St Anthony's Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St Anthony's Hospital is operated by Spire Healthcare. The hospital has 64 beds. Facilities include seven operating theatres, three wards, an eight bed level three critical care unit, X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, critical care, services for children and young people, and outpatients and diagnostic imaging. We inspected surgery, medicine, children and young people, critical care and outpatients.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 29 to 30 October 2019, as an unannounced visit to the hospital.

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

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

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

Services we rate

Our rating of this hospital/service stayed the same. We rated it as **Good** overall.

We found good practice in all areas:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. They used an electronic record system that allowed them to capture incidents, track any actions taken in response and provide relevant staff with feedback.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in the workplace and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation

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

- Records were not always clear and legible to all staff providing care. Some entries from medical staff were difficult to read, and not clearly labelled as an entry from a medical professional. This meant staff could not always clearly read the medical plans for the patients.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Fridge temperatures and controlled drugs were not always checked on a daily basis.

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

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals (London & South)

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Critical care	Good	Critical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. The hospital has an eight bedded high dependency unit providing level 3 care. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Services for children & young people	Good	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, responsive, and well led. We did not rate effective and caring during this inspection.
Outpatients	Good	We rated this service as good because it was safe, caring, responsive and well-led. We did not rate effective during this inspection.

Summary of findings

Contents

Good

St Anthony's Hospital

Services we looked at:
Medical care (including older people's care); Surgery; Critical care; Services for children & young people; Outpatients

Summary of this inspection

Background to St Anthony's Hospital

St Anthony's Hospital is operated by Spire Healthcare. Spire Healthcare Limited acquired the hospital in May 2014 from the Roman Catholic charity, Daughters of the cross, which had run the hospital since 1904. It is a private hospital in Sutton, Surrey. The hospital primarily serves the communities of the south-west London.

The hospital has had a registered manager in post since 2017. At the time of the inspection, a new manager had recently been appointed and was in the process of being registered with the CQC.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and three specialist advisors with expertise in surgery, critical care and paediatrics. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about St Anthony's Hospital

The hospital has three wards and is registered to provide the following regulated activities:

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

During the inspection, we visited St Georges Ward, Marie Terese Ward, theatres, critical care, and outpatients. At the time of the report St Terese ward was not in use, and there was only one paediatric patient. We spoke with over 40 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with over 40 patients and relatives. During our inspection, we reviewed over 60 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected two times, and the most recent inspection took place in June 2017 with the hospital being rated good overall.

Activity (July 2018 to June 2019)

- In the reporting period July 2018 to June 2019 there were 60,451 inpatient and day case episodes of care recorded at the hospital; of these 7% were NHS-funded and 93% other funded.
- 3% of all NHS-funded patients and 33% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 54,928 outpatient total attendances in the reporting period; of these 95% were other funded and 5% were NHS-funded.

336 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Seven regular resident medical officer (RMO) worked on a 7 day on 7 day off rota. The hospital employed 63 registered nurses, 29 care assistants and receptionist, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (July 2018 to June 2019)

- One Never event in surgery.
- One serious incident in surgery.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)

Summary of this inspection

- No incidences of hospital acquired Methicillin-sensitive Staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- 91 complaints

Services accredited by a national body:

- Sterile Services Department is registered by the Medicines and Healthcare products Regulatory Agency (MHRA)
- The hospital had applied to be accredited for Joint Advisory Group on GI endoscopy (JAG) accreditation.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe improved. We rated it as **Good** because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. They used an electronic record system that allowed them to capture incidents, track any actions taken in response and provide relevant staff with feedback.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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

Summary of this inspection

- Records were not always clear and legible to all staff providing care. Some entries from medical staff were difficult to read, and not clearly labelled as an entry from a medical professional. This meant staff could not always clearly read the medical plans for the patients.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Fridge temperatures were not always checked on a daily basis, this meant that inspectors could not be assured that medicines were being stored at safe temperatures. Controlled drugs were not always checked on a daily basis.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

Summary of this inspection

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

However:

- We found that up to date policies and procedures were not always available to staff. Policies were in line with national guidance but a significant number had gone past their planned review date. The provider did not fully review their policies and procedures as per their own guidance, 29 of their policies we reviewed were past their review date, including five which had expired in 2017 or earlier. This meant leaders could not be assured that staff could access and use the most up to date evidence-based guidance when caring for patients.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Summary of this inspection

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

Are services well-led?

Good

Our rating of well-led stayed the same. We rated it as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on improvement of services and patients experience. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in the workplace and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems and processes to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions and improvements. The information systems were secure. Data or notifications were submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Spire St Anthony's hospital is an acute independent hospital that provides outpatient, day care and inpatient services. The hospital is owned and managed by Spire Healthcare Limited. A range of services such as physiotherapy and medical imaging are available on site. The hospital offers surgical procedures as well as rapid access to assessment and investigation. Services are available to people with private or corporate health insurance or to those paying for one off

treatment. Fixed prices, agreed in advance are available. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

The surgical provision consisted of 64 inpatient beds located across two wards, St George's ward and Marie Therese ward. Surgical facilities also included seven operating theatres however two were used for medical procedures these being the cardiac catheter laboratory and ambulatory care for endoscopy and colonoscopies. St Anthony's included these services in their surgical services, however they are included in this report under medical care. Surgical facilities also include an extended recovery unit, access to a level three critical care unit, a separate paediatric bay, access to pharmacy support, diagnostic imaging, physiotherapy and follow up outpatient facilities.

The hospital provided surgical specialties for both adults and children, across a range of specialties including cardiothoracic surgery, orthopaedics, general surgery, neurospinal, cosmetic, urology and gastroenterology.

Staffing in surgery consisted of Resident Medical Officers (RMO) and consultants (working under practicing privileges), nursing staff, physiotherapy, and support staff. There was also on-site support available from pharmacy and imaging.

Our unannounced inspection of the surgery provision took place over two days from the 29th to the 30th October. During our inspection we spoke with over 20 members of staff including managers, medical staff, nursing staff, hospital staff and support staff, and allied health professionals. We spoke with twelve patients and four family members and reviewed fifteen sets of medical records. We completed checks of clinical and non-clinical equipment, and reviewed information provided by the hospital.

Good

Medical care (including older people's care)

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

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

Good

We did not rate safe at the last inspection. At this inspection we rated it as **good.**

Mandatory training

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

Staff completed mandatory training or provided evidence that it had been completed at another service (which included agency staff). The service provided training directly to nursing staff and allied health professionals, while some consultants and Resident Medical Officers (RMO) could complete training at another service or NHS trust and share the evidence.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules were a mix of classroom delivered training and e-learning. Staff stated they felt this worked well and they were given adequate time to complete training. Staff could access training at other hospitals owned by the corporate provider if necessary.

Mandatory training courses included resuscitation training, infection control, fire safety, complaints handling, safeguarding adults and children, moving and handling, conflict resolution, and information governance amongst others.

The hospital and corporate targets for training were 95%. Completion rates for training at the hospital were 100% for most mandatory training modules, with an overall average of over 95%.The hospital had recently employed a practice development nurse. We saw an extensive education programme had been put in place. Staff told us that they now found it much easier to complete their mandatory training and that education had improved.

As well as mandatory training for the hospital, staff working with paediatric patients completed training in paediatric basic life support (PBLS) or immediate life support (PILS), while service leads completed European paediatric life support (EPLS).

Safeguarding

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

All staff were required to complete safeguarding level 2 training for adults and children annually. We saw that all staff had completed the training. Level 3 training was provided to all registered clinical staff involved in the care of children and young people. Safeguarding children level 4 was provided to staff who were the safeguarding leads. The Director of clinical services for the hospital was the safeguarding lead for the hospital. The training provided also raised awareness of issues related to female genital mutilation (FGM) and PREVENT (Protecting people at risk of radicalisation)

Staff we spoke with knew how to raise any safeguarding concerns. They were able to describe different types of safeguarding concerns and could explain how they would respond if they witnessed or suspected abuse. Staff knew who the safeguarding lead was, and who they could raise concerns with in the lead's absence.

Good

Medical care (including older people's care)

Cleanliness, infection control and hygiene

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

Ward and theatre areas such as the cardiac cath lab and endoscopy were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were mostly up-to-date and showed that all areas were cleaned regularly. We saw that weekly and monthly cleaning schedules were used, and that these were mostly completed. We saw that 'I am Clean' stickers were used on all pieces of equipment on the wards to indicate when the equipment had last been cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). All patients on the wards were placed in a single occupancy room to prevent the spread of infection for example, infectious diarrhoea, methicillin-resistant Staphylococcus aureus (MRSA) , tuberculosis (TB) and chickenpox amongst others.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had enough supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.

Staff followed the hospital infection prevention and control policy, they were bare below the elbow and used hand sanitisers appropriately. We saw all staff both clinical and non-clinical, adhering to good hand hygiene policy. We saw that new admissions were screened for infections such as MRSA, Methicillin sensitive staphylococcus aureus (MSSA), c-difficile and e-coli. We saw the cardiac cath lab and endoscopy had appropriate decontamination processes in place and since our last inspection, there was a new sterile services department on site.

Staff disposed of clinical waste safely. Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions. We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

In the period between July 2018 and June 2019, the service reported no cases of Hospital identified methicillin-resistant Staphylococcus aureus (MRSA), Escherichia coli (E. coli), or Clostridium difficile (C. difficile). Admissions to the surgery ward were assessed for MRSA and C. Difficile, and we saw this reflected in patients' records.

Environment and equipment

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

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

The medical patients undergoing procedures in the cardiac cath lab were cared for within the surgical provision which consisted of 36 inpatient beds. Patients undergoing endoscopic procedures were cared for in a two bay area within the ambulatory care unit.

Patients could reach call bells and we saw that staff responded quickly when called. The design of the environment followed national guidance. Overall, the areas we visited were in a good state of repair with Marie Therese Ward having undergone a refurbishment since our last inspection.

Staff carried out daily safety checks of specialist equipment. Equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Staff told us they felt the equipment used by them was modern and well maintained.

The service had enough suitable equipment to help them to safely care for patients. Resuscitation equipment stored on the resuscitation trolley was readily available and easily accessible. The hospital had a system to ensure it was checked regularly, fully stocked, and ready for use.

The service had suitable facilities to meet the needs of patients' families. There was a family/day room available for patients and families to use in the event that they didn't want to stay in their room.

The hospital participated in Patient-led assessments of the care environment (PLACE) visits. PLACE visits are a system

for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. PLACE reports were reviewed by the senior leadership team to establish areas for improvement.

Assessing and responding to patient risk

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

Qualified staff used the national early warning score two (NEWS2), a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We saw that NEWS 2 scores were fully and accurately completed, and regularly reviewed. All staff were provided with NEWS 2 and sepsis specific training. We saw staff also used a sepsis care bundle for identifying and managing patients with sepsis.

Cardiac cath lab, endoscopy, ambulatory care and ward staff were able to describe the escalation pathway for any patients that became unwell, including the process for admitting patients to the hospitals' intensive care unit.

The service reported one incident of venous thrombo-embolism (VTE) - a medical condition where blood clots develop in the veins - within the hospital between July 2018 and June 2019. A VTE risk assessment tool was included in the hospital prescription charts that were audited monthly. Data provided by the hospital showed compliance for patients being risk assessed for VTE was 100%. On inspection, we viewed patient records and they demonstrated that all patients had undergone VTE assessments on admission.

Patient risk was discussed each day in the morning huddles and twice daily nursing handovers. The morning huddle provided an overview of activity (including any alterations to theatre lists) and key risks each day, and included attendance from surgery staff, as well as the heads of all departments. The huddle also identified what roles different members of staff would be undertaking in the event of a cardiac arrest. For example, we saw that one member of staff would be managing airways, while another would be keeping timed notes during the cardiac arrest. We saw that notes from each morning huddle were typed up and shared with staff by email that morning.

During the inspection, we observed that the cardiac Cath lab and endoscopy staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection. The hospital used the World Health Organization (WHO) Surgical Safety Checklist to minimise the risk of incidents during surgery and we saw these being used in both endoscopy and the cardiac cath lab.

Staff shared key information to keep patients safe when handing over their care to others. We saw shift changes and handovers between theatre, ITU and the wards included all necessary key information to keep patients safe. There was adequate medical cover and specialist availability for on-going treatment and care.

A daily multidisciplinary clinical huddle, led by the director of clinical services, reviewed all medical patients to ensure patient`s needs were being fully met and any issues dealt with directly.

Critical care outreach was also available 24/7 for all medical patients who were at risk of deterioration. This allowed such patients to be reviewed on the ward, and prevented unnecessary admissions to the critical care unit.'

Nursing and support staffing

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

The hospital used a provider wide nursing tool to plan skill mix required against patient activity and complexity of need. Staffing allocation was arranged seven days in advance to provide an overview and allow rotas to be rearranged if needed. Theatres used the Association for Perioperative Practice (AFPP) staffing guidelines to ensure there were adequate numbers of appropriately trained staff available for each theatre.

The hospital employed 42 whole time equivalent (wte) nursing staff on its inpatient wards, and 37 wte staff in theatre. We saw that the inpatient wards had vacancies for four full time nurses, and theatres had vacancies for three theatre nurses and one healthcare assistant. During our inspection, we saw that both the ward and theatres were adequately staffed and that planned staffing numbers

matched the actual numbers of staff on duty. Staff we spoke with told us that they rarely had any staffing issues. The hospital reported staff sickness rate as 7% for the inpatient ward and less than 5% for theatre staff.

We saw that for the reporting period of July 2018 to June 2019, the service had an average agency use of 14%. We were told that this was due to the hospital taking on additional contractual work for another service provider. We saw that for the period of May 2019 to July 2019, all shifts were filled, meaning there was never any staffing shortages. We saw a mix of shift patterns with some staff doing early and late shifts, and others doing long shifts. We were told that the ward manager could adjust the staffing to meet the acuity of the patients on the ward, as well as being able to adjust the staffing according to caseload. We were given examples of shifts patterns being adjusted to meet the personal needs of the staff.

Medical staffing

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

Medical treatment at the hospital was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the cardiac cath lab and endoscopic theatre service and many doctors we spoke with had worked at the hospital for many years. There were 336 doctors employed or practicing under rules or privileges.

There was an RMO on the wards 24 hours a day, seven days a week, who liaised with the consultant and nursing teams. Each RMO worked 12 hours on duty and 12 hours on-call. The RMOs worked for seven days and then had seven days off. Nursing staff told us they had good relationships with RMOs and felt well supported by them. RMOs told us they felt well supported and had good working relationships with all consultants and were able to contact the consultants and anaesthetists out of hours. The ward RMO could also get support from the ITU RMO if required.

RMOs told us that in the event they had not been able to have adequate rest breaks, a cover doctor was arranged. However, doctors told us that they were able to have adequate breaks and had not needed to arrange extra cover.

We were told that all substantive RMOs completed mandatory training via Spire's mandatory training system. The director of clinical services could access their profiles to ensure regular checking of outstanding / completed modules and maintain a matrix log to easily track the progress of each employed RMO. For all agency RMOs, the agency provided a full and comprehensive CV which included the mandatory training modules completed with date, which were reviewed by both the agency and the director of clinical services prior to their first shift.

Records

Staff kept detailed records of patients' care and treatment. Records were up-to-date and easily available to all staff providing care, however records were not always clear and legible.

Patient notes were comprehensive, and all staff could access them easily. Patient records were multi-professional clinical notes, which included those from consultants, anaesthetists, nursing staff, physiotherapists, occupational therapists, dietician and nurse specialists. Patient records were paper based, meaning notes were handwritten.

During the inspection, we reviewed fifteen sets of patient notes which included both medical and surgical patients. We found that some entries from the medical staff were difficult to read, and not clearly labelled as an entry from a medical professional. This meant staff could not always clearly read the medical plans for the patients. However, we saw that medical plans were also verbally discussed with the ward staff.

Information governance was part of mandatory training for all staff. We observed staff adhering to best practice in relation to information governance. We saw that medical records were stored securely in the nurses station room, meaning that the general public were unable to access them. We did not see any patient identifiable information displayed in public areas.

Patients' observation charts were kept by the patient's bedside. We saw that all observations had been recorded and reviewed in line with national (NEWS2) and local

guidelines. We saw all nursing documentation were appropriately completed. This included risk assessments such as falls, malnutrition screening, and risk of developing pressure sores. We saw fluid charts were well maintained, and pain assessments completed and reviewed as required.

We saw all theatre (cardiac cath lab and endoscopy) documentation were fully completed, including WHO theatre checklists, and observations undertaken appropriately, while in both theatres and the recovery area.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw that staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw the ward was visited by a dedicated pharmacist twice a day. The hospital had its own pharmacy which was open from 9am to 5pm Monday to Friday, and also open on Saturdays between 9am and 1pm. Outside of these hours, staff could access an on-call pharmacy through the hospital's nurse in charge.

We reviewed ten medication charts of both medical and surgical patients and found them to be consistently and legibly completed. Staff documented information on patient allergies and patient risks as necessary in the patient record. We saw that any medication omissions had clearly documented reasons for their omission.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. We saw that medicines were stored securely in locked cupboards in the patient's rooms. We saw that stock medication were securely stored in locked cupboards within the locked treatment room.

Inspectors found that controlled drugs (CDs) were to be checked on a daily basis and correctly documented in the CD register, with access to them restricted to authorised staff. We found that the checks had not been completed on four separate days. However, on checking the records, inspectors noted that all controlled medications were fully accounted for. Inspectors also saw that the fridge temperatures were not checked on a daily basis, as per hospital policy. This meant that inspectors could not be assured that medicines were being stored at safe temperatures.

We saw resuscitation trolleys were located at an easily accessible and well ventilated area, away from radiators. The medicines contained within, consumables, and cylinders were in date and records of expiry dates were also kept in the pharmacy as a backup check.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. They used an electronic record system that allowed the service to capture incidents, track any actions taken in response and provide relevant staff with feedback.

When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service reported no never events for medical services during the past 12 months prior to the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.

The incident reporting culture was very strong, and feedback was provided to staff that reported incidents. None of the staff we spoke with mentioned any concerns about patient's safety. Significant events were also highlighted in the staff handovers and daily operational huddles. We saw that the service reported incidents such as wound infections that occurred after a patient went home. For example, we saw that a patient had acquired an infection over two weeks after discharge. This was not attributable to the hospital, however the service still investigated the incident to see if there were any lessons that could be learnt.

Staff we spoke with felt there was a learning culture and that they could raise issues without worrying about repercussions.

Good

Medical care (including older people's care)

The Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a policy which described the Duty of candour process. Staff we spoke to, understood the Duty of candour requirement and its implication to clinical practice. Staff could give examples of when Duty of candour had been applied on both the medical ward and the endoscopy unit.

Safety Thermometer

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

The safety thermometer is a collection of data submitted by all hospitals which shows a snapshot of inpatients suffering avoidable harm, usually on one day each month. The safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE), a blood clot which starts in a vein.

Monthly safety thermometer data were displayed on quality and safety performance noticeboards. These boards were installed during our inspection, however staff told us that prior to this, they were displayed in the nurses station. We saw that for the month of September 2019, for the hospital there had been three serious incidents reported, no falls, no hospital acquired pressure ulcers and no VTEs. Managers told us that the serious incidents had all occurred within the surgical services, the hospital had investigated each to see If there were any lessons to be learnt.

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

Good

We did not rate effective at the last inspection. At this inspection we rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, we found that up to date policies were not always available to staff.

The hospital used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to guide the treatment they provided. For example, the most recent version of the national early warning score system (NEWS2) was used to assess and respond to any changes in a patient's condition.

Staff told us that clinical guidelines and policies were available on both the hospital intranet and printed out in a folder on the ward. We reviewed the printed versions of the policies and found that 52 of the policies had expired. Inspectors brought this to the attention of the managers who reviewed the electronic version of the policies, and found that 29 of the policies had either been withdrawn or had not been updated, with a further three policies due to expire. It was noted that all the policies that were out of date or withdrawn were Spire policies and not local hospital issued policies. We saw that all local policies were current and up to date. Senior Spire managers told us that this had been due to a clerical error and showed us evidence that the policies had been either reviewed, had review periods extended, or had been removed prior to the inspection. We saw that all printed polices had been immediately removed from the ward areas, and all electronic policies had either been removed, had their review period extended, or had been immediately updated on the services internal internet.

Nutrition and hydration

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

The service had a process to ensure patients did not eat prior to undergoing a general anaesthetic. Each patient was asked to confirm when they last ate and drank during the checking process on arrival to both the ward and theatre. We were told that the number of patients treated as nil by mouth prior to their operation was kept to a minimum, so that patients were allowed to drink fluids. The hospital complied with national guidance that patients

should receive clear fluids up to 2 hours before surgery and food up to 6 hours. Hydration scores were audited quarterly with high levels of compliance. To encourage patients to stay hydrated before their procedure, the hospital had developed a 'Think Drink' programme. This involved every patient being given a 330ml bottle of water at their pre-assessment appointment. The bottle was labelled 'Think Drink' and patients were encouraged to drink it between their last meal and two hours prior to their operation. This had been recognised by the provider centrally as an oustanding idea and was shared as a 'Good Practice Flash' across the provider's network of hospitals for others to adopt.

Staff made sure patients had support with nutrition and hydration to meet their needs. Any patients that had specific dietary needs would be identified at pre-assessment for surgery, and catering staff could then prepare accordingly. Staff told us a dietician was available to provide advice and support if needed.

Patients we spoke with told us that they had been told when they should be nil by mouth from when they attended their pre-operative clinic. All patients we spoke with told us that they had been given enough food and drink while on the ward, as their procedure allowed, and that their specific dietary requirements had been catered to. For example, one patient required gluten free meals, and another was lactose intolerant. They told us that the ward had catered for their needs and they still had a large selection of foods from which to choose.

We saw that staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool called malnutrition universal screening tool (MUST) to monitor patients at risk of malnutrition and saw that these were completed for each patient.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment was included as part of the patient pathway documentation. Assessments of patient's pain were also included in all routine sets of observations. As part of the 'intentional rounding' process, where staff attend patients at set intervals to check a range of patient related clinical and vital signs, staff ensured that patients were comfortable, their pain well managed and recorded this in their medical notes. We saw that staff used a non-verbal pain chart to assess the pain of a patient who had difficulty communicating their pain verbally, and for any patients who did not speak English.

Patients we spoke with told us that their pain was well controlled, and if they required any extra pain relief, they received this soon after requesting it, and did not have to wait long periods of time.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Patient outcomes and hospital performance were monitored through local clinical governance meetings as well as joint meetings for clinical leads from the corporate provider. Where issues of performance or areas for improvement were identified, the hospital put actions plans in place to improve. Performance in relation to action plans was monitored by the service and speciality leads and reported on through the quality and safety meetings.

The Clinical Scorecard was used to review performance against externally and internally set quality standards. Compliance targets were set for each measure and this information was shared quarterly via the quality report. We saw that the hospital had an extensive audit programme to evaluate the quality of care being received by patients. The results were reviewed in regular quality and safety meetings, and changes to service delivery were planned as necessary. The audit programme included corporate provider benchmarking against other sites through an audit programme and benchmarks. Senior managers told us that the hospital was performing well against other locations. The hospital also contributed to the national Patient led assessment of the care environment audit (PLACE), and family and friends feedback for NHS patients.

Good

Medical care (including older people's care)

Information provided by the hospital showed that there had been nine cases of unplanned returns to theatre between July 2018 and June 2019, compared to eight at time of the last inspection. We were told that these were patients were surgical patients. In addition, there had been 15 unplanned readmissions to the hospital within 28 days of discharge, compared to 16 at the time of the last inspection.

The hospital provided data on the cancelled procedures for the hospital within the reporting period. In the last 12 months, July 2018 to June 2019, there had been 16 cancelled procedures for a non-clinical reason. Of the above cancelled procedures, all of patients were offered another appointment within 28 days of the cancelled appointment.

During the inspection we saw that the endoscopy service was in the process of becoming accredited with the Joint Advisory Group (JAG) accreditation. They service had undergone an inspection by the accreditation group, had passed, and were waiting for a date for the formal assessment to be undertaken. Management told us the hospital was aiming to be assessed and accredited under the JAG clinical accreditation scheme by the end of March 2020

Competent staff

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

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

The hospital had an induction policy which outlined that new starters in the department were supported to complete their induction program, and be familiar with their working environment, only using equipment that they were competent to use and identifying their learning needs. We saw that trained nurses also had competency folder they were required to complete.

All staff we spoke with told us that they had received an appraisal within the last 12 months. We saw that over 98% of contracted nursing, healthcare assistants and allied health professionals staff were appraised in 2018/2019 and all the medical staff.

Since our last inspection, the service had introduced a practice development lead nurse (PDN) role, who had responsibility for monitoring mandatory training, ensuring staff competencies, and supporting staff development. The PDN ran regular training sessions for ward staff, often in collaboration with consultants on specific topics. Staff told us they were positive about the support and involvement of the PDN. The practice development nurse also monitored the nursing revalidation process and staff were supported in collating their evidence for revalidation. Revalidation is a new process since 2016 where nurses and midwives need to demonstrate to the Nursing and Midwifery Council that they can practice safely and effectively.

Any concerns related to the consultants around their competency was dealt with via the Medical Governance and Assurance Policy. Ongoing compliance with practising privileges was monitored by the senior management team, with support from the medical advisory committee(MAC).

Multidisciplinary working

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

The medical care service included consultants, RMOs, anaesthetists, nursing staff (ward and theatre), physiotherapy, as well as allied health professionals, such as dietitians. Staff stated they had good working relationship across all disciplines. Staff stated they worked well together and this was supported by effective and supportive management. Staff also stated they had good working relationships with the intensive care, surgical and paediatric teams.

Care planning took place at pre-assessment with input from the multidisciplinary team, including doctors, nurses and allied healthcare professionals as needed.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The hospital had several

daily safety huddles to ensure effective MDT communication. This included a whole hospital huddle at 09:15hrs, a clinical safety huddle at 08:30 as well as a theatre huddle and a ward MDT meeting.

There was a service level agreement in place with a local NHS Trust for transfer arrangements should a patient's condition deteriorate, and they required additional care following a surgical procedure. The hospital resuscitation team on each shift was also multidisciplinary, and roles where allocated in the clinical safety huddle. This meant that in the event of a resuscitation, the team already knew what roles they would be responsible for. For example, we saw that one of the nurses had been allocated to doing compressions.

Seven-day services

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

There was a resident medical officer (RMO) on the wards 24 hours a day, seven days a week, who worked closely with the nursing teams and communicated with consultants if there were concerns. RMOs reported that they also had close working relationships with the ITU RMO and were able to seek their support and advice if needed.

The cardiac cath lab and endoscopic theatres were open for use between 8am and 8pm Mondays to Saturdays. Staff we spoke with did not raise any concerns regarding the availability of theatre slots for patients.

The wards had access to pharmacy input Monday to Friday 9am to 5pm, and Saturdays between 9am and 1pm. Staff could access support from an out of hours pharmacy if needed.

There were designated on-call rotas that specified who was to provide support for radiology, pathology, pharmacy, physiotherapy or who was the on-call manager.

Health promotion

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

During our inspection, we saw health promotion leaflets available for all patients and relatives. This included advice from the British Heart Foundation, as well as information on diet and nutrition, smoking cessation, wound management, and warning signs of acute illness. Information leaflets on potential clinical risks such as sepsis and diabetes were also publicly displayed.

Hospital staff provided advice to patients on managing their care after discharge. Staff also encouraged patients to contact the ward if they had any questions. During the inspection we saw that one patient who had been discharged the day before had contacted the ward as they were concerned about their wound. The ward advised them to come to the hospital, the person was seen by a consultant, reassurance was given, and the patient was discharged.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff had received training in Mental Capacity Act 2005 (MCA) and consent. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments. The training took account of young adults and children. All staff we spoke to could tell us where they could seek support if needed and identified the safeguarding leads by name.

We saw that consent to treatment was clearly documented in the patient notes, and observed all staff gaining verbal consent from patients before undertaking any interactions and interventions.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We saw that during shift handover, and at the daily safety meeting, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Good

Medical care (including older people's care)

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

Good

We did not rate caring at the last inspection. At this inspection we rated it as **good.**

Compassionate care

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

During the inspection, we saw staff on the wards treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they delivered to patients during their interactions. Care that we observed was patient centred.

We saw that patient's privacy and dignity were maintained whilst they were on the surgical ward, while in theatres, and while being transferred to and from the ward. Each patient had access to their own room. Patients were taken to and from theatres discreetly and with a chaperone as appropriate.

We spoke with six patients on the wards during the inspection, and four family members. Patients and family members spoke very positively about the care they received, and how they were treated by the staff on the wards. Patients told us staff were respectful of families and kept them updated while the patients were in theatres.

The hospital provided patient satisfaction survey data, which showed that from February 2019 to July 2019, the average number of patients and family members who would recommend the service was 94%. The response rate for this period was between 16% and 20%.

Emotional support

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

Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional needs, Staff understood the impact that patient's care, treatment, condition and surgery had on their wellbeing. Staff we spoke with stressed the importance of treating patients as individuals. We observed that staff spoke with patients compassionately and empathetically.

Staff told us of the pastoral care that was available for the patients on the ward and knew how to contact the different services both within and out of hours.

Patients and relatives commented that they had been well supported emotionally by staff.

Understanding and involvement of patients and those close to them

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

Family members of patients were positive about the care the patients received and stated that staff members were professional and welcoming. Family members also stated they were kept well informed of treatment plans and were included in conversations about treatment as necessary. They told us that they were kept regularly updated while the patient was in theatres which gave them reassurance. There was evidence of discussions of patient care with those close to them in the patient records.

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

Good

We did not rate responsive at the last inspection. At this inspection we rated it as **good.**

Service delivery to meet the needs of local people

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

The hospital provided medical care to both private patients and to NHS patients within the local area. Staff and patients we spoke to stated that the patient experience of private and NHS patients regarding care was the same.

Good

Medical care (including older people's care)

There was clear signage inside the main hospital building, which meant it was straightforward for visitors to locate the surgical wards. The provider's website provided useful information about the service, procedures that were provided, payment options, and the referral process.

Meeting people's individual needs

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

The service visiting hours were 10am to 8:30pm every day of the week. Staff told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours. Visiting times were clearly displayed on the ward.

The wards provided food that catered to dietary requirements. Patients had access to a wide variety of meal choices that could meet various cultural needs and personal preferences. Patients and relatives had free access to hot and cold drinks and could request snacks in between mealtimes. Patients told us they were happy with the quality of the food that they received. Patients in the ambulatory care area had access to drinks and snacks as required.

Staff were aware of how to access translation services if patients or families were unable to communicate in English. Some staff stated they spoke other languages so could offer some translation, however also stated that they would use interpreters where appropriate, particularly for patients consenting to treatment. We saw information displayed around the wards in other languages, and patients were informed they could request information in their preferred language as needed.

Staff understood the information and communication needs of patients with a disability or sensory loss. A hearing loop was available for patients who were deaf or hearing impaired.

Both the wards and theatres had processes in place to help care for patients who may have dementia. Patients with a diagnosis of dementia were identified on the patient information board and in the rooms. Their care needs were also discussed at the safety huddles to ensure that their safe environment was maintained, and their care needs met. This included ensuring they had a familiar escort to theatre, as well as providing 1 to 1 nursing care if required. The service had developed a resource box to enable them to make reasonable adjustments for patients living with dementia to make their stay as comfortable as possible. This included dementia friendly clocks, plates and signage which would be added to bedrooms as required depending on individual needs.

The hospital had a learning disabilities lead nurse who provided support, advice and training for staff caring for patients with learning disabilities. Staff we spoke to knew who to contact for support and advice if needed when caring for patients with dementia or learning disabilities.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

The hospital ran an appointment system which was supported by the booking team and allowed patients to choose pre-assessment appointments and surgery times that suited them. Patients also had the option of direct booking online if they were private patients. Patients undergoing procedures in the cardiac cath lab would present to the ward and then transfer to theatre. Those undergoing endoscopic procedures went directly to the ambulatory care area. They would transfer to theatre and return to the ambulatory care area after being recovered in the surgery recovery area.

Staff we spoke with told us there was no difference in the clinical services or expertise available to either private or NHS patients. At the time of inspection, the hospital activity was approximately 5%NHS and 95% private.

All patients attended a pre-assessment clinic to establish suitability for surgery, identify any complexities, and to discuss the procedure with the patient and their family. Pre-assessment clinics were run by a dedicated nursing team, supported by consultants and any areas of concern were identified using the risk assessment proforma, and recorded for future use.

The medical service was incorporated within the surgical service and consisted of 36 inpatient beds which included

Good

Medical care (including older people's care)

both day case and longer stay patients. Medical care facilities also included two operating theatres, these being a general theatre for endoscopic procedures, and a dedicated purpose built cardiac cath lab.

Patients with co morbidities and mobility issues undergoing cardiac cath lab procedures were prepared for their operation or procedure on the ward and waited to be escorted to theatre. Ambulant patients did not need to go to the ward and would present directly to the cardiac cath lab where they would be prepared for their procedure. After their procedure, patients were transferred to the recovery room to recover and ensure they were stable and pain free. Then they were collected and returned to a room on the ward. Patients undergoing endoscopic procedures would present directly to ambulatory care where they would be prepared for their procedure they would return to ambulatory care having had their procedure and be discharged the same day.

The hospital had a pathway in place for patients that had their surgery cancelled on the day and had introduced steps to minimise the risk of this happening. These steps included daily discussions of lists in theatres and confirmation of what is needed ahead of time, ward safety briefings, and the safety huddle. Any cancellations, including on the day, were discussed as a regular agenda item at weekly operational senior leadership and speciality meetings, with the data also examined at the clinical governance meetings.

Patients were seen by the RMO and consultant before their discharge could be completed and signed off. Results of the treatment were communicated to the patients' GP and other healthcare providers as necessary. Discharge summaries also reflected input from other MDT staff as needed, such as physiotherapy.

Learning from complaints and concerns

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

The hospital subscribed to the independent sector complaints adjudication service (ISCAS) code of practice in managing complaints. They also submitted their self-assessment against the code in 2018. The clinical governance manager had responsibility for overseeing the management of complaints. All clinical complaints were reviewed and approved by the hospital's director of clinical services.

A total of 91 formal complaints (written and verbal) were received and investigated by the hospital in from August 2018 – July 2019, compared to 70 received during 2017-2018. None of the complaints were referred for independent adjudication.

The hospital logs all complaints onto an electronic system. A written formal acknowledgment was sent within 48 hours of receiving the compliant, where the patient was advised of the hospital's complaints process and timeframes to expect. Complainants were also provided with a 'Please Talk to Us' leaflet which sets out the process for managing complaints.

The hospital made changes in response to complaints and analysed patterns and trends to promote service improvements. Staff within surgery told us that complaints were discussed at ward meetings, and any lessons learnt and changes to be made would be fed back at these meetings. Staff would also share information about concerns and complaints via email. We saw that complaints were discussed at monthly complaints meetings and quarterly clinical governance meetings.

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

Good

We did not rate well-led at the last inspection. At this inspection we rated it as **good.**

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The same management team oversaw both the surgical and medical care services. The service had a clear management structure in place. Responsibility for

medicine and surgery came under the director of clinical services, with local management provided by a theatre manager, a matron, a cath lab manager, and a ward manager.

During the inspection, staff told us that us that the senior leadership, the hospital and the organisation were visible on the wards and were approachable to all staff. We observed ward and theatre staff interacting well with the surgery and hospital leadership during the inspection and saw good working relationships.

Ward level nursing leadership was provided by a ward manager who managed the co-located areas of the surgery ward on both Marie Terese and St Georges wards. Staff stated that the manager was very supportive to staff, and they felt they could bring any concerns to her if needed.

The Director of Clinical Services provided clinical support to staff, as well as leadership for the delivery of care and bed management. Nursing and medical teams worked closely together to plan and deliver care. Staff from both disciplines were positive about the working relationship on the ward.

Medical support and advice was provided by the Medical Advisory Committee (MAC), which was chaired by the MAC Chair and attended by the hospital director and director of clinical services and had representation from consultants from each major surgical speciality. RMOs told us that they felt well supported by both consultants and anaesthetists and found them approachable and responsive to any concerns.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on improvement of services and patients experience. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had clear vision and strategic goals, based upon the corporate Purpose, Vision, Mission and Values. Leaders told us they wanted to ensure an open and inclusive culture at all levels, one in which staff communicated well, worked together to achieve organisational goals and cared for each other. Their purpose was 'Making a Positive difference to our patients live through outstanding personalised care'. The corporate vision was to be recognised as a world class healthcare business.

The hospital recently developed a new hospital strategy under the headings outstanding clinical practice; our people; exceptional service delivery; the hospital of choice for self-pay treatment; and deliver sound, financial performance. The new strategy was launched in September 2019.

Staff we spoke with during the inspection knew of the new strategy, and departments had been asked to contribute their aims to help the hospital reach their objectives. Leaders told us that the strategy will be reviewed quarterly and action plans will be developed to help with the delivery of the strategy.

Culture

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

During the inspection all staff we spoke with spoke highly of the senior leaders, and told us they were honest, caring and approachable. Staff told us they were proud to work at the hospital. There was evidence of leaders and teams working collaboratively to deliver good quality of care. We observed one of the daily safety huddles during the inspection and found this to encourage contributions from all staff attending.

Staff we spoke with felt they were encouraged to challenge any behaviours that did not meet the standards of practice set by the hospital. Staff stated that they felt they could challenge consultants and anaesthetists on their practices and were encouraged by management to do so. Staff told us of an example of when this had occurred, and changes that had occurred as a result.

The contribution of staff was recognised through an awards system for excellence in their roles. Staff could be nominated monthly to achieve an award from the hospital, which was then possible to go further to win a provider wide recognition award.

Good

Medical care (including older people's care)

Governance

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

The medical care services had the same governance structure as the surgery services, and had a clear governance structure in place. The director of clinical services led a team of speciality nurses and was supported by a clinical governance and risk manager. The director of clinical services reported into the hospital director.

There was a board to ward corporate governance framework in place which oversaw service delivery and quality of care. This included monthly governance meetings which discussed safeguarding, regulatory updates, the clinical scorecard, incidents, audits, training, reports from subcommittees, and any other clinical issues and audits.

We saw that minutes of governance meetings were shared with staff though emails and were also available for staff to read in dedicated governance folders on the ward. Staff we spoke with during the inspection were clear about the governance structure in the organisation and knew their roles in governance.

The service had effective systems to monitor the quality and safety of surgery. The service had a dedicated clinical governance team who managed incidents, complaints, risk and health and safety. The service had a culture of strong incident reporting and used local incident scoping meetings to ensure timely responses to incidents. Action plans were developed to address areas of poor performance, and reports on the progress of action plans were fed back to staff through the governance committees.

The Medical Advisory Committee (MAC) met quarterly and reviewed matters relating to the delivery of clinical care across the hospital and new practising privilege applications from consultants. The MAC was chaired by an appointed lead, and featured representation from all surgical specialities provided by the hospital. The meetings were well attended by consultants from each clinical area.

Managing risks, issues and performance

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

The service had a local risk register which was updated regularly. The risks highlighted on the risk register were current and control measures had been put in place to minimise it with regular updates provided. There were leads allocated to each of the item placed on the risk register responsible for overseeing mitigation actions. Leaders we spoke with knew what the highest risks were, for example staffing, and we saw that these were all identified on the risk register with a responsible person allocated to each risk.

The hospital had a dedicated Risk Champion, and we saw that risk was a monthly agenda item at hospital meetings. Staff we spoke with aware of the key risks to the hospital. The key risks were reinforced to staff through team meetings, in the daily briefing huddle, and were displayed on noticeboards.

Managing information

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

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had required access to record systems to allow them to perform their work effectively.

Senior staff informed us they were General Data Protection Regulation (GDPR) compliant and that patient information was managed in line with data protection guidelines and legislation. On inspection, we observed staff compliance with information governance guidance. The provider told us there had been no data security breaches at the hospital within the past 12 months prior to the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role.

Good

Medical care (including older people's care)

Patient's records were stored in line with personal data security standards and entries made in patient's records could be easily ascertained attributed to the person creating them.

When required, the department submitted reports and notifications promptly to support shared learning and to share information with external bodies.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery. The information was also timely and relevant.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

The corporate provider had introduced the Freedom to Speak Up Guardian roles across all hospital sites. The role here was provided by nurse managers and offered staff a confidential route to raising concerns. Staff we spoke with were aware of the role of the guardian and stated it was a useful resource to have in place.

The Freedom to Speak Up Guardian for the service had been very proactive in advertising the role. During the inspection we saw posters with photographs, names and contact numbers of the guardians displayed in staff communal areas. We saw a dedicated freedom to speak up folder available for all staff to read, which explained the role, and gave support and advice to staff, the guardian also provided statistics to managers for the service on how many contacts they had each month and would raise any concerns in hospital meetings if needed.

The hospital gathered patient opinion using the Friends and Family Test (FFT) and the Patient Led Assessment of the Care environment (PLACE). In addition, senior staff 'walked around' the clinical areas several times a day to ensure oversight and highlight any concerns and be visible and accessible to staff, patients and relatives.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

The service had an active cardiac support group which had been running for over 23 years for former patients and their partners which had speakers and staff on hand to answer queries. This group provided education to maintain good health outcomes such as dietetic advice, medication advice, exercise advice and emotional support.

The service had introduced the 'Think Drink' campaign to encourage patients to stay hydrated prior to undergoing surgery. It has been proven that patients who are more hydrated have better outcomes from surgery. The Think Drink campaign involves patients being given a bottle of water at their pre-assessment appointment, which has been labelled 'Think Drink'. Patients were encouraged to drink the water between when they last ate, and 2 hours before their operation

Good

Surgery

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

Are surgery services safe?

Good

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

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

Mandatory training

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

Staff completed mandatory training or provided evidence that it had been completed at another service (which included agency staff). The service provided training directly to nursing staff and allied health professionals, while some consultants and Resident Medical Officers (RMO) could complete training at another service or NHS trust and share the evidence.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules was a mix of classroom delivered training and e-learning. Staff stated they felt this worked well and they were given adequate time to complete training. Staff could access training at other hospitals owned by the corporate provider if necessary.

Mandatory training courses included resuscitation training, infection control, fire safety, complaints handling, safeguarding adults and children, moving and handling, conflict resolution, and information governance amongst others.

The hospital and corporate targets for training were 95%. Completion rates for training at the hospital were 100% for most mandatory training modules, with an overall average of over 95%.The hospital had recently employed a practice development nurse. We saw an extensive education programme had been put in place. Staff told us that they now found it much easier to complete their mandatory training and that education had improved.

As well as mandatory training for the hospital, staff working with paediatric patients completed training in paediatric basic life support (PBLS) or immediate life support (PILS), while service leads completed European paediatric life support (EPLS).

Safeguarding

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

All staff were required to complete safeguarding level 2 training for adults and children annually. We saw that all staff had completed the training. Level 3 training was provided to all registered clinical staff involved in the care of children and young people. Safeguarding children level 4 was provided to staff who were the safeguarding leads. The Director of Clinical Services for the hospital was the

safeguarding lead for the hospital. The training provided also raised awareness of issues related to female genital mutilation (FGM) and PREVENT (Protecting people at risk of radicalisation)

Staff we spoke with knew how to raise any safeguarding concerns. They were able to describe different types of safeguarding concerns and could explain how they would respond if they witnessed or suspected abuse. Staff knew who the safeguarding lead was, and who they could raise concerns with in the lead's absence.

Cleanliness, infection control and hygiene

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

Ward and theatre areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were mostly up-to-date and showed that all areas were cleaned regularly. We saw that weekly and monthly cleaning schedules were used, and that these were mostly completed. We saw that 'I am Clean' stickers were used on all pieces of equipment on the wards to indicate when the equipment had last been cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). All patients on the wards were placed in a single occupancy room to prevent the spread of infection for example, infectious diarrhoea, methicillin-resistant Staphylococcus aureus (MRSA) , tuberculosis (TB) and chickenpox amongst others.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had enough supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.

Staff followed the hospital infection prevention and control policy, they were bare below the elbow and used hand sanitisers appropriately. We saw all staff both clinical and non-clinical, adhering to good hand hygiene policy. We saw that new admissions were screened for infections such as MRSA, Methicillin sensitive staphylococcus aureus (MSSA), c-difficile and e-coli. We saw theatres had appropriate decontamination processes in place and since our last inspection, there was a new sterile services department on site.

Staff disposed of clinical waste safely. Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions. We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

There had been three incidents of surgical site infection during the reporting period. In theatres, we observed that staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and followed recommended best practice. Where a surgical site infection was identified, the IPC nurse would lead on a root cause analysis (RCA) to establish if performance could be improved. During the inspection, we saw that since the reporting period, the number of surgical site infections had increased. We saw that the infections were acquired weeks after the patients had returned to their own residence and therefore were not attributable to the hospital. However, the hospital still took ownership of the infections and investigated to see if there were any lessons that could be learnt. The hospital was part of an Infection Control Link group with local providers which shared information about patients and supported best practice.

In the period between July 2018 and June 2019, the service reported no cases of Hospital identified methicillin-resistant Staphylococcus aureus (MRSA), Escherichia coli (E. coli), or Clostridium difficile (C. difficile). Admissions to the surgery ward were assessed for MRSA and C. Difficile, and we saw this reflected in patients' records.

Environment and equipment

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

The surgical provision consisted of 64 inpatient beds, which were also for medical patients undergoing procedures in

the cardiac catheter laboratory. Surgical facilities also included six operating theatres, and a separate paediatric area. Patients were able to be transferred to either the surgical ward or the critical care unit after their procedure.

Three of the theatres had laminar flow air filtration systems. These were mainly used for orthopaedic procedures and enabled containment and control of airflow, so reducing the risks of cross contamination and infection due to air borne organisms.

Patients could reach call bells and we saw that staff responded quickly when called. The design of the environment followed national guidance. Overall, the areas we visited were in a good state of repair with Marie Therese Ward having undergone a refurbishment since our last inspection.

Staff carried out daily safety checks of specialist equipment. Equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Staff told us they felt the equipment used by them was modern and well maintained.

The service had enough suitable equipment to help them to safely care for patients. Resuscitation equipment stored on the resuscitation trolley was readily available and easily accessible. The hospital had a system to ensure it was checked regularly, fully stocked, and ready for use.

The service had suitable facilities to meet the needs of patients' families. There was a family/day room available for patients and families to use in the event that they didn't want to stay in their room.

The hospital participated in Patient-led assessments of the care environment (PLACE) visits. PLACE visits are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. PLACE reports were reviewed by the senior leadership team to establish areas for improvement.

Assessing and responding to patient risk

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

Qualified staff used the national early warning score two (NEWS2), a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We saw that NEWS 2 scores were fully and accurately completed, and regularly reviewed. All staff were provided with NEWS 2 and sepsis specific training. We saw staff also used a sepsis care bundle for identifying and managing patients with sepsis.

Theatre and ward staff were able to describe the escalation pathway for any patients that became unwell, including the process for admitting patients to the hospitals' critical care unit. During the inspection, we saw one patient had deteriorated on the ward. The patient was immediately reviewed by the consultant and transferred to the critical care unit for closer monitoring. The patient was discharged back to the ward the following day having received more intensive treatment which stabilised their condition. During the reporting period, the hospital had 15 unplanned patient transfers to other health care providers. This was a reduction from our last inspection.

The service reported one incident of venous thrombo-embolism (VTE) - a medical condition where blood clots develop in the veins - within the hospital between July 2018 and June 2019. A VTE risk assessment tool was included in the hospital prescription charts that were audited monthly. Data provided by the hospital showed compliance for patients being risk assessed for VTE was 100%. On inspection, we viewed patient records and they demonstrated that all patients had undergone VTE assessments on admission.

Patient risk was discussed each day in the morning huddles and twice daily nursing handovers. The morning huddle provided an overview of activity (including any alterations to theatre lists) and key risks each day, and included attendance from surgery staff, as well as the heads of all departments. The huddle also identified what roles different members of staff would be undertaking in the event of a cardiac arrest. For example, we saw that one member of staff would be managing airways, while another would be keeping timed notes during the cardiac arrest. We saw that notes from each morning huddle were typed up and shared with staff by email that morning.

During the inspection, we observed that theatre staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed recommended practice. This guideline offered best practice advice on the

care of adults and children to prevent and treat surgical site infection. The hospital used the World Health Organisation (WHO) Surgical Safety Checklist to minimise the risk of incidents during surgery.

Staff shared key information to keep patients safe when handing over their care to others. We saw shift changes and handovers between theatre, ITU and the wards included all necessary key information to keep patients safe. There was adequate medical cover and specialist availability for on-going treatment and care.

Nursing and support staffing

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

The hospital used a provider wide nursing tool to plan skill mix required against patient activity and complexity of need. Staffing allocation was arranged seven days in advance to provide an overview and allow rotas to be rearranged if needed. Theatres used the Association for Perioperative Practice (AFPP) staffing guidelines to ensure there were adequate numbers of appropriately trained staff available for each theatre.

The hospital employed 42 whole time equivalent (wte) nursing staff on its inpatient ward, and 37 wte staff in theatre. We saw that the inpatient wards had vacancies for four full time nurses, and theatres had vacancies for three theatre nurses and one healthcare assistant. During our inspection, we saw that both the ward and theatres were adequately staffed and that planned staffing numbers matched the actual numbers of staff on duty. Staff we spoke with told us that they rarely had any staffing issues. The hospital reported staff sickness rate as 7% for the inpatient ward and less than 5% for theatre staff.

We saw that for the reporting period of July 2018 to June 2019, the service had an average agency use of 14%. We were told that this was due to the hospital taking on additional contractual work for another service provider. We saw that for the period of May 2019 to July 2019, all shifts were filled, meaning there was never any staffing shortages. We saw a mix of shift patterns with some staff doing early and late shifts, and others doing long shifts. We were told that the ward manager could adjust the staffing to meet the acuity of the patients on the ward, as well as being able to adjusting the staffing according to caseload. We were given examples of shifts patterns being adjusted to meet the personal needs of the staff.

The service reported that a multidisciplinary safe staffing meeting was held on a daily basis, and was led by The Director of Clinical Services. We were told that the purpose of the meeting was to gain assurance that the hospital staffing for the next day was appropriate to meet the needs of the patients due to be cared for, and helped departments support each other through any staffing issues such as sickness absence.

The Director of Clinical Services also held a weekly multidisciplinary meeting to review and plan for the week ahead, with input from the pre-operative assessment team. This ensured patient's individual needs such as dietary, psychologiucal, religious and additional equipment needs were met and communicated to all teams in advance.

Medical staffing

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

Surgical treatment at the hospital was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the hospital for many years. There were 336 doctors employed or practicing under rules or privileges.

There was an RMO on the surgical wards 24 hours a day, seven days a week, who liaised with the consultant and nursing teams. Each RMO worked 12 hours on duty and 12 hours on-call. The RMOs worked for seven days and then had seven days off. Nursing staff told us they had good relationships with RMOs and felt well supported by them. RMOs told us they felt well supported and had good working relationships with all consultants and were able to contact the consultants and anaesthetists out of hours. The ward RMO could also get support from the ITU RMO if required.

RMOs told us that in the event they had not been able to have adequate rest breaks, a cover doctor was arranged. However, doctors told us that they were able to have adequate breaks and had not needed to arrange extra cover.

We were told that all substantive RMOs completed mandatory training via Spire's mandatory training system. The director of clinical services could access their profiles to ensure regular checking of outstanding / completed modules and maintain a matrix log to easily track the progress of each employed RMO. For all agency RMOs, the agency provided a full and comprehensive CV which included the mandatory training modules completed with date, which were reviewed by both the agency and the director of clinical services prior to their first shift.

Records

Staff kept detailed records of patients' care and treatment. Records were up-to-date and easily available to all staff providing care, however records were not always clear and legible.

Patient notes were comprehensive, and all staff could access them easily. Patient records were multi-professional clinical notes, which included those from consultants, anaesthetists, nursing staff, physiotherapists, occupational therapists, dietician and nurse specialists. Patient records were paper based, meaning notes were handwritten.

During the inspection, we reviewed fifteen sets of patient notes. We found that some entries from the medical staff were difficult to read, and not clearly labelled as an entry from a medical professional. This meant staff could not always clearly read the medical plans for the patients. However, we saw that medical plans were also verbally discussed with the ward staff.

Information governance was part of mandatory training for all staff. We observed staff adhering to best practice in relation to information governance. We saw that medical records were stored securely in the nurses station room, meaning that the general public were unable to access them. We did not see any patient identifiable information displayed in public areas.

Patients' observation charts were kept by the patient's bedside. We saw that all observations had been recorded and reviewed in line with national (NEWS2) and local guidelines. We saw all nursing documentation was appropriately completed. This included risk assessments such as falls, malnutrition screening, and risk of developing pressure sores. We saw fluid charts were well maintained, and pain assessments completed and reviewed as required.

We saw all theatre documentation was fully completed, including WHO theatre checklists, and observations undertaken appropriately, while in both theatres and the recovery area.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw that staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw the ward was visited by a dedicated pharmacist twice a day. The hospital had its own pharmacy which was open from 9am to 5pm Monday to Friday, and also open on Saturdays between 9am and 1pm. Outside of these hours, staff could access an on-call pharmacy through the hospital's nurse in charge.

We reviewed ten medication charts and found them to be consistently and legibly completed. Staff documented information on patient allergies and patient risks as necessary in the patient record. We saw that any medication omissions had clearly documented reasons for their omission.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. We saw that medicines were stored securely in locked cupboards in the patient's rooms. We saw that stock medication were securely stored in locked cupboards within the locked treatment room.

Inspectors found that controlled drugs (CDs) were to be checked on a daily basis and correctly documented in the CD register, with access to them restricted to authorised staff. We found that the checks had not been completed on four separate days. However, on checking the records, inspectors noted that all controlled medications were fully accounted for. Inspectors also saw that the fridge

temperatures were not always checked on a daily basis, as per hospital policy. This meant that inspectors could not be assured that medicines were being stored at safe temperatures.

We saw resuscitation trolleys were located at an easily accessible and well ventilated area, away from radiators. The medicines contained within, consumables, and cylinders were in date and records of expiry dates were also kept in the pharmacy as a backup check.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. They used an electronic record system that allowed them to capture incidents, track any actions taken in response and provide relevant staff with feedback.

When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service reported one never event during the past 12 months prior the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event. The service showed the event had been very thoroughly investigated, lessons had been learnt, and systems and processes had been put in place to prevent the incident from reoccurring.

The incident reporting culture was very strong, and feedback was provided to staff that reported incidents. None of the staff we spoke with mentioned any concerns about patient's safety. Significant events were also highlighted in the staff handovers and daily operational huddles. We saw that the service reported incidents such as wound infections that occurred after a patient went home. For example, we saw that a patient had acquired an infection over two weeks after discharge. This would not be attributable to the hospital, however the service still investigated the incident to see if there were any lessons that could be learnt.

Staff we spoke with felt there was a learning culture and that they could raise issues without worrying about repercussions. The provider produced 48-hour flash reports as an opportunity to learn from events on a wider scale. These were used to highlight either complaints or incidents that had led to a change of practice. The 48-hour flash reports were shared throughout every hospital within the group and each hospital had to acknowledge that they had been read and distributed throughout the local service. The service had created a similar process to flag near misses or incidents internally. We saw these discussed at the daily huddle.

The Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a policy which described the Duty of candour process. Staff we spoke to, understood the Duty of candour requirement and its implication to clinical practice. Staff could give examples of when Duty of candour had been applied on both the wards and in theatre.

Safety Thermometer

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

The safety thermometer is a collection of data submitted by all hospitals which shows a snapshot of inpatients suffering avoidable harm, usually on one day each month. The safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE), a blood clot which starts in a vein.

Monthly safety thermometer data were displayed on quality and safety performance noticeboards. These boards were installed during our inspection, however staff told us that prior to this, they were displayed in the nurses station. We saw that for the month of September 2019, there had been three serious incidents reported, no falls,

no hospital acquired pressure ulcers and no VTEs. Managers told us that the serious incidents had all occurred post discharge, but the hospital had investigated each to see If there were any lessons to be learnt.

Are surgery services effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, we found that up to date policies were not always available to staff.

The hospital used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to guide the treatment they provided. For example, the most recent version of the national early warning score system (NEWS2) was used to assess and respond to any changes in a patient's condition.

Staff told us that clinical guidelines and policies were available on both the hospital intranet and printed out in a folder on the ward. We reviewed the printed versions of the policies and found that 52 of the policies had expired. Inspectors brought this to the attention of the managers who reviewed the electronic version of the policies, and found that 29 of the policies had either been withdrawn or had not been updated, with a further three policies due to expire. It was noted that all the policies that were out of date or withdrawn were Spire policies and not local hospital issued policies. We saw that all local policies were current and up to date. Senior Spire managers told us that this had been due to a clerical error and showed us evidence that the policies had been either reviewed, had review periods extended, or had been removed prior to the inspection. We saw that all printed polices had been immediately removed from the ward areas, and all electronic policies had either been removed, had their review period extended, or had been immediately updated on the services internal internet.

Nutrition and hydration

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

The service had a process to ensure patients did not eat prior to undergoing a general anaesthetic. Each patient was asked to confirm when they last ate and drank during the checking process on arrival to both the ward and theatre. We were told that the number patients treated as nil by mouth prior to their operation was kept to a minimum, so that patients were allowed to drink fluids. The hospital complied with national guidance that patients should receive clear fluids up to 2 hours before surgery and food up to 6 hours. Hydration scores were audited quarterly with high levels of compliance. To encourage patients to stay hydrated before their procedure, the hospital had developed a 'Think Drink' programme. This involved every patient being given a 330ml bottle of water at their pre-assessment appointment. The bottle was labelled 'Think Drink' and patients were encouraged to drink it between their last meal and two hours prior to their operation.

Staff made sure patients had support with nutrition and hydration to meet their needs. Any patients that had specific dietary needs would be identified at pre-assessment for surgery, and catering staff could then prepare accordingly. Staff told us a dietician was available to provide advice and support if needed.

Patients we spoke with told us that they had been told when they should be nil by mouth from when they attended their pre-operative clinic. All patients we spoke with told us that they had been given enough food and drink while on the ward, as their procedure allowed, and that their specific dietary requirements had been catered to. For example, one patient required gluten free meals, and another was lactose intolerant. They told us that the ward had catered for their needs and they still had a large selection of foods from which to choose.

We saw that staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool called malnutrition universal screening tool (MUST) to monitor patients at risk of malnutrition and saw that these were completed for each patient.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment was included as part of the patient pathway documentation. Assessments of patient's pain were also included in all routine sets of observations. As part of the 'intentional rounding' process, where staff attend patients at set intervals to check a range of patient related clinical and vital signs, staff ensured that patients were comfortable, their pain well managed and recorded this in their medical notes. We saw that staff used a non-verbal pain chart to assess the pain of a patient who had difficulty communicating their pain verbally, and for any patients who did not speak English.

Patients we spoke with told us that their pain was well controlled, and if they required an extra pain relief, they received it soon after requesting it, and did not have to wait long periods of time.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Patient outcomes and hospital performance were monitored through local clinical governance meetings as well as joint meetings for clinical leads from the corporate provider. Where issues of performance or areas for improvement were identified, the hospital put actions plans in place to improve. Performance in relation to actions plans was monitored by the service and speciality leads and reported on through the quality and safety meetings.

The Clinical Scorecard was used to review performance against externally and internally set quality standards. Compliance targets were set for each measure and this information was shared quarterly via the quality report. We saw that the hospital had an extensive audit programme to evaluate the quality of care being received by patients. The results were reviewed in regular quality and safety meetings, and changes to service delivery were planned as necessary. The audit programme included corporate provider benchmarking against other sites through an audit programme and benchmarks. Senior managers told us that the hospital was performing well against other locations.

Patient Reported Outcome Measures (PROMs) are 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. Data provided by the hospital showed that the hospital achieved 100% completion of these questionnaires. The hospital also contributed to the national Joint Registry, Patient led assessment of the care environment audit (PLACE), family and friends feedback for NHS patients, as well as outcomes databases for cardiac surgery, angioplasty and ablation.

The hospital told us they had introduced an Enhanced Recovery Programme in 2018, which comprised a MDT approach and had achieved a reduction of inpatient stay length of 1 day for hip replacement patients and reduced inpatient stay for knee replacement patient of 0.8 days.

Information provided by the hospital showed that there had been nine cases of unplanned returns to theatre between July 2018 and June 2019, compared to eight at the time of the last inspection. We were told that these were mostly cardiac patients. In addition, there had been 15 unplanned readmissions to the hospital within 28 days of discharge, compared to 16 at the time of the last inspection.

The hospital provided data on the cancelled procedures for the hospital within the reporting period. In the last 12 months, July 2018 to June 2019, there had been 16 cancelled procedures for a non-clinical reason. Of the above cancelled procedures, all of the patients were offered another appointment within 28 days of the cancelled appointment.

Competent staff

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

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

The hospital had an induction policy which outlined that new starters in the department were supported to complete their induction program, and be familiar with their working environment, only using equipment that they were competent to use and identifying their learning needs. Trained nurses also had a competency folder they were required to complete.

All staff we spoke with told us that they had received an appraisal within the last 12 months. We saw that over 93% of contracted nursing, healthcare assistants and allied health professionals staff were appraised in 2018/2019 and all the medical staff.

Since our last inspection, the service had introduced a practice development lead nurse (PDN) role, who had responsibility for monitoring mandatory training, ensuring staff competencies, and supporting staff development. The PDN ran regular training sessions for ward staff, often in collaboration with consultants on specific topics. Staff told us they were positive about the support and involvement of the PDN. The practice development nurse also monitored the nursing revalidation process and staff were supported in collating their evidence for revalidation. Revalidation is a new process since 2016 where nurses and midwives need to demonstrate to the Nursing and Midwifery Council that they can practice safely and effectively.

Any concerns related to the consultants around their competency was dealt with via the medical advisory committee(MAC) guidelines. Ongoing compliance with practising privileges was monitored monthly by the MAC.

Multidisciplinary working

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

The surgical service included surgical consultants, RMOs, anaesthetists, nursing staff (ward and theatre), physiotherapy, as well as allied health professionals, such as dietitians. Staff stated they had good working relationship as a surgical team and across all disciplines. Staff stated they worked well together and this was supported by effective and supportive management. Staff also stated they had good working relationships with the intensive care, medical and paediatric teams.

Care planning took place at pre-assessment with input from the multidisciplinary team. including doctors, nurses and allied healthcare professionals as needed.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The hospital had several daily safety huddles to ensure effective MDT communication. This included a whole hospital huddle at 09:15hrs, a clinical safety huddle at 08:30 as well as a theatre huddle and a ward MDT meeting.

There was a service level agreement in place with a local NHS Trust for transfer arrangements should a patient's condition deteriorate, and they required additional care following a surgical procedure. The hospital resuscitation team on each shift was also multidisciplinary, and roles where allocated in the clinical safety huddle. This meant that in the event of a resuscitation, the team already knew what roles they would be responsible for. For example, we saw that one of the nurses had been allocated to doing compressions.

Seven-day services

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

There was a resident medical officer (RMO) on the surgery ward 24 hours a day, seven days a week, who worked closely with the nursing teams and communicated with consultants if there were concerns. RMOs reported that they also had close working relationships with the ITU RMO and were able to seek their support and advice if needed.

Theatres were open for use between 8am and 8pm Mondays to Saturdays. Staff we spoke with did not raise any concerns regarding the availability of theatre slots for patients.

Surgical wards had access to pharmacy input Monday to Friday 9am to 5pm, and Saturdays between 9am and 1pm. Staff could access support from an out of hours pharmacy if needed.

Good

Surgery

There were designated on-call rotas that specified who was to provide support for radiology, pathology, pharmacy, physiotherapy or who was the on-call manager.

Health promotion

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

During our inspection, we saw health promotion leaflets available for all patients and relatives. This included advice from the British Heart Foundation, as well as information on diet and nutrition, smoking cessation, wound management, and warning signs of acute illness. Information leaflets on potential clinical risks such as sepsis and diabetes were also publicly displayed.

Hospital staff provided advice to patients on managing their care after discharge. Staff also encouraged patients to contact the ward if they had any questions. During the inspection we saw that one patient who had been discharged the day before had contacted the ward as they were concerned about their wound. The ward advised them to come to the hospital, the person was seen by a consultant, reassurance was given, and the patient was discharged.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff had received training in Mental Capacity Act 2005 (MCA) and consent. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments. The training took account of young adults and children. All staff we spoke to could tell us where they could seek support if needed and identified the safeguarding leads by name.

We saw that consent to treatment was clearly documented in the patient notes, and observed all staff gaining verbal consent from patients before undertaking any interactions and interventions.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We saw that during shift handover, and at the daily safety meeting, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Are surgery services caring?

Good

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

Compassionate care

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

During the inspection, we saw staff on the surgery ward treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they delivered to patients during their interactions. Care that we observed was patient centred.

We saw that patient's privacy and dignity were maintained whilst they were on the surgical ward, while in theatres, and while being transferred to and from the ward. Each patient had access to their own room. Patients were taken to theatres discreetly and with a chaperone as appropriate.

We spoke with six patients on the surgical wards during the inspection, and four family members. Patients and family members spoke very positively about the care they received, and how they were treated by the staff on the wards. Patients told us staff were respectful of families and kept them updated while the patients were in theatres.

Inspectors were told about the care of a patient with Locked In Syndrome which showed compassionate care. Inspectors were told the patient was non English speaking. The nursing team reorganised their shifts to ensure the patient had staff who spoke their native language on every shift. This enabled the patient to communicate more easily and feel "heard" with basic communication.

The hospital provided patient satisfaction survey data, which showed that from February 2019 to July 2019, the average number of patients and family members who would recommend the service was 94%. The response rate for this period was between 16% and 20%.

Good

Surgery

Emotional support

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

Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional needs, Staff understood the impact that patient's care, treatment, condition and surgery had on their wellbeing. Staff we spoke with stressed the importance of treating patients as individuals. We observed that staff spoke with patients compassionately and empathetically.

Staff told us of the pastoral care that was available for the patients on the ward and knew how to contact the different services both within and out of hours.

Patients and relatives commented that they had been well supported emotionally by staff.

Understanding and involvement of patients and those close to them

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

Family members of patients were positive about the care the patients received and stated that staff members were professional and welcoming. Family members also stated they were kept well informed of treatment plans and were included in conversations about treatment as necessary. They told us that they were kept regularly updated while the patient was in theatres which gave them reassurance. There was evidence of discussions of patient care with those close to them in the patient records.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

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

The hospital provided surgical care to both private patients and to NHS patients within the local area. Staff and patients we spoke to stated that the patient experience of private and NHS patients regarding care was the same.

There was clear signage inside the main hospital building, which meant it was straightforward for visitors to locate the surgical wards. The provider's website provided useful information about the service, procedures that were provided, payment options, and the referral process.

Meeting people's individual needs

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

The service visiting hours were 10am to 8:30pm every day of the week. Staff told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours. Visiting times were clearly displayed on the ward.

Surgical wards provided food that catered to dietary requirements. Patients had access to a wide variety of meal choices that could meet various cultural needs and personal preferences. Patients and relatives had free access to hot and cold drinks and could request snacks in between mealtimes. Patients told us they were happy with the quality of the food that they received.

Staff were aware of how to access translation if patients or families were unable to communicate in English. Some staff stated they spoke other languages so could offer some translation, however also stated that they would use interpreters where appropriate, particularly for patients consenting to treatment. We saw information displayed around surgical wards in other languages, and patients were informed they could request information in their preferred language as needed.

Staff understood the information and communication needs of patients with a disability or sensory loss. A hearing loop was available for patients who were deaf or hearing impaired. Staff made specific arrangements for involving

patients with additional needs and their families, in planning and providing care and treatment. During our inspection we were told of one patient with mental health issues who had had a tour of the hospital to familiarise themselves prior to being admitted, and the same nurse providing the tour made sure they were on duty to care for them during their admission. A full MDT meeting to discuss the patients' best interests was also held.

Surgical wards and theatres had processes in place to help care for patients who may have dementia. Patients with a diagnosis of dementia were identified on the patient information board and in the rooms. Their care needs were also discussed at the safety huddles to ensure that their safe environment was maintained, and their care needs met. This included ensuring they had a familiar escort to theatre, as well as providing 1 to 1 nursing care if required.

The hospital had a learning disabilities lead nurse who provided support, advice and training for staff caring for patients with learning disabilities. Staff we spoke to knew who to contact for support and advice if needed when caring for patients with dementia or learning disabilities.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

The hospital ran an appointment system which was supported by the booking team and allowed patients to choose pre-assessment appointments and surgery times that suited them. Patients also had the option of direct booking online if they were private patients.

Staff we spoke with told us there was no difference in the clinical services or expertise available to either private or NHS patients. At the time of inspection, the hospital activity was approximately 5% NHS and 95% private.

All patients attended a pre-assessment clinic to establish suitability for surgery, identify any complexities, and to discuss the procedure with the patient and their family. Pre-assessment clinics were provided by the surgical consultant and any areas of concern were identified using the risk assessment proforma and recorded for future use.

The surgical service consisted of 64 inpatient beds which included both day case and longer stay patients and a separate paediatric area. Surgical facilities also included six operating theatres, a cardiac cath lab and an 8 bedded critical care unit.

Patients were prepared for their operation or procedure on the ward and waited to be escorted to theatre. After their procedure, patients were transferred to the recovery room to recover and ensure they were stable and pain free. Then they were collected and returned to a room on the ward, or to ITU if previously arranged prior to admission, or if necessary.

The hospital had a pathway in place for patients that had their surgery cancelled on the day and had introduced steps to minimise the risk of this happening. These steps included daily discussions of lists in theatres and confirmation of what is needed ahead of time, ward safety briefings, and the safety huddle. Any cancellations, including on the day, were discussed as a regular agenda item at weekly operational senior leadership and speciality meetings, with the data also examined at the clinical governance meetings.

Patients were seen by the RMO and consultant before their discharge could be completed and signed off. Results of the treatment were communicated to the patients' GP and other healthcare providers as necessary. Discharge summaries also reflected input from other MDT staff as needed, such as physiotherapy.

Learning from complaints and concerns

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

The hospital subscribed to the independent sector complaints adjudication service (ICAS) code of practice in managing complaints. They also submitted their self-assessment against the code in 2018. The clinical governance manager had responsibility for overseeing the management of complaints. All clinical complaints were reviewed and approved by the hospital's director of clinical services.

Good

Surgery

A total of 91 formal complaints (written and verbal) were received and investigated by the hospital in from August 2018 – July 2019, compared to 70 received during 2017-2018. None of the complaints required referral for independent adjudication.

The hospital logs all complaints onto an electronic system. A written formal acknowledgment was sent within 48 hours of receiving the compliant, where the patient was advised of the hospital's complaints process and timeframes to expect. Complainants were also provided with a 'Please Talk to Us' leaflet which sets out the process for managing complaints.

The hospital made changes in response to complaints and analysed patterns and trends to promote service improvements. Staff within surgery told us that complaints were discussed at ward meetings, and any lessons learnt and changes to be made would be fed back at these meetings. Staff would also share information about concerns about complaints via email. We saw that complaints were discussed at monthly complaints meetings and quarterly clinical governance meetings.

Are surgery services well-led?

Good

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

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Surgical services had a clear management structure in place. Responsibility for surgery came under the director of clinical services, with local management provided by a theatre manager, a deputy matron, a cath lab manager, and a ward manager.

During the inspection, staff told us that us that the senior leadership of surgery, the hospital and the organisation were visible on the wards and were approachable to all staff. We observed ward and theatre staff interacting well with the surgery and hospital leadership during the inspection and saw good working relationships.

Ward level nursing leadership was provided by a ward manager who managed the co-located areas of the surgery ward on both Marie Terese and St Georges wards. Staff stated that the manager was very supportive to staff, and they felt they could bring any concerns to her if needed.

Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management. Nursing and medical leadership teams worked closely together to plan and deliver care. Staff from both disciplines were positive about the working relationship on the ward.

Medical support and advice was provided by the Medical Advisory Committee (MAC), which was chaired by the MAC Chair and attended by the hospital director and director of clinical services and had representation from consultants from each major surgical speciality. RMOs told us that they felt well supported by both consultants and anaesthetists and found them approachable and responsive to any concerns.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on improvement of services and patients experience. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had clear vision and strategic goals, based upon the corporate Purpose, Vision, Mission and Values. Leaders told us they wanted to ensure an open and inclusive culture at all levels, one in which staff communicated well, worked together to achieve organisational goals and cared for each other. Their purpose was 'Making a Positive difference to our patients live through outstanding personalised care'. The corporate vision was to be recognised as a world class healthcare business.

The hospital recently developed a new hospital strategy under the headings outstanding clinical practice; our people; exceptional service delivery; the hospital of choice for self-pay treatment; and deliver sound, financial performance. The new strategy was launched in September 2019.

Staff we spoke with during the inspection knew of the new strategy, and departments had been asked to contribute

their aims to help the hospital reach their objectives. Leaders told us that the strategy will be reviewed quarterly and action plans will be developed to help with the delivery of the strategy.

Culture

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

During the inspection all staff we spoke with spoke highly of the senior leaders, and told us they were honest, caring and approachable. Staff told us they were proud to work at the hospital. There was evidence of leaders and teams working collaboratively to deliver good quality of care. We observed one of the daily safety huddles during the inspection and found this to encourage contributions from all staff attending.

After our inspection the service told us that all new staff attended a session with the hospital Director entitled "Breakfast with Bryan". This enabled new team members to understand the hospital strategy and made an instant relationship with the senior managers to build confidence to later raise any issues they may have, and to feel a valued member of the hospital from the outset.

Staff we spoke with felt they were encouraged to challenge any behaviours that did not meet the standards of practice set by the hospital. Staff stated that they felt they could challenge consultants and anaesthetists on their practices and were encouraged by management to do so. Staff told us of an example of when this had occurred, and changes that had occurred as a result.

The contribution of staff was recognised through an awards system for excellence in their roles. Staff could be nominated monthly to achieve an award from the hospital, which was then possible to go further to win a provider wide recognition award.

Governance

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

Surgical wards had a clear governance structure in place. The director of clinical services led a team of speciality nurses and was supported by a clinical governance and risk manager. The director of clinical services reported into the hospital director.

There was a board to ward corporate governance framework in place which oversaw service delivery and quality of care. This included monthly governance meetings which discussed safeguarding, regulatory updates, the clinical scorecard, incidents, audits, training, reports from subcommittees, and any other clinical issues and audits.

We saw that minutes of governance meetings were shared with staff though emails and were also available for staff to read in dedicated governance folders on the ward. Staff we spoke with during the inspection were clear about the governance structure in the organisation and knew their roles in governance.

The service had effective systems to monitor the quality and safety of surgery. The service had a dedicated clinical governance team who managed incidents, complaints, risk and health and safety. The service had a culture of strong incident reporting and used local incident scoping meetings to ensure timely responses to incidents. Action plans were developed to address areas of poor performance, and reports on the progress of action plans were fed back to staff through the governance committees.

The Medical Advisory Committee (MAC) met quarterly and reviewed matters relating to the delivery of clinical care across the hospital and new practising privilege applications from consultants. The MAC was chaired by an appointed lead, and featured representation from all surgical specialities provided by the hospital. The meetings were well attended by consultants from each clinical area.

Managing risks, issues and performance

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

The service had a local risk register which was updated regularly. The risks highlighted on the risk register were current and control measures had been put in place to minimise it with regular updates provided. There were leads allocated to each of the items placed on the risk register responsible for overseeing mitigation actions. Leaders we spoke with knew what the highest risks were, for example staffing, and we saw that these were all identified on the risk register with a responsible person allocated to each risk.

The hospital had a dedicated Risk Champion, and we saw that risk was a monthly agenda item at hospital meetings. Staff we spoke with aware of the key risks to the hospital. The key risks were reinforced to staff through team meetings, in the daily briefing huddle, and were displayed on noticeboards.

Managing information

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

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had required access to record systems to allow them to perform their work effectively.

Senior staff informed us they were General Data Protection Regulation (GDPR) compliant and that patient information was managed in line with data protection guidelines and legislation. On inspection, we observed staff compliance with information governance guidance. We were not made aware of any data security breaches that occurred at the hospital within the past 12 months prior to the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Patient's records were stored in line with personal data security standards and entries made in patient's records could be easily ascertained attributed to the person creating them.

When required, the department submitted reports and notifications promptly to support shared learning and to share information with external bodies.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery. The information was also timely and relevant.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

The service told us they used multiple approaches to communicate with all staff members including use of a closed social media page which allowed for thankyou's to be given and information to be passed to the staff body in an informal way.

The senior management team also ran a programme of regular open forums for all staff which allowed them to update the teams on planned changes, and give staff the opportunity to be involved and contribute ideas. This also gave the teams an opportunity to raise concerns and ask questions.

The corporate provider had introduced the Freedom to Speak Up Guardian roles across all hospital sites. The role here was provided by nurse managers and offered staff a confidential route to raising concerns. Staff we spoke with were aware of the role of the guardian and stated it was a useful resource to have in place.

The Freedom to Speak Up Guardian for the service had been very proactive in advertising the role. During the inspection we saw posters with photographs, names and contact numbers of the guardians displayed in staff communal areas. We saw a dedicated freedom to speak up folder available for all staff to read, which explained the role, and gave support and advice to staff, the guardian also provided statistics to managers for the service on how many contacts they had each month and would raise any concerns in hospital meetings if needed.

Good

Surgery

The hospital gathered patient opinion using the Friends and Family Test (FFT) and the Patient Led Assessment of the Care environment (PLACE). In addition, senior staff 'walked around' the clinical areas several times a day to ensure oversight and highlight any concerns and be visible and accessible to staff, patients and relatives.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

The service had an active cardiac support group which had been running for over 23 years for former patients and their partners which had speakers and staff on hand to answer queries.

The service had introduced the 'Think Drink' campaign to encourage patients to stay hydrated prior to undergoing surgery. It has been proven that patients who are more hydrated have better outcomes from surgery. The Think Drink campaign involves patients being given a bottle of water at their pre-assessment appointment, which has been labelled 'Think Drink'. Patients were encouraged to drink the water between when they last ate, and 2 hours before their operation.

Good

Critical care

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

Are critical care services safe?

Good

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

Mandatory training

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

All substantive nursing staff and resident medical officers completed mandatory training through the provider's online mandatory training system, or through face to face sessions, depending on the topic. Staff were also required to complete competencies relevant to critical care.

The hospital provided information on mandatory training compliance rates for all 23 staff working in critical care. As of 12 September 2019, compliance rates for all ten mandatory training courses were 100%. This included key safety courses such as fire safety, health and safety, infection control, information governance, and manual handling. This meant that all staff had received training essential to providing safe patient care.

The director of clinical services had access to the training profiles of staff to ensure regular checking of outstanding and completed modules and maintained a log to track the progress of each employed resident medical officer.

All staff we spoke with during the inspection confirmed they were up to date with mandatory training, and they received email or face to face reminders from leaders when they were due to complete modules.

Leaders obtained a CV for all agency staff which included the agency staff member's compliance with mandatory training modules. Leaders reviewed these prior to their first shift. The hospital required any agency they worked with to monitor and enforce ongoing completion of mandatory training in line with the provider's national contract.

Safeguarding

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

All 23 staff working in critical care had completed training in safeguarding adults level two, and safeguarding children and young people level three. This meant all staff had received training essential to protecting patients from abuse and neglect.

There were two nursing staff who acted as the adult and child safeguarding leads, whom staff could seek advice from.

There were corporate policies for safeguarding adults and children which staff could access in printed form and on the hospital intranet. The safeguarding vulnerable adults policy was under review at the time of the inspection, awaiting sign off from the corporate provider executive committee. The hospital told us staff had access to local support networks to protect patients from abuse and neglect.

Cleanliness, infection control and hygiene

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

Good

Critical care

The critical care unit was visibly clean and tidy. All soft furnishings such as chairs were wipeable. Disposable curtains were in date and had a date for replacement. We saw there was wall mounted antibacterial hand gel and personal protective equipment by each bed side. We noted all staff were bare below the elbow. There were also several handwashing sinks and antibacterial hand gel inside and outside the critical care unit, to ensure staff and visitors had as many opportunities to wash their hands as possible.

The infection control lead conducted quarterly hand hygiene audits, which checked staff were washing their hands or using antibacterial hand gel at every opportunity. We viewed the hospital-wide audit results from quarter two 2019 which showed a compliance rate of 100%. The infection control lead also carried out an Aseptic Technique Audit in August 2019, across several departments in the hospital. This showed a compliance rate of 87%, which was below the target of 90%, but actions had been identified to improve compliance.

The hospital had access to a consultant microbiologist under a service level agreement who attended the quarterly Infection Control Committee. Staff told us the microbiologist would see any patients on the critical care unit if staff requested support.

Staff could use the two side rooms available if patients required isolation.

Staff displayed infection rates on a board in the unit, which showed that there had not been any infections in the unit for over three months.

Environment and equipment

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

The unit provided mixed sex accommodation for critically ill patients in line with national guidance. There were some single rooms and curtains to maintain patients' privacy

Staff ensured equipment was maintained and serviced in line with guidelines. We viewed three sharps bins which were signed and dated when brought in to use and were not overfilled. We observed two gas analysers, and both had been portable appliance tested and were in date for testing.

Staff told us if there were any problems with the environment or equipment, they could escalate to the hospital estates team, cleaning team, or external contractors if required. Staff we spoke to confirmed they had enough equipment to care for patients safely.

We viewed the resus trolley which was sealed by a numbered tag. The contents of the resus trolley was checked monthly (or at any time the seal was broken) by two members of staff. We saw records which confirmed this.

Assessing and responding to patient risk

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

The unit provided both level two and level three critical care support, therefore staff were capable of caring for patients with higher clinical care needs. Staff used the National Early Warning Score (NEWS) tool to assess patients observations and escalate if they deteriorated.

Staff had access to a sepsis care bundle which they could use to identify signs of sepsis early, and act as quickly as possible to obtain key observations and tests and arrange for antibiotics to be prescribed. All staff on the critical care unit had received sepsis training as part of their mandatory training.

We saw contact numbers for the surgeons and anaesthetists who had carried out surgeries on patients receiving care in the critical care unit were easily accessible for staff, should they need to seek advice.

If a patient deteriorated beyond the capabilities of the critical care unit to care for them, the hospital had a service level agreement in place with a nearby NHS acute trust to transfer the patient.

We observed a morning nursing handover where nursing staff shared key information such as medical history, medication given and planned, neurological status, observations such as blood pressures, and any diagnostic tests needed. This meant that all staff were informed and prepared in order to assess and respond to patient risk.

There was a critical care outreach team for the hospital. We saw staff agreed at the daily safety huddle who would be involved in the team and would carry out specific tasks

such as compressions and administering blood or IV fluids**.** Leaders told us the critical care outreach team was pro-active and would visit patients at regular intervals for a minimum of 48 hours post discharge from the critical care unit, as well as attending to patients when they deteriorated. The hospital told us the outreach service had reduced unplanned admissions to the critical care unit.

Nurse and support staffing

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

The critical care unit used a safer staffing tool to calculate how many staff were needed to care for the number of patients.

The ratio of nursing staff to patients in the critical care unit was 1:1 for level three patients and 1:2 for level two patients. Data submitted by the hospital showed that this ratio had been maintained throughout May to July 2019. Level two patients are those requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care. Level three patients are those requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes complex patients requiring support for multi-organ failure.

Patients receiving care in the critical care unit were usually attending for pre-booked elective treatments. Staff discussed planned admissions at the daily management briefing and the twice weekly hospital planning meeting, which included discussion of any patients requiring additional support or staffing skills.

There were seven whole time equivalent nursing and support staff working in the critical care unit, and a unit manager. The unit manager told us they were assured that staffing was safe. During our inspection we saw the unit manager attend the daily safety huddle to provide accountability for this and confirm staffing was safe in the unit on that day.

There was a dedicated pharmacist for the unit, who attended regularly to review prescribing and medication charts. Staff told us they could seek advice from the pharmacist at any time and we saw pharmacists attended the daily safety huddle, so they were aware of the priorities of the critical care unit.

The unit did not have dedicated physiotherapists. However, staff confirmed they could seek support of these professionals either through staff working elsewhere at the hospital, or locums who had practising privileges to work at the hospital. Staff told us if patients required input from physiotherapists, this could be arranged on the same day. Physiotherapists also saw patients needing surgery during their pre-operative assessment, and this information was shared with staff working in the critical care unit.

In the event of short staffing, sickness or annual leave, the unit manager could arrange cover from experienced bank nurses or agency staff.

Medical staffing

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

The critical care unit had two permanent intensivist resident medical officers (RMOs) who stayed at the hospital, and worked on seven days on, seven days off rota.

A consultant intensivist carried out twice daily ward rounds. We saw that staff discussed when the consultant would be attending during handovers. Staff also discussed RMO staffing during daily safety huddles.

The consultant intensivist also provided 24 hours a day, seven days a week out of hours cover by telephone and was available to attend the hospital within 30 minutes. There was also a cardiac registrar available on call at all times.

The hospital provided us with information which showed that should the intensivist RMOs have busy periods which did not allow for sufficient rest and sleep, an agency RMO could replace the ITU RMO, enabling them to have a period of rest.

Good

Critical care

On our last inspection, we found consultants saw patients within an hour of admission to the critical care unit and carried out morning and afternoon reviews. On this inspection, we found this remained the same.

Records

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

We looked at two sets of patient notes and saw these were fully complete, including risk assessments for nutrition, venous thromboembolism, and skin damage, pain scoring, allergies, and documentation of observations using the National Early Warning Score system. All entries we viewed in the unit were signed, dated and legible, and staff had written information clearly and concisely, such as post-operative instructions from consultants.

The hospital conducted hospital-wide quarterly records audits which looked at a sample of patient records from across the hospital. This showed the recording compliance score for NEWS was 99%, pain scoring was 100%, VTE and falls risks assessments were 100%, all against a target of 95%.

Staff also conducted quarterly detailed records audits specifically for the critical care unit. On our last inspection, we told the provider they should ensure doctors record twice daily reviews of patients and evidence of updates to treatment plans. On this inspection, we looked at the 2019 audit for doctor's patient reviews and saw the unit had met the target of 95% for recorded twice daily doctor reviews of patients. The unit also consistently met the target of 100% for doctors correctly signing and dating records, and clearly documenting treatment plans. This was an improvement upon our last inspection and showed the hospital had reliable systems to ensure medical staff completed the required documentation.

Medicines

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

We inspected areas where medicines were stored and found all items we checked were in date. We also found staff used systems to rotate stock regularly, to ensure that items with the earliest expiry date were used first.

Medicines and controlled drugs were stored securely in the clinical room, in locked cupboards. Pharmacists conducted quarterly security of medicines audits and gave feedback to staff. We viewed a controlled drugs audit from June 2019, and saw the unit had scored 94% compliance, an improvement from the previous audit.

We saw pharmacists attended hospital-wide safety huddles, at which critical care staff were also present, to share medicines-related information such as reminders to make sure requests for medications for patients to take with them on discharge were submitted early.

Incidents

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

Staff were aware of their responsibilities to report incidents and near misses. Staff reported incidents using an electronic system, which was monitored by senior staff and leaders.

Staff we spoke to could give examples of recent incidents they had reported, the learning that was shared from the investigation, and how improvements were made as a result. For example, staff told us of a recent incident where monitoring of arterial blood gases was not as frequent as it should have been, and that processes had been improved to prevent this from reoccurring. Staff told us that all unplanned admissions to the critical care unit were reported as an incident so that the patient's care could be reviewed.

Staff told us they discussed incidents and learning from investigations during their staff meetings. We saw this was the case when we attended a hospital-wide huddle during our inspection.

We viewed an example of a root cause analysis report from September 2019. We saw this investigation report contained the identified cause of the incidents, evidence of actions taken to prevent it from happening again, and clear

learning points. The report had been shared with all staff in the critical care unit through notice boards in staff area and had been discussed in team meetings. This meant that leaders ensured lessons learned were widely circulated.

When an incident occurred anywhere across the corporate group of hospitals, the provider would send a 'flash alert' to all staff within 48 hours, to share learning. This also included any national patient safety alerts. Staff confirmed they received these and they discussed the 'flash alert' in their service-specific and hospital-wide meetings.

The hospital told us the critical care team attended and participated in the hospital morbidity and mortality meetings to present any cases which they were involved in and participate in discussions about other cases. These meetings involved consultants and members of the multidisciplinary team. The hospital told us the meetings were carried out in a supportive way with a no blame culture, and were focused on the wellbeing of the patient.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of healthcare providers to notify patients of and provide reasonable support when something went wrong, even if someone was not harmed. On our last inspection we found the duty of candour had not been activated in any relevant reported incidents. On this inspection, we found the provider had made improvements to review the trigger threshold for activating a duty of candour response, even when no or low harm results from sub optimal care. Staff we spoke to gave examples of when they had activated the duty of candour in an incident of no harm. Staff also confirmed that compliance with duty of candour had improved since our last inspection. The hospital told us the duty of candour was now being consistently applied in all relevant cases.

Safety Thermometer

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

During our inspection, a quality and safety board was installed on the unit, which had been planned for several months. This gave staff, patients and visitors a clear view of safety performance, including measures such as who the nurse in charge was, days since the last infection recorded, staffing, and days since the last medicines incident. Staff told us this information was used to initiate improvements, as well as recognise good practice.

Information on infections, returns to theatre, and unplanned admissions for St Anthony's Hospital were also published on the provider's website, in a section the provider called their 'healthcare standards'.

There was also a performance indicator scorecard for the critical care unit, which was divided in to Safe, Effective, Caring, Responsive and Well Led sections. This showed good performance overall compliance with safety indicators. For example, the numbers of infections on the unit remained at 0% throughout 2019, against a target of 3%. Numbers of pressure ulcers in 2019 remained at 0% against a target of 0%.

Are critical care services effective?

Good

We have not previously rated effective for this service. We rated it as **good.**

Evidence-based care and treatment

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

Staff were able to give examples of national evidence-based guidance they used in their every day work, such as the Intensive Care Society guidelines. Unit staff told us they were kept informed of changes to guidelines from Spire's monthly National Safety Updates, which highlighted new National Institute for Health and Care Excellence (NICE) guidance, updated policies and internal and external safety alerts. The hospital carried out regular self-assessments against critical care standards, through local audit programmes. For further detail, please see the patient outcomes section, below.

For our detailed findings on policies please see the Effective section in the Surgery report.

Nutrition and hydration

Good

Critical care

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

Staff discussed whether patients had enough to eat and drink, and any dietary requirements during handovers. Religious, cultural and special dietary meals could be sourced either within the hospital or outsourced, should patients require them. The hospital told us catering staff were trained in allergy protocols. Patients in the critical care unit generally did not require parenteral nutrition (intravenous administration of nutrition), but staff could arrange this if required.

Staff could seek advice from dietitians if required.

Pain relief

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

We saw staff discussed patient's pain level and any pain management plans during handovers. Patients told us their pain had been well managed.

The hospital also conducted quarterly audits on pain management across the hospital services. This showed that 60% of patients were given pain relief immediately upon the onset of acute pain, 20% within five minutes, 13% within 15 minutes, and the remaining 7% had already received pain relief.

Patient outcomes

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

All departments and services in the hospital were required to give a verbal update at the hospital's monthly clinical audit, safety and effectiveness (CASE) meetings.

The hospital was part of the South West London Critical Care Network which monitored patient outcomes in critical care and aimed to improve them. The unit manager attended these monthly meetings to gather information on best practice and outcomes and shared with staff working in the unit. The service participated in the National Cardiac Service database.

The critical care unit conducted quarterly local audits on infections such as Ventilator-associated pneumonia and Central Venous Catheter infections.

The unit conducted local audits on several topics including cleaning, patient records, regularity of observations, and the environment. The controlled drugs audit showed a compliance score of 94%. The environmental audit showed a score of 95%. The records audits included assessments of observation scoring and accuracy, pain recording, venous thromboembolism risk assessments, and consultant documentation. Most aspects of this audit achieved a compliance score of 95% and above, which met the hospital target. However, the compliance score was 88% for intraoperative temperature recording and 93% for pregnancy testing. Results of the audits were rated red, amber or green for compliance. If there were areas of lower compliance identified in the audits, staff would draw up an action plan to address the issues.

The unit did not currently contribute data to the Intensive Care National Audit and Research Centre. However, at the time of our inspection, there was a corporate project in progress at provider level to complete a gap analysis of outcomes data produced by the unit and national dashboards. Staff had planned to issue a new dashboard where patient outcomes would be rated on a red, amber green scale. We requested information about this new proposed dashboard from the hospital, which showed it would cover unplanned and delayed admissions, readmissions within 48 hours, numbers of unit-acquired infections, patients being discharged directly home or out of hours, and a sepsis audit. At the time of writing, the dashboard had not gone live, although the hospital was recording the data.

Competent staff

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

Staff were required to complete competencies online or face to face, depending on the task. All staff we spoke to on

the critical care unit had completed relevant competencies for their role, in line with the National Competency Framework for Registered Nurses in Adult Critical Care Units.

All resident medical officers had a daily timetable outlining minimum expectations of the role and areas to cover. Staff told us if they had any concerns about the competency of any resident medical officer, they would be confident to raise them directly to the Director of Clinical Services. Leaders had adapted their recruitment processes to ensure staff had the right competencies for the role. For example, leaders asked scenario questions during interviews, including situations involving caring for a patient post cardiac surgery.

We spoke to a student nurse who told us they received excellent support from their mentor, had a thorough development plan and had been able to access a variety of experiences to progress their skills.

Staff we spoke with confirmed they had received a recent appraisal which gave them opportunities to discuss their development and training needs. For our detailed findings on appraisals, please see the Effective section in the Surgery report.

Multidisciplinary working

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

The critical care unit held weekly 90 minute meetings on Fridays, attended by allied health professionals such as pharmacists and physiotherapists, nursing staff, the consultant lead for the critical care unit and senior leaders such as the hospital director. The meeting included multidisciplinary discussion of all patients for learning, and planning for the following week. Staff spoke of good working relationships between multidisciplinary professionals. If staff were not working in the unit on Fridays, they would be able to engage in multidisciplinary discussions in the daily whole hospital huddle and clinical safety huddle.

The unit did not have dedicated physiotherapists, dietitians or speech and language therapists. However, staff confirmed they could seek support of these professionals either through staff working elsewhere at the hospital, or locums who had practising privileges to work at the hospital. Staff told us if patients required input from such therapists, this could be arranged on the same day. Physiotherapists also saw patients needing surgery during their pre-operative assessment, and this information was shared with staff working in the critical care unit.

Seven-day services

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

The hospital was staffed 24 hours a day, seven days a week in line with the hospital's critical care policy.

Out of hours cover was provided by the respective consultant and an ITU Registrar was on site 24/7 to provide medical assessment and treatment as required whilst the consultant is contacted. Ward nursing staff were able to call consultant surgeons, anaesthetists or physicians involved in patients care directly if they were required out of hours

Health promotion

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

Patients could access the hospital cardiac support group, which included presentations from multidisciplinary professionals. This meant patients could gain a better understanding about the procedures involved in their care and treatment and could seek support from other people who had been through similar treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

All clinical staff participated in mental capacity training via Spire's mandatory training portal, in order to support patients who require additional support.

We asked staff about their knowledge in this area. Staff confirmed that if they had concerns about patient's ability to consent they would escalate to senior staff or one of the safeguarding leads. Staff recognised that a best interests meeting would be necessary to decide whether a patient lacked capacity and steps needed to be taken to protect

them which may have implications for their liberty. However, staff told us they did not have any incidents where Deprivation of Liberty Safeguards had needed to be implemented.

For our detailed findings on consent please see the Effective section in the Surgery report.

Are critical care services caring?

Good

We have not previously rated caring for this service. We rated it as good.

Compassionate care

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

Patients described staff as 'very polite', 'very helpful', 'lovely' and 'very attentive'. One patient also told us 'I would recommend this hospital to anyone due to the high quality of care'.

We observed staff greeting patients, asking how they were and speaking to them in a kind and reassuring manner.

We saw information showing 94% of patients would recommend Spire St Anthony's Hospital to their family and friends following their treatment (based on patient satisfaction data from quarter two of 2019). This meant that most patients were happy with the care they received at the hospital overall.

There was a specific section applicable to the critical care unit in the Spire Privacy and Dignity policy. This outlined that staff in the critical care unit would ensure privacy and dignity during the whole period of time the patient is in the unit, by using the curtain around the bed space, speaking in a lowered tone, ensuring lighting is adjusted to help with rest and recovery, and assisting with hygiene and enabling toilet facilities in a sensitive and comfortable manner. Throughout our inspection, we observed that staff complied with this policy.

Emotional support

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

One patient told us they had been nervous, but all staff had helped to allay their fears by reassuring them.

We saw that staff shared information on how patients and their families were feeling emotionally during handovers, which meant that all staff were aware of how to support them.

Staff could refer patients who had undergone treatment for cardiac conditions and received care in the critical care unit to the cardiac support group, where they could talk about their worries and fears with others who have experienced similar concerns. The support group ran monthly and also offered health education to all cardiac patients post operatively.

Understanding and involvement of patients and those close to them

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

Patients confirmed that all staff introduced themselves prior to caring for them.

Patients told us that nursing and medical staff explained their care and treatment in a way they could understand and had opportunities to ask questions. Patients we spoke to were aware of plans and next steps for their care and treatment, demonstrating that staff had kept them involved and informed.

Are critical care services responsive?

Good

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

Service delivery to meet the needs of local people

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

Good

Critical care

The critical care unit served private patients, either self-funding or funded by private medical insurance as well as NHS patients through specific contractual arrangements.

A visitors' waiting room was available near the unit with a water cooler and tea and coffee facilities. A restaurant in the hospital catered for visitors

There was free parking available for patients and visitors.

Meeting people's individual needs

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

There was a dementia awareness program for the hospital and a dedicated dementia lead staff could seek support from. Leaders told us all staff completed online training on dementia.

Translation services were also provided for patients who could not speak English, either face to face or over the phone.

All areas of the hospital were wheelchair accessible, and there were dedicated disabled toilets and parking spaces.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

From December 2017 to November 2018, bed occupancy rates for level three critical care remained around 10% or less, and bed occupancy rates for level two intensive care remained between 20% and 30%. Therefore, the service was able to admit, treat and discharge patients in line with national standards.

On our last inspection we found the majority of admissions to the unit were pre-planned following elective surgery. Patients were identified as requiring critical care at their pre-assessment check and if necessary a decision was taken to request a critical care bed. This allowed the unit to plan ahead in order to meet the needs of specific patients. Staff in theatres and recovery told us they worked well with the critical care unit. On this inspection, we found this good practice remained the same.

Staff discussed any patients with an extended length of stay during safety huddles.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Staff we spoke with could give examples of recent feedback and complaints from patients, and how this information had been used for learning or to make improvements. For example, a patient had complained that they felt staff had left them alone for too long, and leaders responded by re-emphasising the need for regular intentional rounding.

We saw 'Please Talk to Us' leaflets were available around the hospital in leaflet holders, which set out the provider's complaints process.

If a patient raised a complaint or concern, the critical care manager would see the patient to discuss their concerns and would then raise the complaint with the governance manager.

Leaders kept a hospital-wide log of complaints, so that investigations could be tracked and learning shared with staff in huddles and team meetings.

Are critical care services well-led?

Good

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

Leadership

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

Staff told us leaders such as the hospital director visited the critical care unit and were visible throughout the hospital. We observed that this was the case throughout the hospital during our inspection.

The unit manager was experienced in critical care and held the qualifications and expertise necessary for the role.

Good

Critical care

Staff described their managers as supportive, and gave them opportunities to develop, such as through external courses and opportunities to carry out internal projects and audit.

Staff told us they felt there had been investment in the critical care unit, including the provision of new equipment, which showed leaders understood the priorities of the service.

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

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with staff. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There was a hospital-wide strategy comprised of five key elements; outstanding clinical performance, striving to have the right people with the right skills in the right place, exceptional service delivery, to be the hospital of choice for self-pay treatment, and to deliver sound financial performance. This was arranged in the form of a diagram and was displayed around the hospital areas we visited.

Senior leaders told us the vision and strategy was developed in partnership with staff and patients. For example, each head of department was required to discuss the strategy with staff and decide whether it was achievable and what steps were required to turn it in to action. Senior leaders also told us that staff objectives were linked to the vision and strategy.

Senior leaders told us that some key drivers in the strategy were developed directly from patient feedback, and they would be informing patients of their progress through "you said, we did" displays around the hospital.

Culture

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

Staff described the culture on the unit as positive, and 'like a family'. We observed through handovers and interactions between staff and patients, that staff demonstrated a patient-focused approach. For example, staff considered how patients and their families were coping emotionally with their care and treatment.

Staff told us they felt valued and respected. For example, staff were pleased that they received time off in lieu if they were required to attend meetings or training outside of their normal working hours.

Staff told us they could access opportunities for career development, such as through external courses and national training programmes. Staff told us they had been supported by their managers to take these up.

Staff told us they would feel comfortable to raise concerns to senior leaders, about the service or about individual clinicians, and some staff could give examples of where they had done so.

Governance

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

We viewed an organisational structure chart which showed the critical care unit manager was accountable to the director of clinical services.

There was a critical care committee led by the critical care unit manager, which fed up to the Hospital Clinical Governance Committee, which in turn fed up to the senior leadership team.

There was a governance folder in the critical care unit which all staff had access to, containing incident reports and associated learning, information for staff on clinical reviews and minutes from team meetings.

The hospital told us the critical care unit conducted a quarterly critical care steering group with input from both medical staff and the wider multidisciplinary team. The group looked at incidents, complaints, service delivery issues, mortality and morbidity relating to critical care and designed strategies for improvement.

Good

Critical care

Staff told us they felt the governance of the service were robust, and they were clear about what they were accountable for and to whom.

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

Managing risks, issues and performance

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

There was a risk register for the hospital which all departments contributed to. The register categorised the issues identified with a clear risk rating system of low, moderate or severe with green, amber and red coloured ratings. The hospital identified dates to review the issues before they were closed. The Director of Clinical Services had oversight of the risk register and we saw that mitigation was in place for the risks and they had review dates for each of the issues.

We saw the local risk register for the critical care unit was available to all staff and was displayed on the unit quality board. This included risks around staffing and unplanned admissions. This was aligned with what staff told us and what we observed during the inspection. Staff were able to tell us of ongoing work to reduce and mitigate these risks.

Managing information

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

The service produced monthly activity reports which included service performance measures and these reports were monitored and discussed in staff meetings, medical advisory committee meetings and hospital senior leadership meetings.

Performance dashboards were used for staff to discuss and monitor performance at monthly senior management team meetings.

We saw that patient records were stored securely, there were arrangements in place to ensure that data and notifications were submitted to stakeholders and regulatory agencies when required.

Engagement

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

Patients were encouraged to complete a patient satisfaction survey after their discharge from the hospital, or the end of their treatment. The results from surveys were analysed by an independent third party and communicated back to the hospital on a monthly basis for learning and action. Results showed 94% of patients would recommend Spire St Anthony's Hospital to their family and friends following their treatment (based on patient satisfaction data from quarter two of 2019).

Staff told us they had opportunities during weekly team meetings to make suggestions for the improvement of services. There were also weekly hospital-wide safety huddles, as well as engagement opportunities run to acknowledge events such as Antibiotic Awareness Week and National Stress Awareness Day.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The executive team were responsive to requests and suggestions for improvement. Staff told us they felt leaders had invested in the service through the provision of new equipment.

All staff were focussed on improving the quality of care that they were providing. For example, during handovers and through our conversations with staff, staff expressed a desire to provide the best possible patient care.

At the time of our inspection, there was a corporate project in progress at provider level to complete a gap analysis of critical care outcomes data, produced by the unit and national audits. This included adjusting the presentation of data to make it easier for non-clinical colleagues to understand.

Good

Services for children & young people

Safe	Good
Effective	
Caring	
Responsive	Good
Well-led	Good

Are services for children & young people safe?

Good

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

Mandatory training

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

All substantive nursing staff and resident medical officers completed training through the provider's online mandatory training system, or through face to face sessions, depending on the topic. This included key safety courses such as fire safety, health and safety, infection control, information governance, and manual handling. We requested mandatory training rates broken down specifically to staff working in the children and young people service, which showed 100% compliance across all modules, against a target of 95%. This meant all staff had received training essential to providing safe patient care.

The lead paediatric nurse had access to the training profiles of staff to ensure regular checking of outstanding and completed modules.

All staff we spoke with during the inspection confirmed they were up to date with mandatory training, and they received email or face to face reminders from leaders when they were due to complete modules.

Leaders obtained a CV for all agency staff which included the agency staff member's compliance with mandatory training modules. Leaders reviewed these prior to their first shift. The hospital required any agency they worked with to monitor and enforce ongoing completion of mandatory training in line with the provider's national contract.

Safeguarding

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

Spire had a national safeguarding policy which the hospital followed. The children's lead nurse was the named nurse for safeguarding. This nurse and the named consultant for safeguarding were both trained in child safeguarding to level four. The nurse was able to deliver level two child safeguarding training to other paediatric nurses. All staff caring for children and young people were up to date with safeguarding training.

The safeguarding learning package contained specific relevant issues such as child sexual exploitation, domestic violence, female genital mutilation and preventing radicalisation. The hospital told us they updated all mandatory modules annually to ensure they reflected latest guidelines.

The service provided us with information to show that any consultants who were listed on the hospital paediatric register were required to provide evidence of up to date level three safeguarding children training before appointments could be made for them to treat children and young people under the age of 18.

Staff reviewed the GP summary of every child and young person prior to admission to check if they were known to social services or mental health services.

The lead paediatric nurse maintained regular communication with the named nurse for child protection at a local clinical commissioning group and local safeguarding children board. The hospital told us the lead paediatric nurse attended local safeguarding children board training and meetings to ensure the hospital stayed up to date with the latest information. The service contributed to the local safeguarding children dashboard managed by these groups to monitor outcomes.

The lead paediatric nurse operated a tracking system where staff were required to inform the paediatric service if a child attended for treatment at any non-paediatric area of the hospital, such as diagnostics. This meant the lead paediatric nurse could attend that area and offer support if required, and ensure safeguarding processes were complied with.

In areas where there were no dedicated paediatric waiting areas, such as diagnostic facilities, there were signs stating that children under 16 years of age must not be left unattended.

Cleanliness, infection control and hygiene

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

All the areas we visited where children were treated were visibly clean and tidy.

Rooms that were not in use but had been cleaned had a sign on the door informing staff the room had been cleaned and advising them to keep the door closed, to prevent the spread of bacteria and infection. Patient rooms were cleaned again before use.

Personal protective equipment such as gloves and aprons were stationed in several places in the children's ward and children's treatment room in outpatients. There were several handwashing sinks and antibacterial hand gel available. We saw that all staff working in the paediatric service were bare below the elbow in line with national guidance.

Staff told us areas in which children were treated were subject to audit by the infection control lead, who monitored compliance with best infection prevention and control practice. For example, staff told us they had recently bought adaptable toilet seats for children on the advice of the infection control lead.

The infection control lead conducted quarterly hand hygiene audits, which checked staff were washing their hands or using antibacterial hand gel at every opportunity. We viewed the hospital-wide audit results from quarter two 2019 which showed a compliance rate of 100%.

Environment and equipment

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

The children's ward was located as a wing of the main medical ward. The children's ward was separated from the medical ward by a secure door. Staff had swipe cards to access the children's ward, and visitors had to ring a doorbell to gain access. This meant the children's ward was secure in line with national guidance, which prevented access by unauthorised persons.

Staff ensured equipment was maintained and serviced in line with guidelines. We viewed three sharps bins which were signed and dated when brought in to use and were not overfilled. We viewed three items of equipment and saw these had been serviced and were clearly labelled with the date by which their next service was due.

We saw a list of all emergency equipment and where it was stored was displayed on the ward. This meant any new or agency staff could access equipment they needed quickly.

Equipment was labelled with 'I am clean' stickers to show when it had been cleaned. Staff told us if there were any problems with the environment or equipment, they could escalate to the hospital estates team, cleaning team, or external contractors if required. Staff we spoke to confirmed they had enough equipment to care for patients safely.

We viewed four paediatric resus trolleys, including those in theatres and on the children's ward, which were sealed by a numbered tag. We viewed a sample of emergency drugs and equipment in the trolleys and found they were in date

and contents was aligned with checklists. The contents of the resus trolley were checked monthly (or at any time the seal was broken) by two members of staff. We saw records which confirmed this.

Paediatric surgery was carried out in theatre six, located away from other theatres. There was also a dedicated paediatric recovery room. This meant children did not have to walk past other theatres in use, and adult and paediatric patients were treated in separate areas from each other.

Assessing and responding to patient risk

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

The service used paediatric early warning scores (PEWS) to monitor patients for any signs of deterioration. This included monitoring observations such as respiratory rate, pulse, and temperature. We saw a copy of the PEWS chart which showed a clear escalation plan for staff to follow depending on the PEWS score.

All resident medical officers (RMOs) and the lead paediatric nurse were required to have up to date advanced paediatric life support training. RMOs worked on 24 hours shifts on call, therefore there was always someone on duty with this level of training

If a patient deteriorated beyond the capabilities of the service to care for them, the hospital had a service level agreement in place with a nearby NHS acute trust to transfer the patient.

Nurse staffing

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

There were two permanent registered children's nurses, including the lead nurse. Due to the small numbers of patients seen, all children and young people attending the hospital for surgery were cared for on a one to one basis. One of the nurses was dedicated to outpatient clinics three times a week to support consultants treating children and young people and carrying out minor procedures.

If the service required additional nursing support, the lead nurse told us they could easily book paediatric trained staff from the hospital bank.

Medical staffing

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

All children and young people were cared for by a named consultant with practising privileges at the hospital. All consultants caring for children and young people in either a surgical or anaesthetic context were required to provide evidence that they undertake clinical paediatric activity within their scope of practice in the NHS, and this was recorded on the consultant register. Practising privileges were reviewed by the senior management team annually. The medical advisory committee became involved if there were any concerns.

Amongst the 34 consultants who had practising privileges to treat children at the hospital, there was a lead paediatric anaesthetist, and a paediatric representative to the medical advisory committee. The service had an agreement with a consultant paediatrician to offer non urgent medical advice during the working week. The service also had a paediatric steering group which met regularly to review the service. All consultants with practising privileges to treat children and young people were invited to attend to give their views and contribute to service developments through this forum.

Records

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

We looked at four sets of patient notes and saw these were fully complete, including risk assessments for pain scoring, allergies, and documentation of observations using the

paediatric early warning score system. All entries were signed, dated and legible, and staff had written information clearly and concisely, such as post-operative instructions from consultants.

The hospital conducted quarterly records audits which looked at a sample of patient records from the children's service specifically. This showed the recording compliance score for paediatric early warning scores (PEWS) was 100%, pain scoring was 100%, and risk assessments for the environment, inpatient care, outpatient care and pre-assessment were all 100%.

Medicines

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

Medicines were stored securely in locked cabinets and paediatric drugs were stored separately from adult drugs. We viewed a sample of ten medicines and saw these were within expiry date. Staff rotated stock to ensure items with the closest expiry date were used first. Staff clearly labelled liquid medication to show when it had been opened.

Staff carried out daily checks of the medicine fridge, and we saw these were documented and temperatures were within range.

We saw that staff documented any medication allergies in patients' notes.

This was not a dedicated children's pharmacist, but the pharmacist had access to the Paediatric Formulary and to paediatric advice if required. Staff confirmed the pharmacist attended the children's ward and outpatients frequently, to check medication charts and restock medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

Staff were aware of their responsibilities to report incidents and near misses. Staff reported incidents using an electronic system, which was monitored by senior staff and leaders.

Staff we spoke to could give examples of recent incidents they had reported, the learning that was shared from the investigation, and how improvements were made as a result. For example, changes made to the process of taking blood from children.

Staff told us they discussed incidents and learning from investigations during their staff meetings. We saw this was the case when we attended a hospital-wide huddle during our inspection.

When a significant incident occurred anywhere across the corporate group of hospitals, the provider would send a 'flash alert' to all staff within 48 hours, to share learning. Staff confirmed they received these and they discussed the 'flash alert' in their service-specific and hospital-wide meetings.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of healthcare providers to notify patients of and provide reasonable support when something went wrong, even if someone was not harmed. Staff we spoke to could describe what the duty of candour was and could gave examples of when they had activated the duty of candour.

Safety Thermometer (or equivalent)

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

There was a clinical scorecard displayed on the children's ward which contained key performance information such as staff compliance with completion of risk assessments. Results from quarter two of 2019 were displayed on the ward during our inspection, which showed staff had met 100% compliance for completion of consent forms, pre-assessment, environmental risk assessment, inpatient and outpatient risk assessments, and pregnancy testing. Compliance with recording of paediatric early warning scores was 96% and recording of temperature control was 95%. Information on the number of infections was also

displayed. During the period July 2018 to June 2019, the hospital did not report any Methicillin-resistant Staphylococcus aureus (MRSA), MSSA, C.diff or E.coli infections.

Are services for children & young people effective?

We did not have enough evidence to rate effective. The children's surgery service treated only small numbers of patients, and insufficient outcome evidence was available. From July 2018 to June 2019, the service saw 144 children and young people for inpatient or day case treatment, and 3,551 children and young people as outpatients.

Evidence-based care and treatment

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

Staff were able to give examples of national evidence-based guidance they used in their everyday work, such as guidelines from the Royal College of Paediatrics and Child Health.

Staff told us updates to best practice were discussed during the paediatric committee meetings, where a multidisciplinary team agreed whether to adopt new methods. For example, the lead paediatric nurse told us they had recently discussed whether to implement a new pain scoring chart for children weighing under 50 kilograms.

For our detailed findings on policies, please see the Effective section in the Surgery report.

Nutrition and hydration

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

The hospital followed the standard pre-operation fasting guidelines and advised parents and older young people at the pre-admission assessment, that they should fast for a period of six hours for food and two hours for clear fluids before their procedure. We saw staff gave parents and young people leaflets explaining this at their pre-admission appointment, and staff told us they tried to emphasise this. One parent told us staff had made sure their child received optimal nutrition and hydration during their inpatient stay.

Staff monitored patients fasted within guidelines. We viewed the dashboard for the service, which showed in quarter three of 2019, 90% of children were fasted within guidelines, against a target of 65%.

Pain relief

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

Staff used a visual pain scoring tool to assess whether children and young people were in pain. This included pictures of faces and a numbered scale from one to ten, which would help children identify the level of pain they were feeling. For younger children, or for patients unable to communicate, staff used the Face, Legs, Activity, Cry, Consolability (FLACC) scale.

Patient outcomes

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

The lead nurse told us there was score card which measured and compared outcomes for children and young people across the corporate Spire group. The lead nurse told us this was used as a key metric to benchmark the effectiveness of care and treatment and was used to make improvements. For example, in quarter two of 2019, the service saw a reduction in the percentage of patients who had fasted within guidelines prior to surgery to 50%, against a target of 65%. To address this, the lead nurse discussed the issue with staff and encouraged them to re-emphasise the importance of fasting with parents, carers, and young people. As a result, the quarter three results improved to 90%.

The service also took place in national outcome monitoring for children and young people undergoing tonsillectomy through T14 indicator measurement. This consisted of

speaking to children and young people and scoring their symptoms before, two weeks after, and three months after treatment. This information was used to monitor the effectiveness of treatment, and reports were fed back directly to surgeons to use as part of their appraisals. We did not view or request the results of these audits.

There was a comprehensive hospital-wide audit schedule which covered a range of areas including compliance with record keeping and medicines.

All departments and services were required to give a verbal update at the hospital's monthly clinical audit, safety and effectiveness (CASE) meetings.

Competent staff

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

Staff were required to complete competencies online or face to face, depending on the task. This included safeguarding competencies. All staff we spoke to working in the service had completed relevant competencies for their role.

Staff told us they had good access to development, and their managers were supportive of them to go on external courses.

For our detailed findings on appraisals, please see the Effective section in the Surgery report.

Multidisciplinary working

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

Staff spoke of a good working relationship with regular paediatric consultants who attended the hospital to carry out surgeries or hold clinics. Staff described communication as good and fostered a non-hierarchical atmosphere.

Following our inspection, the hospital told us the paediatric lead Nurse had established an active multidisciplinary committee of link members of staff to engage all staff in the care of children and young people, including extending the range of people observing and participating in child safeguarding. This link team fed into the paediatric steering group to drive change and improvement of the service for children and young people and had recently produced a safeguarding resource folder for each department.

Patient records contained details of all the multi-disciplinary input in treatment which included the medical, nursing and anaesthetic teams and recovery staff input.

Seven-day services

Key services were not available seven days a week, due to low patient numbers. However, services were arranged to support timely care for children, young people and their families.

Outpatient paediatric clinics were held on most weekdays. Children could also have appointments with individual doctors with paediatric practising privileges on any day they worked at the hospital. There was a children's clinic until 12.30 on some Saturdays.

Operating lists were approximately one or two days a week at the time of our inspection.

If any child or young person needed to stay overnight on the ward, all key services such as diagnostic scans and pharmacy provision were available for the duration of their stay.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

We saw the service offered a variety of health promotion leaflets on the ward such as a children's guide to handwashing, and information on children's bladder and bowel problems. Staff told us they were confident to signpost children, their parents and carers to health promotion services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Good

Services for children & young people

We saw there was appropriate signed consent for children attending for elective surgery in all records we looked at. Staff were aware of and able to describe how consent issues changed as children became older and were more able to make their own choices. Staff told us they would refer to Gillick competency guidelines, and seek advice from the lead paediatric nurse, director of clinical services, or external safeguarding contacts if required.

Staff told us if patients were experiencing mental ill health they would liaise with Child and Adolescent Mental Health Services (CAMHS), based at a local NHS trust.

Are services for children & young people caring?

We did not rate caring because we only saw a small number of children using the service on inspection, and only spoke to one young person and two parents. We requested to speak to two other parents after our inspection, but they did not respond. From July 2018 to June 2019, the service saw 144 children and young people for inpatient or day case treatment, and 3,551 children and young people as outpatients.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, and respected their privacy and dignity.

Patients and their families told us they were "happy" with the service, and that staff were "kind and friendly", and "brilliant". A parent we spoke to told us they felt the consultant had engaged well with their child during outpatient appointments, and they were well prepared for what to expect. Another parent told us they "couldn't have asked for better staff" to care for their child. We saw staff knocked on ward room doors before entering, to preserve the dignity of children, young people and their families.

Emotional support

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

There were signs displayed around the children's ward encouraging children and young people to seek emotional support from staff.

For younger children, staff encouraged children to write down their worries and 'feed' them to a monster toy, to reassure them.

The hospital told us staff encouraged parents and carers to be present where suitable in the recovery area, after their child's surgery. Staff told us they supported parents and carers throughout their child's care and treatment.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

When children and young people attended the hospital for surgery, the paediatric recovery team saw the child beforehand to help to explain what would happen when they woke up from anaesthesia.

A parent and young person we spoke with told us they had plenty of time to ask questions during outpatient appointments, and staff explained care and treatment in a way they could understand. Parents told us they felt included and involved in plans for their child's care and treatment.

Are services for children & young people responsive?

Good

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

Service delivery to meet the needs of local people

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

Since our last inspection, the service had introduced a dedicated paediatric waiting room and a consultation room. There was also a dedicated paediatric recovery room for when patients came out of theatre. We saw these rooms were decorated in a child-friendly manner, and the rooms

in outpatients contained a selection of toys, books and other materials that could be used for distraction. This was good practice and an improvement upon our last inspection.

In areas where there were not dedicated paediatric facilities, such as the X ray department, the paediatric service provided activity packs for children.

There were facilities for parents and carers to stay overnight with their child on the ward.

In outpatients, young people aged 16 to 17, could choose to be seen under adult services if appropriate.

Meeting people's individual needs

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

Staff used a pre-assessment risk tool to identify any additional needs children and young people might have, such as learning disabilities. The lead nurse audited the completion of the pre-assessment tool. We saw information displayed on the paediatric quality and safety scorecard from quarter two 2019, showing that staff compliance with the tool was 100%.

Staff told us that if a child or young person had specific needs, such as mental ill health, staff held a multidisciplinary team meeting to discuss their care, in addition to liaising with the local Child and Adolescent Mental Health Services. Staff also told us they would plan appointments in partnership with the child or young person and their families, and make sure all staff were aware of and able to meet the child or young person's needs.

Translation services were also provided for children, young people and their families who could not speak English, either face to face or over the phone.

Patient's meals were prepared on site. We saw a menu for a range of age appropriate food. The catering service could also provide for dietary needs such as dairy or gluten free, and cultural or religious meals. A parent we spoke to confirmed their child had been able to choose what they wanted to eat from the menu.

Access and flow

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

The service held a dedicated paediatric theatre list.

If any child or young person did not attend their outpatient appointment or theatre booking, this was flagged up by staff to the lead paediatric nurse, who could then follow up with the child, young person, their parent or carer.

Parents we spoke with said they were happy with the time to assessment, diagnosis and treatment. Staff told us that there were no delays in accessing paediatric intervention once the patient was booked in. One parent told us "everything ran on time as it should have done". Outpatient staff told us there was very little wait for consultant appointments, usually within a week of referral. Parents we spoke with confirmed this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Staff could give examples of learning from complaints. For example, there had been an occasion where a child had been particularly upset by staff's approach to taking blood. As a result of this feedback, the service held a paediatric forum to gather the views of children, young people and their families. The service now offered a variety of distraction techniques and had paediatric-trained HCAs available to offer support during phlebotomy procedures.

We saw 'Please Talk to Us' leaflets were available around the hospital in leaflet holders, which set out the provider's complaints process.

If a child, young person or family member raised a complaint or concern, the paediatric lead nurse would see the patient to discuss their concerns and would then raise the complaint with the governance manager.

Leaders kept a hospital-wide log of complaints, so that investigations could be tracked, and learning shared with

staff in huddles and team meetings. In 2019, the hospital received three complaints about services for children and young people, which were responded to within the response target of 20 working days.

Are services for children & young people well-led?

Good

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

Leadership

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

The lead paediatric nurse was experienced in caring for children and young people, and held the qualifications and expertise necessary for the role.

Staff we spoke with were positive about the leadership of the service and the hospital. One staff member told us "we are fortunate to have managers who listen". Staff described their managers as supportive and gave them opportunities to develop.

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

Vision and strategy

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

Staff in the service for children and young people told us they could easily access the hospital vision and strategy. The lead paediatric nurse told us of plans to develop the service, such as launching a paediatric gastroenterology unit and increasing the provision of transitional care for 16 to 17 year olds.

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

Culture

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

Staff told us they were happy and enjoyed working in the service and at the hospital. Staff told us they always strived to provide the best possible care for children, young people and their families. We observed a co-operative, non-hierarchical atmosphere amongst staff.

Staff told us they could access opportunities for career development, such as through external courses and national training programmes. Staff told us they had been supported by their managers to take these up.

Staff told us they would feel comfortable to raise concerns to senior leaders, about the service or about individual clinicians, and some staff could give examples of where they had done so. All staff spoken with were aware of the hospital's whistleblowing policy. They told us that they would feel happy using this policy to raise concerns if necessary.

Governance

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

The lead paediatric nurse was accountable to the director of clinical services and submitted a monthly governance report to the senior management team. This included numbers of patients seen, any incidents, and safeguarding concerns.

The two paediatric nurses attended all governance committees including the infection control committee and resus committees, to ensure the paediatric service had a clear voice in all hospital-wide governance processes.

The service held a meeting every Friday to debrief from the week past and plan for the following week. This included all nursing and support staff involved in treating children

and young people. The lead nurse told us this was also an opportunity to discuss clinical governance and share any key messages, such as changes to policies and any learning from incidents.

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

Managing risks, issues and performance

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

Staff managed and maintained a risk register for the paediatric service. Staff were able to tell us what risks were recorded on the register and what actions were in place to mitigate the risk. We saw the risk register for the children and young people's service was available to all staff and was displayed on the ward quality board. The risks on the register were aligned to what staff told us they thought the risks were in the service.

Managing information

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

The service produced monthly activity reports which included service performance measures and these reports were monitored and discussed in staff meetings, medical advisory committee meetings, paediatric steering group meetings and hospital senior leadership meetings.

Performance dashboards were used for staff to discuss and monitor performance at monthly senior management team meetings.

We saw that patient records were stored securely. There were arrangements in place to ensure that data and notifications were submitted to stakeholders and regulatory agencies when required.

Engagement

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

The service held regular paediatric forums where children, young people and their families or carers were invited to attend to share their views on the service. The hospital told us where possible staff included children and their families who had previously had a poor experience, and feedback had been given that being part of the forum had changed their perception of the hospital. A play specialist ensured children could participate fully in the forum. We saw an example of a recent paediatric forum where children were taken on a tour around the hospital, including theatres and the X ray department, and could dress up in surgical scrubs. Staff told us of changes they had made to the service in response to feedback gathered at paediatric forums, such as changes to the food menu.

Patients were encouraged to complete a patient satisfaction survey after their discharge from the hospital, or the end of their treatment. The results from surveys were analysed by an independent third party and communicated back to the hospital on a monthly basis for learning and action. Results showed 100% of patients would recommend Spire St Anthony's Hospital to their family and friends following their treatment (based on children and young people patient satisfaction data from October 2019).

Staff told us they had opportunities during weekly team meetings to make suggestions for the improvement of services. There were also weekly hospital-wide safety huddles, as well as engagement opportunities run to acknowledge events such as Antibiotic Awareness Week and National Stress Awareness Day.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The executive team were responsive to requests and suggestions for improvement. Staff told us they felt leaders had invested in the service through the improvements to the environments used in the service, to make it more suitable and welcoming for children and young people.

All staff were focussed on improving the quality of care that they were providing. For example, staff working in the service had set up the recent paediatric forum and led on ensuring the feedback received was implemented.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

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

Mandatory training

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

Staff accessed their mandatory training by a mixture of e-learning and practical sessions and received mandatory training in a variety of topics.

There was a mandatory training policy that detailed which training staff were required to attend. The training included resuscitation, safeguarding, information governance, conflict resolution, infection control, basic life support, fire safety, manual handling and duty of candour. The training records showed attendance was monitored, non-attendance was flagged, and managers were required to take action to ensure that the staff members attended all mandatory training.

Mandatory training completion was linked to staff annual appraisal system; failure to complete mandatory training would be flagged up during yearly appraisal meetings.

Mandatory training rates in outpatients were 98% for all the mandatory training module provided at the hospital. The hospital target was 95%.

We were told medical staff with practising privileges at the hospital completed mandatory training at the hospital they spent most of their time at. For example, those working mainly at an NHS trust would complete this training at their respective trust and were required to submit copies of their training record to the hospital management team.

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Safeguarding policies and procedures were in place even though it had passed its review date. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.

Staff described how they had dealt with safeguarding incidents and how a recent referral in radiotherapy had been initiated to social care.

The service target for completion of safeguarding training was 95%. Hospital data showed that for outpatients staff the compliance rate for safeguarding level 2 training was 96**%**.

There was a chaperone policy and we saw posters throughout the outpatient clinic advising patients how to access a chaperone should they wish to do so.

Cleanliness, infection control and hygiene

The service controlled infection risks well. Staff kept, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.

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

Personal protective equipment such as gloves and aprons were available, and consumable items were checked and found to be within their expiry dates.

We saw appropriate personal protective equipment (PPE) in all of the clinical areas and staff were noted to be using them appropriately.

There were housekeeping staff responsible for cleaning all areas and we found all areas were maintained to a good standard of cleanliness. Patients and relatives told us they were satisfied with the level of cleanliness in the department. Areas we visited were tidy, visibly clean, and uncluttered.

Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions.

Clinical staff followed the hospital infection prevention and control policy, they were bare below the elbow and used hand sanitisers appropriately. We saw staff adhering to good hand hygiene policy in all areas visited. There were infection prevention and control policies and procedures that were readily available to staff, however these were past their review dates.

Environment and equipment

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

The outpatients department was well designed and maintained. Patient waiting areas were clean with sufficient seating for patients and relatives. All clinical areas seen in the outpatients' department were visibly clean and tidy. The hospital had undergone a patient led assessment of the care environment audit (PLACE).

Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired, and we saw evidence of quality assurance tests for equipment used at the outpatient department.

Resuscitation equipment stored on the resuscitation trolley was readily available and easily accessible. The hospital had a system to ensure it was checked regularly, fully stocked, and ready for use. Some items on the resuscitation trolley were checked daily and others monthly. We saw the resuscitation trolley check list for both daily and monthly checks for the period of five months, was completed and signed by staff completing the checks.

Hospital staff carried out regular safety checks of specialist equipment used in the outpatient's department. This included checks of the patient observation equipment and emergency equipment

Portable appliance testing (PAT) for equipment was in use across the outpatient's department and the equipment we reviewed had stickers that indicated testing had been completed and was in date.

All equipment had asset numbers affixed to them and dates that highlighted when they had been serviced and when they were next due for servicing. All the equipment we saw was in date for servicing and calibration.

Fire exits were clearly signposted and visible in appropriate places throughout the department.

Consulting and treatment rooms were equipped with vital signs monitoring devices which were used to carry out patient observations, including machines used for performing electrocardiograms (ECG).

Assessing and responding to patient risk

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

Staff completed patient observations, such as; blood pressure readings, oxygen saturation readings and patient temperatures to assess and monitor patient's health. This is part of the pre assessment for patients undergoing surgery at the hospital.

Staff used recognised tools to complete risk screening and assessments for each patient on arrival and updated them when necessary. For example, all patients who attended outpatients for pre-admission assessments

were asked whether they had any history of falls, high blood pressure and diabetes. If a patient was identified as being at risk of the above, a record of these risks was recorded in the medical records.

The nursing staff that we spoke with were able to articulate what to do in the event of an emergency, such as due to a patient's health deteriorating and were able to highlight where the emergency equipment was and how they would summon assistance.

Emergency resuscitation equipment was available, and all clinical staff had undertaken basic or intermediate life support training depending on where they work within the service. The resident medical officers (RMO) had completed both adult and paediatric advanced life support training.

In the event of a patient becoming acutely unwell, the resuscitation team which included the critical care outreach team and the RMO would be called. If the patient was found to be acutely unwell, then a 999 ambulance would be called to transfer the patient to acute NHS hospital for further treatment if their needs could not be met at the hospital. This was a rare occurrence due to the onsite critical care department, and in 2019 only two patients were transferred from the OPD to an NHS Trust for further treatment.

Nurse staffing

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

There was a total of 15 nursing staff in the outpatients' department, supported by a number of allied health professionals. In addition, there was a pool of bank nurses and healthcare assistants who had been recruited to support the nursing team. Staff records showed that appropriate checks were made that ensured they were safe to work with patients. This included requesting and reviewing criminal history checks and references from previous employers.

We were told that staffing was calculated to meet OPD workload and if it increased, then staffing levels would be increased accordingly. We were told there were no nursing vacancies within the outpatients department at the time of our inspection.

Medical staffing

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

The outpatients (OPD) service was consultant led. Consultants who held clinics were responsible for the care of their patients. Administrators and booking staff organised clinic lists around consultants' availability.

There were approximately 300 consultants with practising privileges providing services at the hospital, however not all of them regularly saw patients in outpatient clinics. This showed that the hospital had a pool of consultants to call upon when required.

There was a process in place for granting practising privileges via the medical advisory committee (MAC). The MAC was responsible for consultant advice and support and ratification of new consultants. For a consultant to maintain their practising privileges at the hospital, there were minimum data requirements with which a consultant must comply. These included registration with the General Medical Council (GMC), evidence of insurance, and a current performance appraisal.

Senior nursing staff told us that clinics were rarely cancelled, but if consultants were on annual leave they would ask a colleague to see their patients. This was confirmed by long term patients we spoke with.

The hospital ensured that there was at least one resident medical officer (RMO) to provide 24 hours, seven days per week medical cover in the whole hospital.

OPD staff were able to request the attendance of the RMO to attend patients in the outpatient's department if required.

Records

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

Good

Outpatients

Information provided prior to our inspection visit demonstrated, and we were told that over the last three months no patient had been seen in outpatients without their medical records. There was a dedicated medical records team with responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured that medical records were readily accessible for each episode of patient care.

Medical records were prepared in advance of outpatient clinics using the outpatient clinic lists. Records were collated by the medical records team for the appropriate clinical department prior to the patient appointment time. Checking processes took place to ensure that patient notes were confirmed as available and complete. Patient records were requested by the administrator before the appointment, to allow sufficient time to identify any gaps or issues.

Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images. Some medical notes were not held electronically. Consultants holding electronic private patient records were required to register as Data Controllers with the Information Commissioner's Office.

Referrals were usually initiated by a phone call from a patients' GP or by the patient self-referring. A letter of confirmation of initial appointment as well as information on costs, a map and general hospital information was sent out. Patients were told to bring the letter with them to the appointment or to ask that the GP faxed a referral letter, to ensure that it was held on the record.

We were told that the outpatient department ensured that test results were appropriately filed in patient records prior to attendance and that medical record tracking and tracing was available.

We reviewed five sets of notes and we found that the records were accurate, complete, legible, up-to-date and signed by all staff who made entry in the record.

Patient records were stored securely, and access was limited to authorised users only.

Medicines

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

Staff we spoke with were aware of medicine management policies and the systems in place to monitor stock control and report medication errors.

Medicines, including control drugs audits were undertaken by the pharmacist. These showed minimal drug errors and staff were trained in medicines administration. Controlled drugs audits were shared with the hospital accountable officer who reported to the Local Intelligence Network. This is an NHS initiative to share information and intelligence about the misuse and unsafe use of controlled drugs.

All medicines in outpatients were found to be in date and stored securely in locked cupboards as appropriate, and in line with legislation. The keys were kept by the senior nurse in charge for the day.

Staff understood and demonstrated how to report medicines safety incidents. This was then escalated and fed back for learning through regular meetings from the pharmacy team through the hospital effectiveness committee.

Staff had access to British National Formulary (BNF) publications as well as all policies and information relating to medicines management available on the hospital online system.

Incidents

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

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The service used an electronic incident recording system that allowed the service to capture incidents, track any actions taken in response and provide relevant staff with feedback. We were told that a supplementary report was

also presented at clinical governance meetings which further broke down incidents by teams such as outpatients. All staff were trained in its use, but we were told the lead nurse usually took responsibility to report this in the electronic system.

All staff had an individual log in to the reporting system and it was everyone's responsibility to report incidents. The system also reported on risks and anyone could add a risk, but staff were encouraged to discuss risks, so they can be correctly categorised.

All staff that we spoke with told us that they were made aware of incidents and subsequent learning and actions via email, as well as on noticeboards and staff meetings. We saw minutes of meetings where it had been documented that incidents had been discussed along with learning and actions.

We were told that the hospital actively encouraged incidents to be reported and that the number of reported incidences had increased as staff confidence in a culture of openness had improved. We were told that all incidents were investigated, with Root Cause Analysis (RCA) being completed as appropriate.

Outpatients incidents were discussed at the monthly team meetings, minutes and action plans from the incidents were shared with staff for learning. Minutes of these were produced and people who had not attended had to sign a record to show that they had read these.

The OPD manager attended a quarterly hospital clinical governance meeting where incidents were discussed, and learning could be shared across departments.

From April 2018 to March 2019, the OPD did not report any incidents classified as a never event. Never events are serious patient safety incidents which should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff we spoke with understood the Duty of candour regulation. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff we spoke with said there was a culture of openness in the service. They kept patients informed when clinics were running late and apologised for any delays or errors. The staff we spoke with told us their manager was "pro-active and visible".

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had not needed to do this, but staff we spoke with were aware of the term and the principle behind the regulation and the need to be open and honest with patients where incidents occurred.

Managers were aware of the requirements for reporting incidents and submitting notification to the CQC. At the time of inspection, the registered manager had not been required to submit any notifications as he was new in post, however the director of clinical services had experience in submitting such notifications.

Safety Thermometer

The service used safety monitoring to improve the service.

The patient safety thermometer is a national tool to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering 'harm free' care. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide. The safety thermometer is used to identify areas of the service that needed attention. It also gives the snapshot of the hospital performance.

The service participated in the safety thermometer and could demonstrate harm free care through its involvement. The provider also had a number of clinical scorecards and service specific dashboards to demonstrate safety outcomes and the outpatient departments displayed safety crosses for daily monitoring of safety systems and outcomes.

Are outpatients services effective?

We did not rate effective: We found the following areas of good practice:

Good

Outpatients

Evidence-based care and treatment

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

Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE). The service had a suite of local policies which were relevant and up to date, however at provider level there were a number of national policies which were past their planned review date, five of which were scheduled for review in 2017. A small proportion of policies were past their planned review date at the time of inspection, however, once identified the provider took immediate action to review the policies, and we received confirmation that these were all either reissued or withdrawn during our inspection window, and that the administration processes had been reviewed to improve oversight, through the formation of a new Policy Assurance Group monthly committee meetings.

NICE guidelines were discussed at governance meetings and the medical advisory committee and the disseminated to the various departmental leads, who implemented them if relevant to their service.

Safety alerts were received by the OPD manager and all relevant alerts were cascaded to staff via email, displayed in the staff office and discussed at team meetings.

Nutrition and hydration

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

Staff told us that patients were not generally offered food during their OPD attendance and consultation; however, the OPD waiting area had a drinks machine and water for patients and their carers/relatives attending the department. Where patients needed to be in OPD for longer periods due to the type of testing they were undergoing, staff would offer refreshments to ensure the patient was always comfortable.

Pain relief

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

The service did not generally provide pain relief to patients who attended outpatients' consultations, but during a minor procedure it could be prescribed and administered by the nursing staff if needed. Staff informed us they made sure patients were comfortable throughout their appointment.

For patients who had a minor procedure in the department, there were patient information leaflets which explained what to do when in pain or if post-procedure pain was experienced.

Patient outcomes

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

The outpatient services conducted regular audits as per the hospital audit schedule. This included infection prevention and control audits, environment audits, medical records audits and other quality management audits. There were few relevant national audits in which the service could participate; however, they do submit data to Private Healthcare Information Network (PHIN) in accordance with the Private Healthcare Market Investigation Order 2014 regulated by the Competition Markets Authority (CMA) and had recently completed the PLACE audit which the outpatient service had contributed to. Learning from clinical audits were fed back to staff via team meetings. We saw evidence that learnings from regular audits were discussed at governance and team meetings.

We were told that outcomes were monitored following discharge through follow up appointments and physiotherapy sessions. All patients received a follow up telephone call soon after surgery to review their progress and check on their wellbeing.

The service provided evidence of benchmarking against similar organisations on monitoring patient outcomes. Director of clinical services had plans to align the service with a local independent hospital to share best practice and compare outcomes.

The service monitored patient outcomes and experience through their monthly clinic audits and patient satisfaction surveys.

There was a good range of local audits within the outpatient department to monitor and report on patient outcomes. Audits included record keeping, patient satisfaction and consent and infection prevention. The audit report showed the department performed better than the hospital target. The service used the audit outcome to improve services further. The service conducted local audits on several topics such as cleaning, completion and availability of patient records, regularity of observations, and the environment. The patient records audit and the controlled drugs audit showed a compliance score of 94%. The environmental audit showed a score of 95%. The records audits included assessments of observation, recording accuracy, pain recording, venous thromboembolism risk assessments, and consultant documentation. Most aspects of the audit achieved a compliance score of 95% and above, which met the hospital target. Some of the local audits, for example infection prevention, were performed as a peer review with departments cross auditing to ensure independence in results.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and there were processes in place to assess staff competencies and suitability for their role.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Effective recruitment systems were in place to ensure staff were suitably skilled to work in their roles.

The hospital had an induction policy which outlined that new starters in the department were supported to complete their induction program, and also being familiar with their working environment, only using equipment that they were competent to use and identifying their learning needs. All new starters also had an appointment with the hospital's Clinical Educator for clinical assessments including clinical competency sign off, medication assessment and aseptic non touch technique (ANTT).

All new starters had a personal development plan agreed with their line manager. All new starters were assigned a buddy, which was an experienced member of staff who they could approach for advice, assistance and support. Staff that we spoke with during our inspection confirmed that this was what happened at the start of their employment in the hospital. New members of staff told us they mostly worked the same shifts as their mentors and buddies if rota and skill mix permitted.

Nursing and allied health professional staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant for their role. This included completing competency framework for areas of their development and they were also supported to undertake specialist courses.

The outpatient's manager appraised staff's work performance and provided additional support to staff if needed. All staff we spoke with told us that they had received an appraisal within the last 12 months. The service appraisal period ran from January to December each year. In the January to December reporting period, 100% of medical staff, nursing staff and healthcare assistants had completed their appraisals.

Managers made sure staff attended team meetings or had access to full minutes of the meetings when they could not attend. This ensured staff were kept updated about changes in practice.

Multidisciplinary working

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

We observed close working relations between clinical and non-clinical staff within the outpatient department. Staff told us that everyone worked together well as a team.

Good

Outpatients

We observed nursing staff working in partnership with consultants, healthcare assistants, administration staff, and physiotherapists. Staff were seen to be supportive of each other to provide the best care and experience for the patient.

We saw evidence of communication to GPs informing them of treatments provided, follow up appointments and medicines for patients to take on discharge.

Seven-day services

The outpatient department did not provide seven-day services.

The outpatient service was provided Monday to Friday 8am to 9pm. They also provided Saturday services from 8am to 2pm. There were no Sunday service provided at the outpatient department.

Health promotion

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

Health promotion leaflets were displayed in relevant areas throughout the OPD, these included healthy eating and advice on smoking cessation.

Consent and Mental Capacity Act

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

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. At the time of our inspection, the OPD manager and clinical staff had completed all required mandatory training which included training on consent and the Mental Capacity Act.

The lead for outpatients had received training on mental capacity but told us they had not seen any patients with mental capacity issues in their service. However, should they have concerns about a patient's mental health or capacity to consent verbally to investigations, they would discuss this with the consultant.

Written consent was obtained from patients by the consultant and then re-checked prior to any treatment. We were unable to observe this process as there were no patients in the department at the time of our inspection who needed to be consented for surgery, however the records we checked demonstrated that patients were consented appropriately, and consent documentation completed and signed fully by all parties concerned.

Consent for minor procedures undertaken in outpatients was completed on the day by the consultant. We saw a blank copy of a checklist that was completed for each procedure which included a check box to show whether verbal or written consent had been obtained, which had to be signed by both the consultant and the patient.

Are outpatients services caring?

Good

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

Compassionate care

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

All patients we spoke with reported that they had received compassionate care and were treated with kindness, dignity and respect at the OPD. We saw patients had their preferred names noted on the front of their care records. We observed staff interacting with patients in a dignified and respectful way.

We spoke with 12 patients in the outpatient waiting area. All patients spoke positively about their experience and told us that staff had respected their privacy and dignity. We observed staff interacting with patients and their families in a compassionate and respectful manner. This included staff visiting the waiting area to check on the status of patients waiting for appointments.

Within the outpatient department there were individual consulting rooms. The rooms displayed 'free/engaged' signs on the door. This provided privacy and dignity to patients during their consultation. In the outpatient department, the reception desk was in an open environment that did not offer much privacy. Staff said they would use a private room if they needed to have confidential discussions with patients.

Good

Outpatients

Patients we spoke with were very positive about the services and told us they received good treatment and were happy to attend the hospital again for further appointments.

Emotional support

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

We observed caring interactions between staff, patients and relatives. Staff reassured patients and relatives about the care and treatment they received. The majority of people we spoke with said they felt they received emotional support from staff, or this would be available if needed.

The service had a policy in place for the use of staff trained as chaperones. Information about requesting a chaperone was displayed in the waiting areas and provided guidance on their availability to patients. Any patient who was undergoing an intimate examination had a chaperone when needed.

Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the hospital.

Staff told us a quiet room was available for breaking bad news if required. The provider told us the majority of staff had completed breaking bad news training. One staff member told us although they had not been given specific training on breaking bad news, they knew they could always ask for advice and get support from other staff members.

Understanding and involvement of patients and those close to them

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

Patients felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further information

We observed and were told by the patients that they were given time to ask questions about their care and treatment. We observed staff introduced themselves and communicated well to ensure that patients and their relatives/friends fully understood about care.

Staff spoke with patients sensitively and appropriately dependent on their individual needs and wishes. Patients we spoke with following their consultation told us that they felt they had been fully informed of upcoming treatments, test results and their next appointment.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

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

Patients booked in at reception on arrival. There was a range of free hot and cold beverages available. Waiting areas provided drinking water, tea and coffee free of charge. There was also a restaurant where patients and their relative could buy food, cold drinks and snacks. We saw there was a range of information leaflets available to patients in the waiting area on a wide variety of topics. There were also magazines and newspapers at the reception which patients could read whilst waiting for their appointments.

Some consultants called reception who then notified the patient. Others came to reception and called their own patients. Reception staff told us this was done on individual consultant preference.

Patient information was on display at reception. It included informing patients that children could not be left alone in the waiting area. Leaflets were available at reception on 'how well did we do?', which included space for patients to say how likely they were to recommend the service and to make comments. Additional information on patient conditions were available in the waiting area.

Good

Outpatients

The facilities and premises were appropriate for the services being delivered. The waiting areas were furnished to a high standard and provided enough comfortable seating. The hospital had its own dedicated car park for which there was no charge. Patients confirmed they could always park easily.

Outpatients clinics ran between 8am and 9pm Monday to Friday. This allowed patients who worked office hours during the week to attend at a time that suited them, and we spoke to patients who told us they were able to get appointment times that suited their needs.

Staff monitored and acted to minimise missed appointments. Staff ensured that patients who did not attend appointments were contacted and appointments were rearranged, as appropriate.

Meeting people's individual needs

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

There were sufficient chairs in the waiting areas to suit individual needs. The reception area was equipped with satellite television. In addition, patients had access to tea and coffee making facilities as well as a water dispenser. Patients and their relatives had access to the restaurant at the hospital.

The environment was appropriate and patient-centred with comfortable seating, refreshments and suitable toilets. The hospital could be accessed by patients that had a physical disability. Wheelchairs were available at the entrance to the outpatients department.

Staff could arrange for face to face interpreting for patients whose first language was not English. A range of literature and health education leaflets were available and given to each patient. Some of these were available in other languages and could also be translated if required.

Access and flow

People could access the service in a way and at a time that suited them. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were better than national standards.

Patients could book an appointment by submitting a form online or by making a telephone call. Patients were offered the most convenient appointment with the preferred consultant. This could also be a same day or next day appointment.

Patients we spoke with told us that they had not had to wait long to get their appointment and when they arrived at their appointment they were seen promptly.

The OPD did not audit referral to treatment times and there were no waiting times to access the service. Patient could be seen within 48 hours of been referred and when they made their own appointment. There were no clinic cancellations reported in the last one year.

Patients told us they were mainly seen on time or within 10 minutes of their appointment time. However, complaints to the department included waiting times which was reported by one patient we spoke with during the inspection and another patient told us that they were not happy at the length of time they had been waiting. The service treated 54,928 in the outpatient department in the 12 months preceding our inspection and had received 6 formal complaints relating to waiting times, a rate of 0.01%.

Staff told us that if clinics were running over 15 minutes late, they would speak to the patients individually and offer refreshments or the opportunity to reschedule the appointment.

We were told that clinics were on occasion delayed due to consultants arriving late and that this was logged as an incident if it was delayed by over 30 minutes. However, this rarely happens at the hospital.

A proactive and holistic approach to pre-operation assessments meant discharge planning began in the outpatient's department before a patient had been admitted for surgery. This proactive approach ensured patients had the right support and equipment in place to support and facilitate safe discharge, which meant the risk of delayed surgical discharges was reduced.

Good

Outpatients

During our inspection, we noted that patients could have their bloods taken on the same day as the appointment and staff were trained to do this. This meant patients did not have to return for a separate appointment at the clinic. Patients said they were seen in a timely manner and they did not encounter lengthy waits in clinic.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

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

Staff informed us they tried to resolve complaints informally. However, if patients wanted to raise it further, they escalated complaints to the patient experience manager.

Information leaflets were available in all OPD reception areas which provided details about the complaints process. The complaints process is hospital wide, there was no separate complaint process for OPD. The leaflets also had details of the independent sector complaints adjudication service. This information was also available on the hospitals website.

There was a system for capturing and learning from complaints. Complaints were discussed at management meetings and we looked at the minutes of these meetings to confirm this. Once a complaint had been concluded a complaint summary and action plan was circulated to the relevant managers to cascade to staff for shared learning.

Are outpatients services well-led?

Good

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

Leadership

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

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The outpatients services manager was highly visible and worked alongside staff to address any immediate issues that challenged the service, such as demand and capacity. To achieve this the service held a daily stand-up huddle to trouble shoot any issues and problem-solve for that day. Staff told us they liked the morning huddle, and they felt it ensured safety issues were identified and risks reduced.

We heard that the hospital director, senior management team and the matron were very visible, speaking with the nursing staff and ward managers when possible. We were told by all staff that senior staff members were seen almost every day.

Vision and strategy

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

The vision of the service was aligned to the formal vision and strategy of the hospital. The service lead told us that their vision was to deliver a high quality, flexible service to their patients. They explained that they proactively monitor demand and capacity and had flexibility within the work force to manage this demand. The vision for OPD services was aligned to the hospital's main vision.

See the surgery report for the vision and strategy of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff said they really enjoyed working at the service and told us they felt valued by their local leader.

Most staff we spoke with told us the service was a positive place to work and that managers promoted an open culture. Staff felt supported and respected and told us they were encouraged to raise concerns and felt listened to and valued.

The service was very patient focused. Patients were given adequate time for their appointment and staff were friendly and supportive to patients and provided them with information about their test results and next appointments.

The outpatient services manager provided input to the staff appraisals and offered and encouraged staff to take additional training opportunities to enhance their skills and career development.

All staff spoken with were aware of the hospital's whistleblowing policy. They told us that they would feel happy using this policy to raise concerns if necessary.

Governance

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

The service had effective governance processes to support the delivery of a good quality service. The Hospital clinical governance committee fed up to the senior leadership team, the senior leadership team then fed up to the board. Governance arrangements within the service included an oversight of patient incidents, documentation errors, lessons learnt, clinical audits and patient experience.

All staff we spoke with understood the management structure at the hospital and knew who they were accountable to.

Monthly staff meetings were held where workload and staffing issues were discussed, including recruitment update and the use of bank and agency staff.

The outpatient service manager and other clinical leads held a monthly meeting. Quality and governance were a regular agenda item. We reviewed three sets of minutes and saw that items discussed included audit results, patient satisfaction, policy and procedure updates, incidents and complaints.

Managing risks, issues and performance

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

The service had systems to identify risks, plan to eliminate or reduce them, the system ensured all risks were formally identified and recorded appropriately. The OPD had a local risk register which all staff contributed to, the local risk register was fed into the hospital wide risk register. We were told the local risk register had clinical, operational, environmental and moving and handling risks identified and each risk was identified as being reviewed or approved.

There was a risk register for the hospital which all departments contributed to, the register categorised the issues identified with a clear risk rating system of low, moderate or severe with a green, amber and red coloured ratings. The hospital identified dates to review the issues before they were closed. Director of clinical services had oversight of the risk register and we saw that mitigation was in place for the risks and they had review dates for each of the issues.

We asked the outpatient service manager of their top risks and saw that these were identified on the risk register. The manager could verbally tell us what action was taken against each risk, this demonstrated that the service manager had oversight of the service risk as recorded on the register. We saw the risk register which was available to all staff. Th e risk register contained risks around staffing shortages, clinic delays and do not attend (DNA's). This was aligned with what staff told us and what we observed during the inspection. Staff were able to tell us of ongoing work to reduce and mitigate these risks.

The Medical Advisory Committee (MAC) was held bi-monthly. It was attended by a lead consultant from each speciality with practising privileges, the hospital director, director of clinical services and head of governance. Minutes demonstrated standing agenda

items covered clinical governance, practising privileges, finance and clinical specialty issues and these were circulated to all consultants. The conditions of practising privileges were monitored closely for compliance and consultants records maintained of appraisal, indemnity insurance and registration.

We reviewed senior management team (SMT) meeting minutes and noted discussion about quality and clinical governance, the risk register, strategic objectives and improvement plans, as well as action plans agreed for improvements.

We reviewed minutes for the governance committees, infection control groups and department team meetings, and noted good attendance at these meetings and key items such as the risk register, clinical audit outcomes, ongoing complaints, patient experience, incidents, documentation and infection control were discussed and actions agreed.

Managing information

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

The service produced monthly activity reports which includes service performance measures and these reports were monitored and discussed in staff meetings, MAC meeting and hospital senior leadership team (SLT) meetings.

Performance dashboards were used for staff to discuss and monitor performance at monthly senior management team meetings.

We saw that patient records were stored securely, there were arrangements in place to ensure that data and notifications were submitted to stakeholders and regulatory agencies when required.

See surgery report for further evidence on managing information at the service.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients were encouraged to complete a patient satisfaction survey after their outpatient consultation. There were collection boxes for patient satisfaction surveys throughout the outpatient areas for patients to drop their completed survey. The results from surveys were analysed by an independent third party and communicated back to the hospital on a monthly basis for learning and action.

Outpatients staff underwent reflective sessions where they reflected on opportunities to improve the outpatient department. As a result of these reflections, staff implemented a new initiative, whereby patients were encouraged to contact the reception desk if they had been waiting more than 20 minutes for their appointment.

Learning, continuous improvement and innovation

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

The executive team were responsive to requests and suggestions for improvement.

All staff were focussed on improving the quality of care that they were providing.

The physiotherapy service had recently started offering patients the use of an anti-gravity treadmill for rehabilitation. This was only available in a few locations across London and had been shown to be beneficial in speeding up recovery time for patients who have had a hip or knee replacement by increasing their confidence and reviewing their walking technique.

The hospital supported the enhanced recovery programme including pre-assessment of health, fluid management and early mobilisation. Physiotherapy was available several times a day to contribute towards enhanced recovery.

Outstanding practice and areas for improvement

Outstanding practice

The service had introduced the 'Think Drink' campaign to encourage patients to stay hydrated prior to undergoing surgery. It has been proven that patients who are more hydrated have better outcomes from surgery. The Think Drink campaign involves patients being given a bottle of water at their pre-assessment appointment, which has been labelled 'Think Drink'. Patients were encouraged to drink the water between when they last ate, and 2 hours before their operation.

The provider produced 48-hour flash reports as an opportunity to learn from events on a wider scale. These were used to highlight either complaints or incidents that had led to a change of practice. The 48-hour flash reports were shared throughout every hospital within the group and each hospital had to acknowledge that they had been read and distributed throughout the local service. The service had created a similar process to flag near misses or incidents internally. We saw these discussed at the daily huddle.

Areas for improvement

Action the provider SHOULD take to improve

Ensure that records are clear, up-to-date and easily available to all staff providing care.

Ensure that systems and processes are used to safely prescribe, administer, record and store medicines, including regular checking of fridge temperatures and controlled drugs.

Ensure that up to date policies and procedures are available to all staff.