of surgery or at the request of the admitting consultant.
- There was a 'buddy system' in place for when consultants were on leave. Consultants had a named colleague who would take over the care of their patients. Details of the named individual was disseminated to staff. However we were not assured this was a robust process as there was no formal update to demonstrate that the named buddy has been checked and was available before each period of absence.
- From May 2015 Spire Little Aston was part of a trial for the new electronic Consultants database which would enable all consultants' information to be stored and accessed remotely. This included cover arrangements known as the 'buddy system' for both consultant surgeons and consultant anaesthetists.
- To date the hospital had uploaded 41% of consultant surgeons and 21% of consultant anaesthetists onto the system. We were told whilst this work was in progress the hospital continued to use the previous system of a card index to store consultants details in and a folder containing details of who was buddying who and when. The card index and folder was available to all ward, theatre and outpatient staff. We were told Spire Little Aston Hospital have had no reported incidents or issues to date with contacting an anaesthetist when required.
- Spire Little Aston had a Medical Advisory Committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if they were deemed competent and safe to do so.
- The role of the MAC also included periodically reviewing existing practicing privileges and advising the hospital on their continuation. They gave examples where practicing privileges had been suspended or withdrawn as a result of concerns raised. This demonstrated that the MAC was an effective body for monitoring the competence of the consultants working at the hospital.
- The hospital had a resident medical officer (RMO) who provided cover on an on call basis for the hospital 24 hours a day. The RMOs worked for seven days and then had seven days off and were supplied by an agency. Staff told us that the RMOs were responsive and would come to assess patients when requested.

Major incident awareness and training

- The hospital had a service major incident plan that informed staff of the actions they should take in the event of emergencies such as fire or power failure. Staff told us that in the event of a power failure any operations in progress would continue with the hospital emergency generator but no other operations would be undertaken until power had been restored.
- Staff told us that a major incident plan folder was available in reception and each head of department had their own personal folder for use in an emergency. Managers told us that a table top exercise had taken place within the last 12 months and the process had been reviewed with the health & safety representatives to assess where further improvements were needed.

Are surgery services effective?

Good

The effectiveness of surgery was good because the hospital was monitoring patient outcomes to provide assurance of the effectiveness of the service. Patients were well cared for on the ward and in theatres. Pain control was well managed. The hospital had identified that there were shortfalls in patients who received adequate fluids prior to theatre and an action plan was in place to address this.

Some national and local audits were completed to establish outcomes for patients and when needed identify where improvements were needed. There were plans in place to accredit the endoscopy unit. Benchmarking was undertaken which compared the hospital's performance to other Spire hospitals and some other independent hospitals.

Good

Surgery

There was evidence of good multidisciplinary working and out-of-hours services were provided when needed. Staff had access to training and development and had received annual appraisals which supported their development needs.

Evidence-based care and treatment

- Policies we looked at were accessible, current and referenced good practice guidelines and where relevant, made reference to professional body guidance and published research papers; for example, the safer staffing policy.
- We saw that the hospital had systems in place to provide care and treatment in line with best practice guidelines such as National Institute for Health and Care Excellence (NICE) guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. For example: an early warning score system was used to alert staff should a patient's condition start to deteriorate.
- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the NICE and the Royal College of Surgeons.
- We saw that the clinical effectiveness of procedures and compliance with clinical pathways and benchmarking with other Spire Hospitals was reviewed and assessed within the monthly clinical governance meetings.
- The hospital had a 'BUPA Quality Accredited Network' bowel cancer review in September 2014 which assessed satisfactory compliance with national guidelines.
- The endoscopy unit could be benchmarked through the Joint Advisory Group (JAG) accreditation system. The endoscopy unit at Spire Little Aston was not JAG accredited. The senior management team had plans to apply for this accreditation early 2016 to demonstrate that the unit delivered care and treatment in line with endoscopy national standards, .

Pain relief

- We spoke with five patients who were all happy with the management of their pain.
- Staff told us and records we looked at confirmed that pain management was discussed with the patient at their pre-assessment appointment and again on admission to the ward. While in theatre recovery staff were supported by anaesthetists to make decisions about pain relief needed by patients.
- We saw records which showed that patients were prescribed regular pain relief and also additional 'as required 'pain relief.
- In the 2014 patient satisfaction survey, 98% of patients felt that staff did 'a great deal' to control their pain. The scorecard benchmarked pain scores and was 21st in the group of 39 Spire Hospitals.
- Within the same time frame the hospital audited pain scores and identified that 99% of patients had an assessment of their pain recorded.

Nutrition and hydration

- Records relating to nutrition and hydration were well completed and provided an audit trail of decisions about hydration and nutrition and the actions completed. Fluid balance charts were consistently completed and we saw that patients had access to drinks and snacks at all times.
- The management of 'nil by mouth' prior to surgery was discussed at the patient's pre-admission assessment. Protocols were in place to ensure that food and fluids were taken in line with consultant advice to ensure the safety of the patient.
- All patients told us that they had been given instructions not to have anything to eat from midnight and no fluids from two hours prior to their admission to hospital. Theatre staff told us that they had discussed the list and informed the ward of the time the patient could continue to drink until. The hospital had been monitoring time that patients had been without fluids and had an action plan in place to improve this.
- The hospital's 2014 PLACE audit scored 59.7% for food served in the hospital ward. We saw the hospital had taken remedial action and introduced a new menu.
- The hospital had a dietician with practising privileges whom staff could contact if required. We saw patients' records which confirmed that patients had seen a dietician and were also reviewed by the dietician after discharge.

Patient outcomes

- We were not assured the World Health Organization (WHO) surgical safety checklist was being used consistently. However, information sent to us in post inspection in September 2015 suggested a significant improvement month on month.

Good

Surgery

- Patient Reported Outcome Measures (PROMs) were standardised validated question sets to measure patients' perception of health and functional status and their health-related quality of life. The hospital invited all patients (private and NHS) who had undergone hip or knee replacement surgery to complete a PROMs questionnaire. PROMs data for groin hernia repairs and knee replacements for the year 2013-2014 showed that the Spire Little Aston patients had above the average expected health gain for these procedures. PROMS information identified that the patients who had hip replacements had health outcomes in line with expectations.
- Information provided by the hospital showed that there had been three cases of unplanned returns to theatre between 1 April 2014 and 31 March 2015. For the time period July to September 2014 there had been two cases of unplanned return. CQC assessed the proportion of unplanned returns to be 'similar to expected' compared to the other independent acute hospitals we hold this type of data for.
- There had been two unexpected readmissions to the hospital within 31 days of discharge between 1 April 2014 and 31 March 2015. CQC has assessed the proportion of unplanned readmissions to be 'similar to expected' compared to the other independent acute hospitals we hold this type of data for.
- Staff told us and we saw information that identified staff were involved with monitoring and improving patient outcomes.
- Spire Little Aston had a nurse 'call back' system. Each call was documented with the advice or recommendation given. The call back documents were reviewed each month by the Clinical Nurse Manager or Senior Sister to check that patients had received appropriate advice, and treatment.

Competent staff

- The hospital provided opportunities for induction learning, development and appraisal.
- New staff were supernumerary for six weeks.
- Staff competencies were assessed both during their induction and thereafter as part of their ongoing development.
- Nursing staff had competency booklets that they completed and were assessed against by an experienced member of staff. This meant that assurances were in place to check appropriate staff practice and competency.
- The hospital had a practice development nurse who supported nurses to develop and assess their competencies
- Nursing staff told us that training was supported for those for whom a need had been identified through the appraisal process.
- 98% surgical staff had had an appraisal in 2014.
- We saw that staff who delivered training within the hospital were supported by their managers and team leaders with protected time to ensure this part of their role was fulfilled.
- There was process in place for checking General Medical Council and Nursing and Midwifery Council registrations, as well as other professional registrations.
- Consultant competencies were assured through the NHS annual appraisal, Spire Little Aston biennial reviews and the General medical council (GMC) revalidation process. All consultants must have an annual appraisal by an approved appraiser to maintain practising privileges at Spire Little Aston Hospital. We looked at a selection of consultant's appraisals for; plastic surgery, trauma and orthopaedic and ear, nose and throat (ENT) consultants and saw the appraisals included areas of; knowledge, skills and performance, safety and quality, communication, partnership and teamwork, maintaining trust and a general summary section.
- Consultant competencies were also assured through the clinical review process. This formed part of the biennial review and included reviewing the clinicians' whole practice appraisal, untoward incidents for example: increased new patient ratio to follow up, overbooking of OPD appointments, behavioural concerns and complaint data. In June 2014 the Consultants handbook was updated to include clarification that in signing up to practicing privileges, consultants must agree to the review of their identifiable performance data by the MAC. This was in response to recommendation number 4, of the Verita review.
- Information we saw identified that the hospital database indicated 97% of consultants have an in-date appraisal (based on 15 months expiry) and 95% have

supplied in-date evidence of indemnity. Examples of appraisal evidence reviewed were in line with Spire's medical appraisal policy and were signed off by an NHS appraiser.
- The role of the MAC was to ensure that consultants were skilled, competent and experienced to perform the treatments undertaken. We were told by the MAC representative any concerns identified with a consultants competence would be managed swiftly.

Multidisciplinary working (in relation to this core service only)

- Multidisciplinary teamwork (MDT) was evident. This ensured that patients' needs could be met across a range of treatments and therapies. We observed medical staff, nursing staff, therapists and pharmacists working together as a team on the ward. Records of care and outcomes were maintained by the whole multidisciplinary team. Ward rounds took place daily, although this mainly included doctors and nurses.
- Staff told us that there were MDT arrangements in place with a local trust for patients' cancer care and treatment. MDT compliance across the cancer service was good. Staff told us and we saw information that confirmed an audit of patients' notes identified that MDT involvement was shown in 100% of patient notes.
- We observed one nurse handover during our announced visit. The handover was unstructured and provided inconsistent information, and did not always detail patients' needs, the operation they had or when they had this operation. This meant that that nurses did not have sufficient information and there was a risk that patients would not receive the care they needed. Managers told us that following feedback we provided after our announced inspection the handover had been observed and improvements made. When we visited unannounced we observed a handover and confirmed that required improvements had been made and staff were positive about this.
- Discharge letters were sent to patients' GPs with details of procedures carried out, follow up arrangements and any medication prescribed.
- Physiotherapy was available on the ward and following discharge when needed.
- There was a dietician and speech and language therapist with practice privileges who could be called upon if required.
- Spire Little Aston has a number of contracted and bank Clinical Nurse Specialists for breast, colorectal, gynaecological and lung cancer as well as a Haematology Clinical Nurse Specialist who wereavailable to provide support and advice to patients. In addition there was a Urology Clinical Nurse Specialist with Practising Privileges to provide advice and support to urology cancer patients

Seven-day services

- Theatres were available 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday (the hospital operated on most Saturdays during the year and offered a regular six day service).
- The theatres were also available for any patient needing to return to theatre 24 hours a day, seven days a week when the need arose. There was a staff on call rota which included scrub staff (specially trained staff who directly assist surgeons in the operating room). Staff worked variable hours to accommodate surgeons' requests.
- There were no formal arrangements for out of hours radiology services. However the radiology manager told us that surgeons worked with identified radiologists who were experienced within that surgical specialism and would provide out of hours cover when required. The manager told us that there had been no occasion when an out of hours radiology service was not provided.
- There was an out-of-hours pharmacy with access available through the nurse in charge of the hospital.

Access to information

- Observation records were kept in each patient's room and were accessible to patients and staff.
- Staff told us they had access to policies and procedures and felt they were kept informed by the management team. Staff told us that they all received a newsletter which updated them about events and incidents at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

- Staff we spoke with were clear about their responsibilities in relation to gaining consent, including those people who lacked capacity to consent to their care and treatment.
- Clinical staff completed child protection level two and Mental Capacity Act as e-learning and Deprivation of Liberty safeguards training as part of their annual two day mandatory training programme (calendar year). Compliance with this training was 72% year to date.
- Consent forms complied with current Department of Health guidance. Consent forms identified the procedure to be undertaken, its associated risks and documented the health care professional responsible for consulting the patient. They also recorded signatures from patients indicating that they were providing consent to undergo the proposed procedure.
- We looked at forms recording consent for those patients undergoing surgery at the time of our inspection and found they were fully completed
- At the end of June 2015, 44% of staff had completed Mental Capacity Act training which was above the Spire average of 35%.
- Staff told us that Deprivation of Liberty Safeguards (DOLS) meant stopping patients leaving or restraining them against their will. The hospital had not made any Deprivation of Liberty Safeguards applications in 2013/14 or the current year to date.

Are surgery services caring?

Good

Surgery services were caring. Patients were treated kindly and with compassion and their privacy and dignity was respected.

Support was available for those patients who were vulnerable or had complex care needs. Patients felt involved in decisions about their care and treatment.

Compassionate care

- Patients spoke in complimentary terms about the staff and the care they received. One person said, “Highly recommend it”, another person said, “All the staff have been so good, I could not have been treated better”.
- The Friends and Family Test (FFT) was undertaken by the Spire Little Aston to capture patient feedback. Results showed that from 1 April 2015 and 31 July 2015 98.9% of respondents said they would recommend the hospital.
- The hospital took part in a BUPA patient satisfaction survey. Findings of the 2014 patient survey identified that 97% of patients had rated the hospital as “Excellent or very good”.
- We observed all staff knocking on doors to patients’ rooms and waiting for a response before entering.
- The 2014 PLACE audit scored the hospital, 73.5% for privacy and dignity. The hospital supplied an action plan to identify how improvements were planned or had already been made

Understanding and involvement of patients and those close to them

- Patients told us that they had received sufficient information prior to their planned surgery. Patients were provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. They told us that they had any risks explained to them.

Emotional support

- Patients had access to support from clinical nurse specialists. For example, breast care, colorectal and stoma nurse specialists. The cancer services manager explained that the hospital employed a breast care nurse but other specialist nurses had practice privileges at the hospital and could be contacted to provide patient support pre and post operatively and when bad news was given.
- The hospital had a clinical psychologist with practice privileges and had regular clinics at the hospital and could provide counselling when needed.

Good

Surgery

Are surgery services responsive?

Good

Surgery services were responsive to the needs of patients using the service. The admission, treatment and discharge pathways were well organised and flexible to meet patients' varying needs.

The majority of patients were admitted on a planned basis for elective surgery this included private patients and NHS patients.

Staff worked in a flexible manner to meet the theatre schedule and ensure patients' needs were met.

There was no differentiation between private and NHS patients in terms of services received. However although there were very few cancelled operations cancellation was more likely for NHS patients.

Learning was taken from complaints and helped to inform service improvement.

Service planning and delivery to meet the needs of local people

- The hospital provided both privately funded care and had a contract to provide identified procedures under the NHS. The hospital had increased its patient activity by 14.5% with 6911 patient discharges in 2014 compared to 6038 patient discharges in 2013.
- The increased patient volumewas mostly due to a growth in NHS business and the availability of additional surgical procedures such as laparoscopic hysterectomy, refractive laser eye surgery and hip arthroscopy
- The hospital did not provide emergency care and all admissions were planned and arranged in advance.

Access and flow

- The admission process and care provided was the same for private patients and NHS patients. The assessment of the patient's suitability for surgery at the hospital was considered at four levels. However some patients including those undergoing major surgery (surgical grade three or above as defined by NICE guidelines) and / or those with one or more other co-morbidities (other health conditions)proceed directly to level three assessment:

  Level one– This included receipt and assessment of the patient's pre-admission medical questionnaire (PAMQ).

  Level two - Nurse-led telephone clinical assessment.

  Level three - Nurse-led pre-operative assessment within the pre-operation clinic (this may also include therapy input dependent on the patient and their planned operation).

  Level four - Anaesthetic referral.
- Patient admissions for theatre were staggered throughout the day to ensure patients did not experience extended waiting times. The lists for theatre were compiled by each consultant surgeon's secretary allowing sufficient time to enable the theatre to be cleared and prepared for the next patient.
- There was a one week 'window' for booking operations and staff confirmed that lists were rarely ever changed past that time.
- A theatre recovery area was available with dedicated staff. If needed, additional help was available to recovery staff from the theatre operating department staff.
- The referral to treatment waiting time targets for NHS patients between 1 April 2014 and 31 March 2015 were met for all areas.
- Patients were seen by the resident medical officer and consultant before discharge and all treatment communicated to patients' GPs.
- Discharge arrangements were discussed pre operatively. Patients told us that they were required to confirm that they had somebody at home to support their care before they could be discharged.
- Between 1 April 2014 and 31 March 2015 the hospital cancelled 14 operations due to non-clinical reasons such as insufficient theatre as a previous operation had taken longer than expected, or no anaesthetist available.

Meeting people's individual needs

Good

Surgery

- All patients had a single room with ensuite toilet and shower facilities.
- Care planning for patients with complex needs such as patients living with dementia or a learning disability commenced at pre-op assessment. Staff told us that a multi-disciplinary planning meeting was held. Staff told us about the arrangements which had been planned for one patient several months before their planned admission.
- There was an interpretation service available for patients and their families who did not have English as their first language.Staff told us that although they used this service the hospital had several staff who spoke different languages and were able to translate when required for basic care needs We spoke with one family whose first language was not English, they confirmed that they had an interpreter.
- Pre-operative information was sent to patients. The information included details about fasting times, admission instructions and a procedure-specific information leaflet
- In the 2014 patient satisfaction survey, 96% of patients said they felt their discharge process was well organised.
- Patients were provided with written information on discharge (including a discharge brochure, procedure-specific information, wound care and a copy of the discharge summary). They were also provided with telephone numbers to call in the event of problems following discharge.
- On discharge further information was provided. Staff said that patients could telephone the ward with any concerns post discharge and contact details were provided.
- Patients were told and received written information about what to expect following their discharge, what medicines they needed to have and what to do if they had any concerns.
- In the 2014 patient satisfaction survey, 82% of patients rated the quality of food as excellent or very good. This was benchmarked as 22 out of 39 hospitals in the Spire group.

Learning from complaints and concerns

- The hospital had received nine complaints about surgical services between 1 January 2015 and 31 March 2015. Information we saw showed that the complaints had been investigated and when needed actions undertaken. For example staff told us that they now checked on patients every hour prior to their operation, this helped to reduce patient anxiety and kept them updated on the progress of the theatre list and possible time of their operation.
- We saw information in the hospital about how to raise concerns using a feedback form titled “please talk to us”. This form could be completed either whilst the patient was in the hospital or it could be sent in after discharge. Staff were encouraged to respond to complaints or concerns at the time of complaint.
- Staff told us about learning shared following recent complaints and how ‘comfort rounds’ now included pre-operative patients. This provided patients with an opportunity discuss any concerns they had and for staff to keep them updated on the progress of the theatre list.
- Complaints were reviewed at the monthly heads of departments meetings, governance meetings and MAC meetings where outcomes, lessons learnt and improvements on practice were discussed.

Are surgery services well-led?

Good

Surgery services were well led.

The hospital’s vision and values were well embedded within surgery services. Staff demonstrated commitment to its vision and values. There was a culture of audit and improvement and transparency when incidents occurred or things did not go right within surgery services.

Arrangements for governance and performance operated effectively. There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. Staff and managers were clear about their ‘duty of candour’.

Staff felt well supported by their immediate managers. Staff were positive about the standard of care they provided and that their achievements were recognised.

Good

Surgery

Vision, strategy, innovation and sustainability for this core service

- Staff were aware of and understood the vision and values of 'Spire' and the hospital and how their role and behaviours would achieve these values.
- Managers told us that they discussed the hospital's values during team meetings, recruitment interviews and staff appraisals.
- Senior managers told us that an application for JAG accreditation of the endoscopy unit would be made in the next six months.
- Independent health services were dependent on demand for its services. Information we saw showed that demand for services at Little Aston had increased in the previous year by 14%.
- There was a positive culture of staff development and empowerment which was supported and encouraged by all managers we spoke with.

Governance, risk management and quality measurement for this core service

- In 2013 Spire Healthcare commissioned an independent review by Verita to understand the circumstances that enabled a former breast care surgeon to practice as they did, which led to the consultant's practicing privileges being withdraw in 2013 and the recall of more than 600 patients at another hospital at Spire Parkway. The report looked specifically at governance arrangements within both Spire Hospitals as the consultant also had practising privileges at Spire Little Aston Hospital, although the majority of care and treatment was largely carried out at Spire Parkway.
- During the inspection we reviewed the 15 recommendations and looked at whether Spire Little Aston had implemented them. We saw evidence to demonstrate that the majority of recommendations had been implemented at the hospital. However, recommendation number four, stated"ensure compliance with Spire's policy regarding biennial review of consultants practising privileges". For Spire Little Aston it meant "continuing to carry out such reviews." We saw this recommendation was outstanding as only 49/301 biennial reviews had been carried out at the time of our inspection, amounting to 16%. There had been a new senior management team at Spire Little Aston, consisting ofthe Hospital Director, Matron and Governance lead, we saw the team had inherited this backlog of biennial reviews and told us they considered this backlog as a priority.Post inspection, we were sent information from the hospital on 30 September 2015 which showed this had increased to 90%. The outstanding 10% were due to Consultant's Scope of Practice forms which were required to be signed off by the MAC representative. However, we were told these forms had been reviewed by the matron and signed off at that level and no concerns had been raised.
- Consultant's clinical practice was reviewed on a regular basis and in a number of ways. For example the monthly clinical dashboard was produced by the Clinical Governance team and discussed at the monthly Clinical Management Group meeting and also at the monthly Senior Management team meeting. We saw meeting minutes to support this and we saw the clinical dashboard was displayed across hospital departments. Any areas that were RAG rated red were automatically escalated to the central governance team and action plans were required to address concerns.
- The quarterly Clinical Governance process reviewed results from the clinical scorecard and involved a number of clinical committees. The clinical scorecard was produced by the Central Clinical team and formed part of the Clinical Governance report. Both systems reviewed all clinical incidents, complaints, infection rates, reported incidents, returns to theatre, hospital readmissions, conversions to overnight stay and cancellations of appointments.
- The risk management and clinical governance meeting was linked into the heads of departments (HOD) senior management team (SMT) and the MAC meetings. This enabled both senior managers and clinicians an opportunity to review risk and take appropriate actions to address and reduce highlighted risks.
- Consultant surgeons and anaesthetists were represented on the MAC. We saw and consultants told us that incidents and complaints were presented and discussed at the MAC. The MAC also discussed any issues and reviews of surgical procedures as required.

Good

Surgery

- We saw actions in place in response to 'serious incidents and never events. This included 'STOP before you block' posters in theatres. Stamps also remained staff to record that pregnancy testing had been completed on all required records.
- The hospital had introduced a reminder process to prompt consultants for information required by the consultants' handbook (up to three reminders were sent). If a consultant was suspended, they had two weeks to supply the required certification; if this was not forthcoming practising privileges were withdrawn. The hospital used scorecards to assess risks and the quality of care provided. If an 'amber' or 'red' risk was identified this meant that the hospital was failing to meet its target in that area and an action plan was identified. We saw and staff told us about action plans to improve performance such as a reduction in falls and the use of different anti-embolism stockings with foot grips.
- There was an assessment of the hospital's performance against other Spire Hospitals which was discussed during SMT and HOD meetings.
- Patient satisfaction scores recorded in the clinical quality report were reviewed at the heads of departments meeting and senior management team meetings. Areas which required improvement were highlighted for further focus.
- The hospital risk register for June 2015 recorded 26 identified surgery risks, of which nine were high risk. We saw that the date the risk was identified was recorded alongside a date that the risk would be reviewed. We saw that timely actions were usually identified although this was not always the case. For example the unsatisfactory monthly figures relating to the WHO surgical checklist was not placed on the risk register. Another example, was the 'red' risk identified for the 'Air flow in SSD',(sterile services department), commented 'New Air Handling Unit required' but no date for this to be addressed was identified.
- A root cause analysis (RCA) investigation was undertaken following each serious incident or post-operative infection. The RCA detailed the investigations undertaken and actions to reduce the risk of further similar incidents in the future.

Leadership/culture of service related to this core service

- The hospital director led the hospital supported by the head of clinical services. Leadership within surgical services was provided by the theatre manager who managed theatre activity and a clinical services manager who managed nursing staff on the ward. A clinical governance manager reviewed clinical governance both within surgery and throughout the hospital.
- The ward and theatre staff told us they felt well led by both local and senior management. They told us they found the ward and theatre manager approachable.
- Staff told us that positive comments about them and the care they had provided were fed back from the hospital director and senior staff which they appreciated
- Staff told us that both the hospital director and head of clinical services were visible and supportive and they could approach them with any concerns. Theatre staff told us that the head of clinical services who had extensive theatre experience would 'scrub'if needed. Several staff told of how they felt the hospital had improved since the employment of the current hospital director and head of clinical services. Staff felt better informed and ideas for improvement were encouraged.
- A managers' feedback sheet had been introduced and was circulated to ward staff highlighting the key changes planned for the following month (e.g. improved communication with patients going to theatre).The clinical services manager had a staff communication board 'the Ed board' in the staff room that updated staff on that month's plan and key areas such as training and development.
- A business coach had been working with the heads of departments (two days per month) to promote staff development.
- Staff and managers told us that poor behaviour / performance was challenged and appropriately addressed.
- Staff told us that the hospital was a friendly place and they liked coming to work. They told us that they would recommend the hospital to their friends and family for care and treatment.
- The clinical governance report identified that there had been a 22% increase in incident reporting from 2013 to

2014, we were told this was due to 'a positive reporting culture' and staff felt empowered to report incidents as they were confident action would be taken to improve services for patients.

- Staff told us they had faith in the management team to drive improvements in care.

Patient and Staff engagement

- Staff involvement was welcomed by the management of the hospital and was facilitated by various means. These included the opportunity for staff to attend an employees' forum, team talks and a staff newsletter. Initiatives to support staff included a "reward drop-in session" and on-site health assessments.
- The staff we spoke to felt valued and that senior managers engaged with them. Staff spoke positively about the 'Inspiring People's Award' which recognised staff achievements and patient compliments. Staff particularly commented how much they valued that these awards were given in person by the hospital director.
- There were quarterly staff briefings led by the hospital director and which included information on strategic priorities and time for staff questions and answers.
- Every month a random selection of staff who had birthdays that month were invited to 'tea with the Hospital Director which was an informal meeting which staff were able to discuss their experience of working in the hospital.
- The hospital had a 'comments and answers' box. Staff could put questions in anonymously if they wished and answers to their questions were shared with staff in the staff newsletter.
- The hospital had a "You said, we did" scheme. This highlighted feedback received from patients and actions taken to address those concerns such as improvements to the fabric of the building and employment of a psychologist at the hospital to provide patient counselling.
- Standardised notice boards had been introduced in each department which included information for staff on the clinical score card, Duty of Candour and Deprivation of Liberty Safeguards.

Good

Outpatients and diagnostic imaging

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

Information about the service

Outpatients services was rated as good overall. Spire Little Aston Hospital are provided from 15 private consulting rooms, used by consultant doctors with practising privileges to work from the hospital, and from a chemotherapy suite. The hospital offers a range of services through its outpatients department, including minor surgical procedures, cancer treatment, health assessments (including those for Australian and New Zealand visa applications) and cosmetic surgery.

Diagnostic imaging was provided on site. Services offered included computerised tomography (CT) and magnetic resonance imaging (MRI) scans, mammography, x-rays, fluoroscopy and ultrasounds.

Sport and general injury rehabilitation, health screening and occupational health facilities are provided through a Spire 'Perform' clinic on site.

Services were provided to patients who were self-funding, those covered by private medical insurance and to NHS patients who had been referred by their GP or who had booked via the NHS 'choose and book' service.

Summary of findings

Overall we judged outpatients and diagnostic imaging services were good.

Effective processes and policies to keep people safe and protected from abuse and avoidable harm were in place, and were regularly checked and monitored. There was a culture of open reporting of incidents and near misses and these were investigated and where necessary changes were made to improve safety.

Staff were well trained, patients were provided with effective, evidence-based care and were kept free from pain. Patient feedback was routinely gathered, assessed, fed back to staff and acted upon. Premises and equipment were adequate to provide effective treatment.

Staff provided compassionate care and emotional support to patients and those close to them. Feedback from patients consistently rated the care they received as good or excellent.

Services were planned and delivered in a way that met the needs of patients, who could access the right care at the right time. Waiting times, delays and cancellations were minimal and services ran on time.

Complaints were dealt with in an open and honest fashion and improvements were made as a result of complaints and concerns.

Good

Outpatients and diagnostic imaging

The leadership, governance and culture of the departments promoted the delivery of high quality person-centred care, and staff understood how the hospital's vision, values and strategic goals affected their roles.

More work was required to bring all outstanding consultant biennial reviews up to date.

Candour, openness, honesty and transparency and challenges to poor practice were the norm. Behaviour and performance that was inconsistent with the department's values was identified and dealt with, regardless of the seniority of the people involved.

The service proactively engaged and involved staff and ensured that their voices were heard and acted on. The leadership actively promoted staff empowerment to drive improvement.

Staff actively raised concerns and those who did were supported. Concerns were investigated in a sensitive and confidential manner, and lessons were shared and acted upon.

Are outpatients and diagnostic imaging services safe?

Good

We found that safety in outpatients and radiology at Spire Little Aston was good and that patients and staff were protected from avoidable harm and abuse.

Staff felt able to raise concerns and report incidents and near misses and were fully supported when they did so.

There were clearly defined policies and processes to keep people safe and safeguard them from abuse. These were understood by all staff and implemented consistently and staff had received appropriate training.

Staff were trained in safeguarding vulnerable adults, children and young people.

Risks to people who use services were assessed, monitored and managed on a day-to-day basis. Staff had appropriate training to manage patients showing signs of deteriorating health and medical emergencies.

Incidents

- Clinical and support staff at all levels were familiar with the hospital's electronic incident reporting system. They had faith in the process and told us that incidents that were reported were thoroughly investigated and feedback was given to staff who were involved.
- Between April 2014 and the end of March 2015 a total of 405 incidents had been reported in the hospital, two of which had been rated as serious incidents.
- Staff told us that they used the incident reporting system to get processes changed for the benefit of patients and that it "works well".
- Staff gave us examples of the type of incidents they had, or would report. These included wound swabs to identify infection, falls and equipment faults. In addition to incidents where harm had occurred, they told us they would report 'near misses' and incidents where no harm had been suffered, but could have occurred.
- All relevant reported incidents were discussed at OPD and radiology's monthly team meetings to ensure that any lessons learned were shared among staff. We were shown copies of the minutes of these meetings, which were shared on the hospital's intranet so that staff who

could not attend in person could be kept informed. The meeting minutes detailed incidents and near misses that had been discussed, and actions taken as a result. One incident that had occurred shortly before our inspection was an x-ray of the wrong knee. As a result of that a policy had been put in place stipulating that two members of staff had to check that the correct site was being x-rayed before the procedure was carried out.

Duty of Candour

- The hospital director had attended a training day for registered managers, which included a session on Duty of Candour which was delivered by a lawyer. This helped to ensure that the hospital complied with their legal duty in this regard.
- Managers of the outpatients and imaging departments demonstrated a good understanding of the hospital's duty of candour obligations should an incident result in harm to a patient. They told us the process meant being open and honest, apologising if the hospital was to blame and keeping an open dialogue with the patient or their representatives during any investigation into their concerns.
- All the staff we spoke to in both departments had a broad awareness of the implications of duty of candour and how it affected their managers and the hospital. We saw there was a Duty of Candour Policy in place.

Cleanliness, infection control and hygiene.

- Over two periods during our inspection, totalling 35 minutes, we observed staff in outpatients walking past a wall-mounted alcohol gel dispenser. Various members of staff passed the dispenser, entering and leaving the department, 38 times during that period, however the alcohol gel was used on only three occasions. We were not assured that regular habitual hand cleansing was well embedded in the staff culture.
- We saw that hand hygiene audits were undertaken and they included observation of staff hand cleansing. The hospital also monitored the quantity of hand gel used within a given time frame on the assumption that there was a link between gel used and appropriate hand hygiene. The hospital target was for the hand sanitiser to be used more than 18 times per day, they had not met this target and an action plan was in place to increase its use.
- The minutes of the hospital's clinical governance committee meeting from February 2015 reported that an internal investigation had shown that nurses preferred hand washing to using alcohol gel. The matter had been escalated to the infection prevention and control committee plans had been made to carry out observational audits.
- Any incident reports about possible wound infections were automatically flagged for the attention of the infection prevention and control lead nurse.
- In the first and second quarters of 2015 no MRSA, MSSA, clostridium difficile or E. coli bacteraemia cases were reported in the hospital.
- We inspected five consulting rooms and found that all of them were clean and had cleaning wipes, alcohol gel or foam and hand washing facilities available. All of the rooms had a cleaning schedule displayed on the door.
- We were given a copy of the 2015 patient-led assessment of the care environment (PLACE) audit report and the hospital's action plan resulting from it. Outpatients had scored a 'qualified pass', achieving one point out of a possible two for all areas of cleanliness. They had scored zero for items under hand hygiene and equipment cleanliness (no cleaning schedules displayed).
- The action plan to address the PLACE audit contained six points, four of which had been completed and two that were ongoing. The plan addressed all of the failings highlighted in the audit and showed that the hospital management were taking action in response to the report.

Environment and equipment

- The consulting rooms were all located on one of four corridors, arranged in a 'hub and spoke' pattern with the nurses' base at its centre. This meant that the door to every consulting room was visible from the nurses' base and consultants were able to attract a nurse's attention quickly if they required assistance.
- We checked sterile, single use items at random in five equipment trolleys and found them all to be in date and sealed in intact packaging.
- At the time of our inspection the outpatients consulting rooms were undergoing a programme of refurbishment. This was being done one room at a time, when the department was closed at weekends, to minimise disruption for and risks to patients and staff.
- Most of the consulting rooms were carpeted. Part of the refurbishment programme involved replacing the carpet

with a wipe-clean floor surface around and below the couch used for patients. Wipe clean floors, materials and surfaces are good practice in clinical environments for infection prevention and control.

- We saw that resuscitation equipment trolleys were checked daily and opened for a comprehensive check monthly. The resuscitation trolley in outpatients was difficult to open due to a buckled lock. We brought this to the attention of the department sister who immediately arranged for it to be repaired.
- Outpatients resuscitation trolleys were equipped with paediatric as well as adult equipment.
- Equipment in outpatients was serviced and maintained by external contractors. We saw service records for five items and all were up to date.
- In accordance with the Ionising Radiations Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) the radiology department had radiation protection audits every three years. We were shown the reports of the audits carried out in 2011 and 2014. The most recent audit (conducted in November 2014) made 12 recommendations, 11 of which related to documentation. The twelfth recommendation was that a radiation protection committee (RPC) should be established in the hospital. We were given minutes of the RPC meetings which showed that this had been set up, and the minutes included actions dealing with the recommendations.
- We were shown maintenance and servicing records for computerised tomography (CT) equipment and found it to be up to date and appropriately completed.

Medicines

- The anaphylaxis (severe allergic reaction) medicines and paediatric resuscitation medicines in the hospital's emergency trolleys were checked and maintained by the hospital pharmacists. We were shown records that evidenced regular, comprehensive checks with medicine batch numbers and expiry dates recorded individually.
- We checked the medicines in the minor procedures room and found they were all in date and properly stored.
- We checked the medicines in the outpatients storage cupboard and found they were all in date and that the system for signing for medicines was correctly followed by all staff.
- Radiographers were given training by the hospital's pharmacists to allow them to administer some medicines specific to their role under a patient group directive (PGD). The medicines involved were omnipaque, visipaque, klee-prep, picolax and buscopan. There was no PGD in place for saline flushes, which are a type of injectable medicine which were used by radiographers. However, by the time of the unannounced inspection a PGD for saline had been implemented.
- We saw that patients received medicines in accordance with their prescriptions and that staff administered medication in line with the hospital's medication policy.

Records

- Patients' records were stored on site for three months then off site at a secure archive facility.
- Notes could be recalled from the on-site medical records department any time up to 3pm. If a patient arrived after that time results of imaging and other investigations were available electronically. Notes of the new consultation would be written up and then collated with the patient's old notes to ensure the record was complete.
- At the end of each day the records trolleys were locked in the outpatients department manager's office. This ensured that patients' records were kept secure.
- Outpatients staff informed the medical records department as soon as appointments were booked for patients to ensure that their records were available on site when they arrived for their consultation.
- Consultants were allowed to take photocopies of patients' notes for their own records but originals had to remain securely stored by the hospital and consultants were not allowed to remove them. Photocopying of notes was done by the hospital staff. This meant that the hospital maintained complete records of the treatment provided to patients. We were told that this rule had been reinforced on the current outpatients manager's appointment when emails were sent to all consultants containing excerpts of the consultants' handbook that dealt with management of patient notes. Compliance with this rule was monitored through spot audits of patients' notes.

- We were shown the procedure for issuing and returning patients' notes from and to the medical records store. This evidenced a robust process to quickly identify any missing notes and ensure that patients' records were kept secure.
- In the 'Perform' physiotherapy clinic waiting area some chairs were positioned where they had a view of the receptionist's computer screen, which sometimes showed personal details of other patients. This meant that people in the waiting area may have been able to read details of other patients. The receptionist told us that this problem had been reported and a new desk was on order, which would be able to be positioned differently so that the screen was not visible to anyone apart from the receptionist. They also told us that the chairs giving a view of the screen were not normally there, but had been added that day due to a higher-than-usual number of patients attending the clinic.

Safeguarding

- The outpatients administration staff had been trained to act as chaperones should patients request the service, and completed competency documents to evidence their training. We were shown copies of the teaching pack and guidelines for chaperones, and the competency document, all of which were comprehensive and provided evidence of chaperones' training, understanding of the role and responsibilities to keep vulnerable patients safe.
- If the chaperone service was provided it was recorded in the patients' notes and countersigned by the chaperone.
- Adult and children's safeguarding level one e-learning was provided for all staff, and was completed within their first three months of employment. In July 2015 94% of staff had completed both training modules. All members of staff completed refresher training on adult and children's safeguarding once per calendar year. By July 2015 74% of staff had completed their refresher training. The remaining 26% had training scheduled before the year end.
- Safeguarding level two training was delivered in a classroom environment as part of clinical staff's mandatory training programme, which ran each calendar year. By July 2015 72% of clinical staff had completed this training.
- The matron/head of clinical services and the hospital paediatric lead had both completed level three safeguarding training. Staff were aware that they could be asked for advice on safeguarding.
- Plans were in place for the clinical governance manager, quality and risk lead nurse and the outpatient services manager to complete level three safeguarding training by the end of 2015. This meant that a larger number of highly qualified staff would be available to advise on safeguarding matters.

Mandatory training

- Radiology staff and all healthcare assistants in outpatients were all trained in adult and paediatric basic life support. Staff nurses and senior staff nurses were trained in adult immediate life support and paediatric basic life support, and were able to undergo paediatric immediate life support training if they wanted to. Nurses of a grade higher than senior staff nurse were all trained in adult and paediatric immediate life support and were able to undergo advanced life support and additional paediatric life support training if they wanted to.
- All qualified nurses were trained in acute illness management, which provides skills in identifying and treating deteriorating patients. Healthcare assistants were provided with a similar course tailored to their skill levels.
- We were given details of the hospital's mandatory training programme for 2015. Training in fire safety and evacuation procedures, infection control, health and safety, compassion and safeguarding was provided annually. Over 93% of staff in outpatients and radiology had completed fire safety, infection control and safeguarding training; 93% of outpatients staff and 88% of radiology staff had completed health and safety training.
- Manual handling was provided biennially, with a target of training 95% of the hospital's staff. 76% of outpatients staff and 70% of radiology staff had completed this training at the time of our inspection. Role-specific training was provided for appropriate staff in managing violence and aggression, controlled drugs, incident reporting, safe use of display screen equipment, the Mental Capacity Act and safe transfusions.
- Training on how to use the incident reporting system was delivered face to face as part of new staff members' induction and was also available as e-learning.

- Bank staff who worked in radiology could either attend Spire's mandatory training sessions or provide evidence that they had completed equivalent training in the NHS, and that it was up to date. Premises-specific mandatory training, such as fire safety, was provided for bank staff.
- Mandatory training for radiology staff was planned by the imaging manager and the hospital's head of clinical services in January of each year. Most training was delivered by in-house staff who had appropriate experience.

Assessing and responding to patient risk

- At the time of our visit radiology had an in-house checklist but did not use the World Health Organisation safety checklist for radiological interventions. Use of this checklist is considered best practice. We raised this with the hospital's senior management team during our inspection and when we returned on an unannounced visit we found that the checklist had been implemented within a week of the management team being informed. We saw three examples of checklists which were all properly completed.
- Radiology provided non-invasive imaging services for children. The department worked in accordance with Spire Healthcare's procedure for the care of children and young people and information, policies and guidelines for diagnostic imaging departments. We were shown copies of both these documents.
- As part of their pre-admission medical questionnaire all patients completed a statement detailing any allergies before medicines were administered. We were given a copy of the hospital's pre-admission medical questionnaire.
- Before any x-ray procedure was carried out radiography staff completed a six-point identity check for patients to ensure that the right patient was undergoing the right procedure.
- A radiologist described a robust process for reporting on any unexpected findings in results of imaging tests. Results of this nature were sent to the relevant NHS multidisciplinary team co-ordinator and the radiologist would also contact the referring consultant directly. This ensured that unexpected findings were promptly and properly investigated and that correct treatment could be arranged for the patient.

Nursing staffing

- Outpatients had not used any agency nurses during the year April 2014 to March 2015.
- Outpatients had 8.1 whole time equivalent qualified nurses and 1.66 whole time equivalent healthcare assistants. The outpatients manager told us that approximately 200 hours per month were covered by bank staff. This equated to around 18% bank nurse use. The Outpatient Manager told us they were discussing increasing permanent nurse staffing with the Head of Clinical Services to reduce the amount of reliance on bank staff.
- An outpatients sister told us that three bank nurses were working full time in the department. This meant that the staff concerned were familiar with the department and were able to work effectively and safely.

Radiology Staffing

- Radiology was staffed by one whole time equivalent (WTE) Imaging Manager and 8.5 WTE contracted Radiographers and five x-ray assistants. The department used five bank radiographers as required, usually to cover Saturdays. This provided sufficient radiology staff to provide a safe service for patients.
- We saw there was no radiologist on call at Spire Little Aston Hospital, we were told this was not general practice across any Spire Hospitals or the independent sector. Post inspection, the senior management team told us most consultants preferred their regular NHS radiologist to report their imaging or a radiologist with experience with that specialism. Therefore a blanket on call register may not guarantee a radiologist with a specific specialism would be available. The senior management team stated and we saw there had been no reported incidents to date where there had been an issue contacting an appropriately skilled radiologist.
- Three of the contracted and one of the bank Radiographers were qualified Mammographers
- The department was supported by a team of seven administration assistants, six of whom were part time. The seven personnel made up an equivalent of four and a third full time staff and this number provided adequate administrative support for the department.

Medical staffing

- Nurses in outpatients told us that when consultants were granted practising privileges at the hospital the senior management team showed them round the

department and introduced them to the nurses. This meant that the consultants were familiar with the layout of the department and that the nurses had met them before the first time they held clinics at the hospital.

- Over 300 consultants held practising privileges at the hospital. Consultants also worked in NHS hospitals or clinics and provided private consultations at Spire Little Aston in addition to their core employment.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

Information about people's care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. Outcomes for people who used services were positive, consistent and met expectations.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities. Accurate and up-to-date information about effectiveness was shared internally and was understood by staff.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to maintain and further develop their professional skills and experience.

Staff could access the information they needed to assess, plan and deliver care to people in a timely way.

Consent to care and treatment was obtained in line with legislation and guidance. People were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

Deprivation of liberty was recognised and only occurred when it was in a person's best interests, was a proportionate response to the risk and seriousness of harm to the person, and there was no less restrictive option that can be used to ensure the person gets the necessary care and treatment .The Deprivation of Liberty Safeguards were used appropriately.

Evidence-based care and treatment

- Outpatients worked to the National Institute for Health and Care Excellence (NICE) guidelines for the use of routine preoperative tests for elective surgery, this applied to all staff including bank and agency.
- New NICE guidelines were reviewed during quarterly clinical governance team meetings and any that applied to services offered by the hospital were cascaded to operational managers and staff.

Pain relief

- We were given copies of two pain management guides that had been produced by the hospital's pain management team. One guide contained basic information on pain assessment and different types of pain medicines, and the other was a more complex information booklet. The more complex booklet went into further detail about how different types of pain management worked and how to get the best results from them, possible side effects, methods of taking pain medicines, help on dealing with sickness and nausea after surgery and 24-hour helplines that could give further advice. The appropriate guide was given to those patients who were going to be managing their pain after discharge from the hospital. Three patients told us they had been given the guide and they had found it very useful.
- Patients told us that they always had adequate pain relief and advice about controlling their pain while under the care of the outpatients department.
- Over 98% of patient surveyed between January and July 2015 answer the question "to what extent did staff control pain" was answered as either a "great deal" or "fair amount".

Patient outcomes

- The hospital carried out a programme of regular audits, including areas such as venous thromboembolism, medical records, pain management and controlled drug policy compliance.

Competent staff

Good

Outpatients and diagnostic imaging

- Radiology staff told us they were given protected time to undertake continuing professional development and were encouraged to undertake external training courses and study.
- Mammographers' competencies were subject to a continual programme of assessment through peer reviews. We were shown examples of peer review records and saw that they demonstrated an effective validation framework.
- Outpatients had recorded that over 98% of their nurses and care assistants had appraisals during 2013 and 2014.
- During 2013 and 2014 97% of the hospital's allied health professionals, which includes radiology staff, had received an appraisal. This figure was not broken down further into separate departments.
- Department managers were informed of new policies by email. Policies were distributed to staff by the administration department and staff signed to acknowledge receipt.
- A newly appointed manager told us they were booked on a 'management fundamentals' course in October 2015. Senior nurses were also being encouraged to enrol on this course. A team leader from ophthalmology told us they had attended this course and found the formal content and the opportunity to learn from staff working at other Spire sites very useful.

Equipment

- Outpatients consulting rooms were equipped with a good range of equipment needed for effective patient consultations. New diagnostic equipment trolleys had been installed since the appointment of the new department manager.
- The diagnostic imaging department was equipped with computerised tomography and magnetic resonance imaging scanners, mammography units, x-ray facilities, and fluoroscopy and ultrasound equipment. This meant that the majority of tests and investigations requested by consultants could be provided on site for their patients.

Facilities

- Staff told us that there was no dedicated administration or rest room for nurses in outpatients. This meant that staff could not work undisturbed when they needed to and that they had to take breaks in the restaurant, in view of patients and patients' relatives. They told us that the hospital director was aware of the problem, and that staff understood that a solution to these issues was affected by the availability of space in the building.
- Staff told us that there were not enough car parking spaces at the hospital, but that the hospital director was aware of this and plans were under way to convert more of the grassed area outside the hospital into hard standing for parking. Staff said that this was waiting for planning approval from the local council before it could go ahead.

Multidisciplinary working (related to this core service)

- Staff told us and we saw that there was a culture of all departments in the hospital working together for the benefit of patients.
- We were shown a copy of a leaflet that had been produced to help GPs make appropriate referrals to the hospital. It included contact details for the NHS contracts lead and NHS coordinator, details of procedures that could be carried out under the NHS 'choose and book' service, a list of exclusions (conditions which meant a patient could not be accepted) and general guidance for GPs. The leaflet also included details of the 'patient pathway', which explained the service that the GPs' patients could expect to receive from the hospital.

Seven-day services

- Apart from CT scanning, imaging services were available from 8.30am to 8pm Monday to Friday and 8.30am to 1pm on Saturdays. CT scanning was available from 9am to 5pm Monday to Friday.
- There was no formal on-call radiologist cover, to cover weekend and night time working. Staff explained that informal arrangements existed with a radiologist who lived near to the hospital and could be called upon in the event of urgent out-of-hours needs. We were told this arrangement had worked in the past. However, we were not assured this informal arrangement was sustainable.

Access to information

- Printed copies of all the hospital's policies were held in outpatients and radiology, and were available on the hospital's intranet. Staff were able to find both the printed and online copies easily when we asked them.

Good

Outpatients and diagnostic imaging

- OPD and radiology staff told us that minutes of their staff meetings were made available as printed copies and on a shared drive on the hospital's computer network.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All clinical staff at the hospital completed Mental Capacity Act and Deprivation of Liberty Safeguards training as part of their annual mandatory training programme, which ran each calendar year. By July 2015 72% of clinical staff had completed their mandatory training and OPD and Diagnostic services were on plan to complete 100% mandatory training by year end.
- Staff we spoke with were able to explain their responsibility to gain consent from patients before carrying out any procedure and were aware of the procedure for assessing whether patients had capacity to consent to their treatment.
- Radiologists discussed procedures with patients and completed consent forms, while ensuring that the procedure was justified in accordance with IR(ME)R.
- Verbal consent was recorded in patients' notes for more minor procedures such as core biopsies.
- Managers at the hospital were aware of Deprivation of Liberty Safeguards (DoLS) but had not needed to make any applications in the 12 months prior to our inspection. DoLS was more commonly needed in inpatients environments but may have been required on occasion when outpatient treatment was being provided for long periods on the same day.

Are outpatients and diagnostic imaging services caring?

Good

We found that caring standards in outpatients and diagnostic imaging was good. We heard of a number of examples where staff went over and above what was expected of them to support patients and their families.

People said staff genuinely cared about them and went out of their way to demonstrate that.

People were supported, treated with dignity and respect, and involved as partners in their care.

Feedback from people who use the service and those who were close to them was consistently positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.

People were involved and actively encouraged to be partners in their care and in making decisions, with any support they needed. People understood their care, treatment and conditions.

Patients' privacy and confidentiality was respected at all times.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were enabled to manage their own health and care when they could, and to maintain independence.

Compassionate care

- All 18 of the patients, some with relatives and/or carers told us staff were always polite and helpful and treated them with the utmost respect.
- All 18 patients we spoke with told us that staff were always compassionate, understanding and provided an excellent standard of care for them.
- We saw staff in outpatients and radiology interacting with patients in a consistently cheerful and helpful manner.
- We were told about an incident when a patient coming in for an appointment had got lost and couldn't find the hospital. Staff spoke with the patient on the telephone and worked out where they were, then a member of staff drove out to meet the patient and led them back to the hospital.
- In over 96% of patient experience surveys between January and July 2015 care and attention provided by nurses had been rated as 'excellent' or 'very good'.
- Patients were given a patient satisfaction survey form. The questionnaire asked how likely they were to recommend the hospital to friends and family; asked them to rate the overall service they had received, their overall impression of the hospital, the information they were given before arrival, the welcome they received from reception staff and the quality of care they received from nursing staff. It also asked patients to say if there was anything the hospital had done particularly well or if they could have done anything to improve the patient's experience.

Good

Outpatients and diagnostic imaging

- Responses from the patient satisfaction survey carried out between April to June 2015 showed that 91% of patients responded 'excellent' overall to the quality of care provided by their Consultant against a target of 72%. 86% of patients responding 'excellent' overall to the care and attention provided by nursing staff against a target of 85%. 73% of patients responded excellent overall to the way they were prepared for being at home. Responses were comparable whether patients were insured, self-pay or NHS.

Understanding and involvement of patients and those close to them

- One parent of a paediatric patient told us that staff had been very understanding and extremely patient with their child, who was living with behaviour problems.
- Patients and relatives told us that they always felt equally supported and involved in the care provided by staff.

Emotional support

- We were told about one patient who had to bring their spouse with them to appointments as the spouse was living with dementia and could not be left alone. Hospital staff always met the patient and spouse at their car, accompanied them in to the hospital and the consulting room and then back to their car after the appointment.

Are outpatients and diagnostic imaging services responsive?

Good

Services were planned and delivered in a way that meets the needs of patients. The importance of flexibility, choice and continuity of care was reflected in the services provided.

Reasonable adjustments were made and action was taken to remove barriers when people found it hard to use or access services.

Facilities and premises were appropriate for the services being delivered.

People could access the right care at the right time and the appointments system was easy to use.

Waiting times, delays and cancellations were minimal and managed appropriately. Services ran on time. People were kept informed of any disruption to their care or treatment.

It was easy for people to complain or raise a concern and they were treated compassionately when they did. There was openness and transparency in how complaints were dealt with. Improvements were made to the quality of care as a result of complaints and concerns.

Service planning and delivery to meet the needs of local people

- The oncology suite had four treatment bays and two private rooms. Patients were offered the choice of where they preferred to receive their treatment.
- A variety of chairs, with and without arms and at different heights, was available in outpatients. This meant that patients with different mobility needs had a choice of seating available to suit their individual requirements.
- Patients told us that they were provided with a sufficient amount of information before admission and on discharge, and that they found it useful.

Access and flow

- Two NHS patients told us that they found the appointment booking system easy to use, that the appointments they had been offered had been within a week of their call and that when they arrived they had been seen on time.
- Four physiotherapy patients told us that their appointments always ran on time.
- Patients were generally given an OPD appointment between 1-2 weeks form the point of referral.
- We were shown results of the hospital's patient satisfaction surveys for January to July 2015. On average 96% of patients rated their admission experience as 'excellent' or 'very good' and 3% of patients rated the experience as 'good'.
- Two radiology receptionists and two radiographers told us that the department operated flexible opening hours to accommodate the needs of their patients.
- Staff in radiology told us that the 'patient pathway' was sometimes hindered by the department being split into two sections, one for x-ray and another for CT and MRI. Patients had told staff that the booking procedure could be complex due to the split.

- Staff told us that the nurses' desk in outpatients was no longer big enough for them and did not provide enough space for them to work effectively. The outpatients manager was aware of this and told us that there were plans to revamp this area to make it more staff-friendly.

Meeting people's individual needs

- Foreign language and British Sign Language interpreter services were available for use by outpatients and radiology staff if required. Outpatients made radiology aware of any need for an interpreter when referring patients. We were shown the hospital's policy for supporting patients who could not speak English or who had a hearing impairment, which stipulated that independent translators must be used and that family members were not to be used as translators. This ensured that those carrying out translations were appropriately qualified to explain complex medical terms.
- Information leaflets were not readily available in languages other than English, however a document translation service was available and was used when patients who did not understand English were due to undergo consultations or have treatment at the hospital.
- Large-print and Braille information leaflets and other documentation could be ordered as required for patients living with impaired vision.
- In the 2015 patient-led assessment of the care environment (PLACE) audit report outpatients had scored a 'qualified pass', achieving one point out of a possible two for condition and appearance, with comments made that the décor was "dated". They had scored zero for one item under access (no handrails in corridors) and two under privacy, dignity and well-being (sufficient space at reception desks so that conversations between staff and patients are not overheard and patients and families not being able to leave consultation rooms without having to return through the general waiting area).
- However on our inspection we judged that the décor was bright and in good order, and while no handrails were present we saw that all patients were escorted by staff who gave assistance if needed, and that there were ample wheelchairs available for patients who had difficulty mobilising.
- The outpatients waiting area was spacious, warm and provided a sufficient amount of comfortable seating for patients and relatives.
- Toys and other items for children were available in the outpatients department and were borrowed by radiology when needed.
- Oncology had a number of specialist bank nurses to call upon when they had patients being treated for less common cancers such as colorectal.
- Patients receiving treatment for cancer could be accompanied by friends or family if they wished. There was no restriction on the length of time visitors could remain with patients and family members, friends and carers who accompanied patients were encouraged to be active partners in the patients' care.
- A clinical psychologist was available in oncology and supported the emotional and psychological needs of patients undergoing treatment for cancer. Specialist cancer nurses were also available to provide expert support for patients undergoing treatment.
- Patients who fell outside the hospital's acceptance criteria due to their weight or body mass index were sometimes referred by GPs. When this occurred the outpatients referral team gave advice and support to help the patient lose weight and meet the admission criteria, rather than being rejected and sent back to their GP.
- There was no designated room for patients to use if they needed privacy after receiving a distressing diagnosis, however staff told us they pre-empted this situation by booking a spare consulting room and ensuring that appropriate specialist staff such as cancer nurses were in the department if patients were going to be given upsetting news.
- Baby changing facilities were available in the outpatients department.

Learning from complaints and concerns

- Complaints received by the hospital in any format were input onto the electronic incident reporting system to ensure that all of them were dealt with. In 2014 the hospital received a total of 80 complaints, and in the first quarter of 2015, 37 complaints were received.
- The main trend identified from complaints about outpatients was about lack of communication when

clinics were running late. As a result of this the matter had been discussed at team meeting so staff were aware of it and staff numbers had been increased on reception to allow better communication with patients.

- A 'you said, we did' notice board was on display in the outpatients waiting area, detailing a number of changes that had been made in response to feedback from patients, relatives and staff. Recent items included:

"You said… the consulting rooms in outpatients were beginning to look tired; we did – we have started a full refurbishment with at least 10 of the rooms to be completed by the end of 2015."

"You said… you weren't always informed if the clinic was running late; we did - asked our reception team to inform you of the waiting time or give you the option to reschedule if the clinic is running late."

"You said….Psychological support services should be available within the chemotherapy unit// we did – a consultant psychologist is now available for appointments at Little Aston."

- Patient feedback forms were displayed in the outpatients department. A post box was available near to the forms for replies to be collected and kept secure. Staff told us the box was emptied and the contents reviewed at regular in intervals. Patient's feedback forms were discussed at team meetings and acted upon where appropriate.

Are outpatients and diagnostic imaging services well-led?

Good

The leadership, governance and culture promoted the delivery of high quality person-centred care.

Staff in all areas knew and understood the hospital's vision, values and strategic goals.

The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability were clearly set out, understood and effective.

The organisation had processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care was accurate, reliable, timely and relevant. A full and diverse range of people's views and concerns was encouraged, heard and acted on. Information on people's experience was regularly reported and reviewed alongside other performance data.

Performance issues were escalated to the relevant committees and the board through clear structures and processes.

The service was transparent, collaborative and open with all relevant stakeholders about performance.

Leaders at every level prioritised safe, high quality, compassionate care and modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.

The leadership actively shaped the culture through effective engagement with staff, people who use services and their representatives and stakeholders.

Candour, openness, honesty and transparency and challenges to poor practice were the norm. Behaviour and performance inconsistent with the values was identified and dealt with, regardless of seniority.

The service proactively engaged and involved staff and ensured that their voices were heard and acted on. The leadership actively promoted staff empowerment to drive improvement.

Staff actively raised concerns and those who did were supported. Concerns were investigated in a sensitive and confidential manner, and lessons were shared and acted upon.

Service developments and efficiency changes were developed and assessed with input from clinicians to understand their impact on the quality of care.

There was a strong focus on learning and improvement at all levels of the organisation.

Vision, strategy, innovation and sustainability and strategy for this this core service

- Staff we spoke with had an understanding of the hospital's vision, mission and strategy and could give examples of what it meant to them in their day-to-day work.
- Staff were well-informed about plans for and developments in the hospital, and understood how their individual job roles contributed towards the senior managers' strategy.
- The outpatients manager told us they planned to expand the hospital's cancer service and to promote the rehabilitation services offered in the 'Perform' clinic.

Governance, risk management and quality measurement for this core service

- The radiation protection committee worked closely with and felt well supported by their external laser and radiation protection advisors.
- The radiation protection committee fed information and guidance into the quality governance and medical advisory committees.
- We were given copies of the minutes of the hospital's quarterly clinical governance committee meetings from 2014 and 2015. The minutes showed that reported incidents were investigated and where necessary changes were made as a result of lessons learnt.
- The outpatients manager told us that all managers received emails warning if any consultants' competency paperwork was not up to date and that their practising privileges were being suspended. On receipt of these emails the manager would check any clinic bookings in place for the affected consultant and would cascade the information to the department's nursing and administration staff.
- Minutes of the senior management team meetings recorded investigations and root cause analyses of complaints and untoward incidents, including learning outcomes that were fed back to staff and consultants involved in the situations.
- We were given copies of the minutes of the hospital's monthly heads of departments meetings from 2015 to date. The minutes showed that the hospital was monitoring the performance of consultants, including areas such as lateness for clinics, unauthorised removal of medical records and clinic overruns. The relevant head of department would address any problems in the first instance and if the situation persisted the hospital director would provide support and intervene if necessary.
- The outpatients manager told us there were no risks recorded on the hospital's risk register for outpatients, a copy of the risk register from June 2015 confirmed this.
- Records were kept of referrals from GPs or NHS trusts where patients did not meet the hospital's admission criteria. If patterns of repeated inappropriate referrals were identified a tailored education pack was produced for the practice or trust and if necessary the hospital's NHS contracts lead would meet with the referring body to discuss the criteria or provide training for staff.

Leadership/culture of service

- All the staff we spoke with told us that the hospital director and matron were visible and approachable and visited every department most days.
- Managers told us that the senior managers were transparent, had an open door policy, were approachable and allowed the managers to manage.
- Three members of staff made a point of approaching us during our inspection and telling us how much the hospital had changed for the better since the arrival of the current hospital director.
- Staff told us they would be confident to 'whistleblow' if necessary and trusted senior managers to treat any such report in a confidential manner.
- A consultant radiologist told us that there was a 'culture of challenge' within diagnostic imaging, where both radiologists and radiographers were encouraged to confront and question anything they perceived as poor practice.

Culture within the service

- One outpatients administration assistant told us that they felt appreciated by the hospital's management and that staff were encouraged to improve themselves in a positive manner. This was done through development targets which were agreed during appraisal meetings and reviews under the 'enabling excellence' programme.
- All of the staff we spoke with told us that the hospital was a good place to work and they felt proud of the service they provided for patients.
- Staff told us that the hospital managers listened to their concerns and could be depended upon to deal with them.

Public and staff engagement

- The hospital director held monthly informal group meetings with members of staff selected at random

from those whose birthday fell in that month. Staff told us that these events were well thought of and well attended, and staff felt that their discussions were confidential.

- We were shown copies of the hospital's monthly in-house patient satisfaction survey from January to July 2015. The results of all areas were consistently over 96% positive.
- Patient comments cards were prominently displayed on the outpatients reception desk.
- The hospital carried out annual consultant satisfaction surveys. The results of these surveys were presented to all staff and used to improve the service provided to consultants and their patients, and the facilities and equipment in the hospital.
- Monthly meetings were held for nurses and administration staff in outpatients. We were shown minutes of these meetings which detailed discussions on a range of subjects such as new services, facilities for consultants, new and leaving staff, staff training, finance, and information governance.

Innovation, improvement and sustainability

- We were given a copy of the hospital's business continuity plan which contained actions to be taken to ensure that patients and staff were kept safe and that the hospital's business could continue, where possible, in the event of an incident disrupting their facilities.

Outstanding practice and areas for improvement

Outstanding practice

Staff from the OPD demonstrated a genuine compassion towards patients and relatives and went above and beyond to ensure patients received their care and treatment often by overcoming obstacles.

Areas for improvement

Action the hospital SHOULD take to improve

- Improve hand hygiene practice within OPD services.
- Ensure all identified risks are recorded on the Hospital risk register evidencing regular review timescales and actions for completion.