Spire Little Aston Hospital

Quality Report

Little Aston Road
Little Aston
Sutton Coldfield
West Midlands
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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

Spire Little Aston Hospital is operated by Spire Healthcare Limited. The hospital has a 24 bedded surgical ward and a separate two bedded extended recovery unit, an eight bedded day case unit and a chemotherapy suite with four chairs and two private rooms. Facilities include one endoscopy theatre and three laminar flow operating theatres and X-ray, outpatient and diagnostic facilities.

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

We inspected this service using our comprehensive inspection methodology. We carried out the inspection from 11-12 June 2019

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

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

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

Services we rate

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

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

Summary of findings

However:

Outpatients:

- The audio consulting room in outpatients was very small and cramped. It would not easily accommodate a patient using a wheel chair safely together with one other person beside the consultant.
- The outpatient service did not have in place an audit programme of patient records to assure continued good quality of records and records management.
- Front line outpatient staff were not active in encouraging patients and visitors to cleanse their hands.
- The hospitals policy for its Cognitive Impairment Adult Framework was incomplete and did not include 'the outpatient phase' as indicated was intended by the contents page.
- There were insufficient patient toilets for outpatient services demand and some degree of privacy was compromised by their location.

Endoscopy:

- There was an inconsistent approach to decontamination and hand hygiene within the endoscopy unit.
- Two sharps boxes were not assembled correctly.

Chemotherapy Suite:

- Room 63 in the chemotherapy suite needed updating to be fully compliant with HBN 00/10- part A (flooring).

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

Heidi Smoult

Deputy Chief Inspector of Hospitals

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. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	Good	Out–patient activity accounted for the majority of the activity at the hospital, a very small proportion of this was for children and young people. There were also a range of diagnostic imaging services and a physiotherapy service. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

Contents

Good

Spire Little Aston

Services we looked at

Medical care (including older people's care); Surgery; Outpatients;

Summary of this inspection

Background to Spire Little Aston Hospital

Spire Little Aston Hospital is operated by Spire Healthcare Limited. It is a private hospital in Sutton Coldfield, West Midlands. The hospital primarily serves the communities of the West Midlands. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since it was registered in 2010.

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 and medicine. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

Information about Spire Little Aston Hospital

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Services in slimming clinics
- Surgical procedures
- Treatment of disease and disorder or injury

During the inspection, we visited the surgical ward, the chemotherapy suite, theatres, the endoscopy unit and outpatients. We spoke with 37 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 16 patients and one relative. We also received 52 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 21 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 three times, and the most recent inspection took place in July 2015 which found that the hospital/ service was meeting all standards of quality and safety it was inspected against.

Activity (March 2018 to February 2019)

- In the reporting period March 2018 to February 2019, there were 7,738 inpatient and day case episodes of care recorded at the hospital; the majority of these patients were privately funded.
- 12% of all NHS-funded patients and 20% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 43,995 outpatient total attendances in the reporting period; the majority of these were privately funded.

327 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Three regular resident medical officers (RMO) worked on a one week on, one week off rota. The hospital employed 58 registered nurses FTE (Full time equivalent), 22 health care assistants and 22 operating department practitioners, 187 other staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Summary of this inspection

Track record on safety

- No never events
- Clinical incidents 658 no harm, 89 low harm, 54 moderate harm, 1 severe harm, 0 death
- No serious injuries

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

Complaints: 81

Services accredited by a national body:

- Sterile Services -SGS accredited
- Macmillan Quality Cancer Environment Mark
- BUPA Imaging Accreditation – MRI/CT
- BUPA Cancer Accreditation – Breast
- BUPA Cancer Accreditation- Bowel
- BUPA Cancer Accreditation- Prostate
- BUPA Cataract Full Pathway

Services provided at the hospital under service level agreement:

- Blood transfusion services
- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Microbiology 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 stayed the same. We rated it as **Good** because:

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse, and they knew how to apply it.
- **Staff 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 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, and gave bank and agency staff a full induction.
- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- **The service mainly 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. However, the endoscopy service needs to ensure a consistent approach to decontamination processes and hand hygiene.

However,

- Two sharps boxes were not assembled correctly within the endoscopy unit.
- Room 63 in the chemotherapy suite needed updating to be fully in line with latest HBN 00/10- part A (flooring) guidance.
- The audio consulting room in outpatients was very small and cramped. It would not easily accommodate a patient using a wheel chair safely together with one other person beside the consultant.
- The outpatient service did not have in place an audit programme of patient records to assure continued good quality of records and records management.
- Front line outpatient staff were not active in encouraging patients and visitors to cleanse their hands.

Summary of this inspection

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 protected the rights of patient's subject to the Mental Health Act 1983.
- **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.
- **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.
- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.

However:

- The hospitals policy for its Cognitive Impairment Adult Framework was incomplete and did not include 'the outpatient phase' as indicated was intended by the contents page.

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 and involved 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 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.

Summary of this inspection

- **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.
- **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.

However**:**

- There were insufficient numbers of patient toilets for outpatient services compared with demand and some degree of privacy was compromised by their location.

Are services well-led?

Good

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

- **Leaders had the integrity, skills and abilities to run the service.** They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.** The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- **Staff felt respected, supported and valued.** They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- **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.

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
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

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

Good

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

Mandatory training

- Please see surgery report for detailed findings.

Safeguarding

- Staff understood their roles and responsibilities in relation to safeguarding. Please see surgery report for detailed findings.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well in most cases.** Staff mostly used equipment and control measures to protect patients, themselves and others from infection. However, one nurse did not fully follow the decontamination pathway in endoscopy. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- All areas inspected were visibly clean and clear of clutter. We saw staff cleaning equipment between uses and items not in use were labelled that they had been cleaned.
- Staff were observed washing their hands and using hand sanitisers and personal protective equipment was available and used as necessary. We saw one instance in the endoscopy unit where staff did not wash their hands after attending a patient, before cleaning a bed.
- Hand hygiene checks conducted in the endoscopy unit over the previous three months showed that staff were cleaning their hands appropriately. There were no reported incidents of infection in the past three months.
- Staff were arms bare below the elbow when completing tasks within the clinical area.
- There were cleaning schedules displayed and staff used checklists to ensure that tasks were completed in line with recommendations. We saw that these were updated and signed when tasks were completed.
- Waste was managed appropriately with items segregated according to their type for example, domestic and waste and arrangements for cytotoxic waste disposal.
- We saw that sharp boxes were assembled correctly and temporarily closed when not in use in the oncology unit. However, two sharp boxes were found to be incorrectly assembled with their lids not snapped down, in the endoscopy unit. We made these sharp boxes safe and informed the matron. The matron produced a poster informing staff to assemble sharp boxes correctly.
- We saw the tracking system used for the endoscopes following decontamination were vacuum sealed. All scopes were leak tested prior to decontamination. This process was fully compliant with HTM 01/06 The Decontamination of Flexible Endoscopes Parts A to E.
- We saw that one nurse did not fully follow the decontamination pathway as they used the interlinking door between the endoscopy procedure room and the decontamination room, to transport equipment, rather than leaving the procedure room before re-entering the

decontamination room. The nurse acknowledged this on discussion with us. There were plans to build a hatch between the two rooms to improve the decontamination process.

Environment and equipment

- **The design, use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, one of the chemotherapy rooms was not in line with latest HBN 00/10- part A flooring guidelines. Hand basins in endoscopy were not in line with latest HBN 00/09 Infection Control in the Built Environment guidelines.**
- The flooring within the main chemotherapy suite and endoscopy unit was in line with HBN 00/10- part A (flooring) guidelines. However, in room 63 (one of the chemotherapy treatment rooms) the flooring was not in line with guidelines. There was no coved skirting and the edging sealant was not intact with gaps to the right of the sink. This meant that it could not be effectively cleaned.
- All patient curtains were disposable and were found to be in date.
- Equipment had been electrical safety tested and was in date.
- The hand wash basins in the endoscopy recovery unit were not in line with HBN 00/09 Infection Control in the Built Environment guidelines. There were plans in place to replace the sinks within the next few months. Architecture plans to build a purpose-built endoscopy unit were also in place within the five-year plan.
- We saw that resuscitation and emergency equipment was in place and checked daily by staff with records maintained.

Assessing and responding to patient risk

- Procedures for monitoring the deteriorating patient and transfer arrangements to an acute NHS hospital were the same as within surgery. Please see surgical report for detailed findings.

Nurse staffing

- The nursing staffing for the surgical ward and theatres were the same staff who looked after medical patients in these areas. Please see surgical report for detailed findings.
- The chemotherapy suite had enough dedicated staff to meet the needs of patients within this area.

Medical staffing

- Please see surgical report for detailed findings.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used electronic systems for both patient records and prescribing. We saw that records contained risk assessments, test results, consent forms, treatment plans and multidisciplinary team records.
- The electronic records were accessible to all staff including consultants, nurses and pharmacists.
- We reviewed seven records, and most were complete and accurate with relevant signatures. One treatment plan did not contain a consultant signature. The chemotherapy lead nurse investigated this and found that the paper medical records had been signed but the most recent copy had not been scanned onto the system. They developed an action plan to inform staff of this issue.

Medicines

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

- Patient diagnosis, staging of cancer, treatment protocols and allergies were clearly documented in the electronic prescribing document.
- All patient chemotherapy treatment regimes were discussed at an NHS multidisciplinary team meeting including consultants, radiologists and nurses, prior to treatment commencing.
- Spire's national team reviewed all chemotherapy regimens.
- Chemotherapy protocols were attached to each patient's electronic prescription.

Good

Medical care (including older people's care)

- All chemotherapy prescriptions were checked by a trained cancer pharmacist, as per BOPA (British Oncology Pharmacy Association) standards.
- Patients receiving chemotherapy had completed consent forms in the records we reviewed.
- Patients were given written and verbal information about how to take medicines at home, including anti-cancer treatments and supportive therapies. The pharmacist discussed medications with patients at the pre-treatment consultation.
- Pharmacists checked all chemotherapy, which was double bagged, prior to bringing it to the unit. Nursing staff then rechecked it prior to administration.
- GPs were informed of changes in medication during treatment, by letter and also as part of the discharge summary.

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 told us, and we saw from minutes of meetings that lessons learned from incidents were discussed at monthly team meetings.
- Between November 2018 and April 2019, seven pathology samples did not reach the lab in time for analysing. An action plan was developed to ensure that samples were taken to the lab as soon as taken. The last nurse on duty was to check the blood box to ensure no samples were left in the unit overnight.
- Please see surgical report for detailed findings.

Safety Thermometer (or equivalent)

- Please see surgical report for detailed findings.

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

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.** Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- The service followed National Institute for Health and Care Excellence (NICE) guidelines for example: early breast care, metastatic breast care and familial breast care.
- We saw that endoscopic procedures were carried out in line with professional guidance.
- Sepsis screening and management was carried out in line with NICE guidance and the UK Sepsis Trust guidelines. Staff had sepsis training in their annual mandatory training. Staff we spoke with were knowledgeable about sepsis and its management.
- Policies and procedures were accessible to staff on the hospital intranet. Policies we reviewed were in date.
- The endoscopy service was not yet Joint Advisory Group (JAG) on gastrointestinal endoscopy accredited.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health**. The service made adjustments for patients' religious, cultural and other needs.
- Staff used the Malnutrition Universal Screening Tool to assess patients' nutritional requirements.
- Staff could refer patients to both internal dietitians and Macmillan dietitians if required.
- Patients were given written information on suitable foods to eat and the nutritional value of different food types whilst undergoing therapy.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way**.
- Staff had access to specialist pain consultants on site and NHS palliative care consultants to support patients pain management. Patients were seen within 24 to 36 hours of referral to the pain team.

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 did not participate in national cancer audits such as the bowel cancer audit, lung cancer audit, prostate cancer audit or older person breast national audit.
- The service did not participate in the national cancer patient experience survey. However, they had recently developed their own patient feedback survey to assess the quality of care.
- Cancer trials were not carried out within the service. Consultants referred patients to NHS trials if appropriate.
- The cancer service used a quarterly cancer dashboard which was a clinical scorecard that they used as a national benchmark tool. This monitored: multidisciplinary (MDT) compliance, UKONS (UK Oncology nursing Society) triage tool, IQEMO (medication) documentation, consent, pre-assessment completed, pharmacy care plan, venous access assessment, Malnutrition Universal Screening Tool nutritional assessment and holistic needs assessment.
- Examples of improvements made because of this were:

  - Investment in information technology to standardise and approve chemotherapy regimens (IQEMO)

  - Improved documentation regarding consent for all stages of the oncology pathway

- - Additional national training for use of the UKONS triage tool including ward nurses for out of hours services.There were trained chemotherapy nurses on call 24 hours a day.
- - Significant improvement over time with MDT compliance for every patient from 60% when they started monitoring it in 2014 to 99% in 2019. From September 2019, any non-compliance is reported as a serious incident requiring investigation for corporate oversight. The service achieved 100% compliance with this.
- The endoscopy service did not use a national comparator tool for Spire, however staff told us they used an endoscopy management system (EMS), where the lead consultant of the Endoscopy User Group reviewed key performance indicators data, to look for any improvements that were required.
- The endoscopy service was in the process of preparing to go for JAG accreditation.

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.
- For appraisal data please see surgical report**.**
- Each oncology nurse had competency folders containing specific oncology competencies to be signed off. Training was provided in extravasation (leakage of intravenously (IV) infused, and potentially damaging, medications into the extravascular tissue around the site of infusion), 24-hour triage system, cytotoxic spillage, venesection (taking blood), intravesical chemotherapy (into the bladder) and central venous access devices.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- All patients with a confirmed diagnosis of cancer were discussed in an NHS multidisciplinary (MDT) team meeting prior to commencement of treatment to discuss treatment regimes. The MDT consisted of

consultants, radiographers, clinical nurse specialists, physiotherapists, social workers and occupational therapists. The service audited these meetings to ensure each patient received an MDT. In the last 12 months 100% of patients received an MDT prior to starting their treatment.

- Dietitians, psychologists, and the pain management team worked closely with the nursing staff to support patients with their individual needs.
- Nursing staff completed holistic needs assessments with patients and shared treatment summaries with GPs to improve communication between the cancer service and primary care.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Staff completed a holistic needs assessment and care planning with patients to support their health promotion.
- A consultant clinical psychologist and clinical nurse specialist in oncology ran a "Living with and Beyond Cancer Group". Sessions included advice on diet, physical activity, and stress and anxiety.

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 were aware of their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberties.
- We saw staff gaining verbal consent prior to carrying out procedures.
- Written consent within patient records was gained from patients prior to commencing chemotherapy treatments.
- Please see surgical report for detailed findings.

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

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We saw that staff were kind, supportive and caring in their interactions with patients.
- Staff had a good rapport with patients and we observed staff chatting in a friendly manner, putting patients at ease.
- We spoke with a mother of a patient who told us that she and her daughter had received exemplary care and they were always treated with care and respect.
- The chemotherapy suite achieved 5* Macmillan Quality Environment Mark in 2018. (This is a framework for assessing whether cancer care environments meet the standards required by people living with cancer.)

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.** They understood patients' personal, cultural and religious needs.
- A specialist cancer psychologist worked with the nurses to support patients' emotional needs. There were no waiting times to access this service.
- Patients spoke very highly of the support they had received from staff.
- Patients relatives/close ones could accompany patients to treatments.
- Compliments received by the service included, "You have all done so much to make my visits easy and stress free at such a difficult time," and "What could have been

a very traumatic time was made easier by your kindness, special care and advice when needed," and "Thank you for your kindness, good humour and the excellent nursing you provided."

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- We saw that staff gave clear explanations throughout all interactions with patients.
- A relative told us that the consultant and the nurses had offered advice and support throughout the whole process.
- Within the endoscopy unit we observed staff giving good explanations to patients of what to expect prior to the procedure.

Are medical care (including older people's care) 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 lead chemotherapy nurse was a member of the local Cancer Alliance (an expert advisory group run by NHS England.) This enabled the service to be kept up-to-date with local clinical guidelines, Cancer Alliance updates and competency frameworks.
- The service offered the Macmillan Recovery Package to its patients including holistic needs assessments, care planning and treatment summaries to GPs.
- Staff provided information to patients on specialist equipment and aids such as 'cold caps' (scalp cooling treatment), wigs and temporary prosthetics.
- A designated quiet room was made available within the hospital each day to break bad news and support distressed patients and relatives.
- The chemotherapy suite offered a 24-hour telephone line to support and advise patients.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences.** Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Staff had training on supporting patients living with dementia and learning disabilities within their annual mandatory training. Dementia leads were also available within the hospital to offer staff support.
- The service could obtain easy read information and patient information in any language and braille from Macmillan.
- A hearing loop was available within the chemotherapy suite for patients with hearing loss.
- The service did not allow relatives to translate for patients whose first language was not English. A formal telephone translation service was used.
- The chemotherapy suite was accessible to patients with reduced mobility or those using a wheelchair.

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.
- There were no waiting times to access the chemotherapy suite.
- If a patient needed to continue their treatment under the NHS, then the consultant arranged the transfer of care back to the NHS trust that they worked at.

Learning from complaints and concerns

Good

Medical care (including older people's care)

- **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.
- All complainants were offered a feedback meeting with the hospital director and matron. Patients received a letter explaining details of the investigation carried out and the outcome.
- There had been no complaints to the chemotherapy suite in the last 12 months.
- We saw that learning from complaints was a regular agenda item on monthly team meetings.

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

Good

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

Leadership

- Please see surgical report for detailed findings.

Vision and strategy

- Please see surgical report for detailed findings.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- We observed effective teamwork and a positive culture within the chemotherapy suite.
- Staff felt well supported by management and told us that the senior management (hospital director and matron) regularly visited their unit to gain feedback.
- Please see surgical report for detailed findings.

Governance

- Please see surgery report for detailed findings.

Managing risks, issues and performance

- Please see surgery report for detailed findings.

Managing information

- Please see surgery report for detailed findings.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- The chemotherapy suite had recently developed their own patient survey. There was also an ideas/tips box on the unit for patients to provide feedback.
- In response to patient feedback, cancer patients were allocated parking badges so they could park closer to the entrance or in consultant spaces.
- The service worked with the local Cancer Alliance (expert advisory group run by the NHS England) to ensure it provided a high- quality service.
- The Macmillan environment lead visited quarterly to ensure the environment met the standards required by people living with cancer.

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 breast care specialist won a national Spire 'Inspiring people award' for setting up the, 'Living with and Beyond Cancer Group'. The group was jointly facilitated by Consultant Clinical Psychologist and Clinical Nurse Specialists in cancer. The group aimed to help patients prepare for their future post diagnosis, identified their concerns and supported their needs.
- Please see surgical report for detailed findings.

Good

Surgery

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

Are surgery 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.

- The provider had a corporate mandatory training policy. Staff were required to undertake wide range of general and role specific mandatory training modules in line with their policy and training schedule.
- Training and development included 'face to face' and 'e-learning' modules. Staff training were kept up to date and each staff member had their own log in system to manage own training online. The service manager also kept their own training record and would also send reminders to inform staff of their training.
- Staff told us that they could access mandatory training when they required it.
- The hospital set an end of year target of 95% for completion of mandatory training. Information provided by the hospital showed the service was on track to achieve all mandatory training modules by the end of 2019. The hospital training commences from January to December. We saw June 2019 figures and 61% staff for ward and theatre had completed their mandatory training which was ahead of the provider's mid-year 50% target.
- Training modules included fire safety and evacuation (97% and 94%), equality and diversity (98% and 91%), health and safety(97% and 92%), infection prevention and control (98% and 92%), safeguarding level one and two for both children and adults, antibribery (97% and 94%), moving and handling (98% and 94%), information governance (95% and 80%) and basic life support (BLS), immediate life support (ILS) and Advanced Life Support (ALS). We saw on the ward and theatres that all relevant clinical staff were either trained in ILS, BLS or ALS. When we requested the audit for the compliance, the data included all staff at the hospital. ALS 100% of staff had completed this training, 96% of staff had completed their ILS training and 83% of staff had completed their BLS against hospital.
- We spoke with senior staff who told us that ALS was not mandatory for all staff, however the hospital would always have at least one staff per shift that was ALS trained to cover the ward and lead the daily resus huddle with support from theatre staff and the resident medical officer (RMO) who was also ALS compliant.
- The hospital also provided an extended recovery unit (ERU). To be eligible to work in this area all staff must had either completed the Spire six-day course or have previous experience in critical care along with level one competencies that were signed off by the hospital ERU lead nurse. Once staff have completed the ERU competencies they were issued with the critical care training certificate. We saw evidence that nine staff in total were eligible to work in ERU. Senior staff told us that this was a rolling programme with spire healthcare also securing places at a university for an accredited programme.

- Management staff told us, and we saw evidence that all staff were required to complete a set of mandatory training courses during their first three months of employment with the service.

Safeguarding

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

- The hospital had identified members of staff for safeguarding leads, three for adults and one for children and young people. We saw on display the "safeguarding never forget the seven 'R's" that was created by the safeguarding team. The "seven R's" was used as a reminder for staff of what to do with a safeguarding concern. Receive, Reassure, Read, Record, Refer, Reflect and Remember.
- Staff were aware of their role and responsibilities in making safeguarding referrals. Staff showed us their clear safeguarding guidance on the hospital internet and told us this was easy to follow.
- Staff we spoke with demonstrated good understanding around safeguarding and knew whom to contact within the safeguarding team.Staff who directly supported children and young people had also completed level 3 safeguarding training. There was a dedicated safeguarding lead to provide expert advice and guidance when necessary.
- Safeguarding vulnerable adults and children level one, two and three was included in the service's mandatory training programme. Whilst on site we saw evidence of 92% that surgical ward staff had completed their safeguarding training and 94% of theatre staff had completed their level one, two and three in safeguarding adults and 95% for safeguarding children level one, two and three.
- The matron, deputy matron and the clinical governance lead nurse and the hospital children's lead had all undertaken and completed level four adult and children safeguarding training. The matron was the overall safeguarding lead for the hospital.
- There were up to date policies in place for the safeguarding and protection of adults at risk and safeguarding children.
- Safeguarding concerns were monitored within the services incident and complaints guidance as needed. Significant concerns were monitored directly by the safeguarding lead who gave staff guidance and support as needed.Where there were lessons to be learnt this was cascaded to staff in a variety of means to make sure that staff could readily access the information and guidance.
- The surgical department had a system in place for recording and reporting Female Genital Mutilation (FGM). FGM, also known as female genital cutting and female circumcision, is the ritual of cutting or removal of some or all the external female genitalia. Staff followed the hospital guidance for FGM and to safeguard their patients. The guidelines discussed the FGM mandatory reporting and caring for women who had undergone FGM.

Cleanliness, infection control and hygiene

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

- We saw that infection control audits had been undertaken in the ward, theatres and recovery; 98% were compliant in theatres and recovery and 92% for the ward. The hospital had eight link team members throughout each department who were specifically responsible for infection prevention and control.
- The Patient-Led Assessments of the Care Environment (PLACE) score for cleanliness in the service was 98.8% for 2018. PLACE is a system for assessing the quality of the patient environment. It is an organisational voluntary patient led assessment which takes place annually.
- The hospital carried out quarterly antimicrobial stewardship inpatient audits, a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms. Audits for October 2018, January 2019 and April 2019 were variable in percentages from 70% to 93%. Action plans were in place to ensure targets were being met.

- The hospital had appropriate policies and procedures in place to manage infection control. A policies and procedure file were accessible on the ward and in theatres. Staff we spoke with were aware and showed us the location of these policies.
- Information relating to the management of patients with a communicable disease was embedded within Spire healthcare's infection prevention and control policy. A communicable disease is one that can easily spread from one person to another through a variety of ways that include: contact with blood and bodily fluids; breathing in an airborne virus; or by being bitten by an insect.
- Staff we spoke with told us that patients who had been identified with any infection control risks were allocated to the end of the theatre list. This meant risks of cross infection to other patients were reduced and the area could be deep cleaned afterwards with the appropriate cleaning materials.
- We saw all areas within the surgical department including patient rooms were visibly clean and tidy and staff adhered to regular cleaning schedules. During our inspection we saw housekeeping staff were visible throughout the department and we observed staff requesting areas to be cleaned. Staff used appropriate clinical waste bags which were stored appropriately.
- Domiciliary staff told us they followed cleaning schedules for each department at the hospital, this included deep cleaning; Once cleaning had been completed staff would sign and date to say areas had been cleaned. We saw cleaning schedules for March 2019 to June 2019 and all were signed and dated.
- We saw all staff across the surgical departments were bare below the elbows. This enabled effective hand cleansing.
- All clinical areas had soap dispensers and paper towels, areas had antibacterial rub dispensers which were allocated throughout the departments and in-patient individual rooms.
- We saw completed documents for bed space checks that covered areas such as consumable trolley stock, oxygen cylinders and suction machine daily checks.
- We saw staff wearing Personal Protective Equipment (PPE) such as gloves and aprons. Staff used hand held sanitizers and washed hands in between patients. In theatres we saw staff wore theatre scrubs, we observed all theatre staff adhered to hand washing and followed the scrubbing cleaning policy. The surgical scrub is a systematic washing of the hands and forearms and scrubbing of finger nails using especially developed techniques and the most effective antibacterial cleansing agent available to render the hands and arms as free as possible from micro-organisms.
- The hospital had a sterile services department on site. There were suitable arrangements in place to ensure that the flow of dirty to clean equipment was in place and reduce the risk of contamination.
- Staff used 'I am clean' stickers to show equipment was clean and ready to be used. We saw in theatres a robust system of in-house decontamination services. Staff were very welcoming of this, due to no theatre delays or turn around rate and meant they had no problems with breakages or missing equipment as this was all managed-on site.
- We saw that hand hygiene audits were undertaken and included observation of staff hand washing. The hospital had a target of 95%, we saw the hospital latest audit for May 2019 which was at 96%.
- Information provided by the hospital identified that from December 2018 to June 2019 there had been no cases of MRSA, C. difficile, E coli, or MSSA infections.
- During the surgical pre-assessment appointment all patients due to be admitted for surgery were swabbed for potential infections such as MRSA. Patients were only admitted for surgery if no infection was identified.
- Between March 2018 and February 2019, the hospital reported a total of 23 surgical site infections resulting from surgeries. This equates to a rate of 0.3% of patients.

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 department consisted of 24 private patient bedrooms with ensuite bathrooms with additional eight beds if needed for bed capacity. Three laminar flow theatres with a recovery area, two bedded extended recovery unit (ERU) and four pre-operative clinic rooms.
- We checked the departments' resuscitation trolleys for both adults and children and found they were well maintained and easily accessible. Staff had signed to verify they completed daily checks.
- Doors to the theatre areas were secured by staff swipe card access to prevent them from being accessed by unauthorised people.
- All staff we spoke with said that they had access to the equipment they needed, at times there were delays but if equipment broke down they would report this to their matron or deputy matron who then organised a replacement.
- We saw evidence that in 2018 the air ventilation safety checks in theatres had been carried out.
- The engineering equipment lead at the hospital was based within the theatre department and had an 'asset management' system in place which had a predefined schedule of maintenance for all equipment on each calendar year. This meant that all the surgical equipment had a schedule, that sat on the asset management database. The system auto generated the work order for surgical equipment and covered all surgical equipment within the hospital, the work order auto dropped off the system and was assigned to the team to visit and carry out servicing.
- Sepsis treatment kits were available. The kits were sealed, within their expiry date and stored securely in the medicine store rooms. There were kits available for patients with allergies to specific antibiotics.
- All sharp implements, clinical and offensive waste were discarded in the appropriate containers and stored in locked cupboards located away from the clinical areas. These were secured by keypads to ensure they were not accessible to anyone without the appropriate pass. Security access was an issue for some locations around the hospital, we saw evidence that swipe card access technology was underway and due to be completed by June 2019.
- All staff undertook fire safety training as part of their mandatory training. We saw all fire exits were clearly marked and fire alarms were regularly checked. We saw evacuation plans on display including evacuation routes and all exit door areas were kept clear.

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.

- During our inspection we saw patient's safety risks were reviewed throughout patient's pathway. At pre-assessment clinic, nurses told us they followed guidelines to ensure appropriate information regarding patients' suitability for their procedure. This captured patients' health risks prior to any clinical intervention or surgeries.
- We saw staff carrying out safety checks prior to, during and after procedures. All safety checks were clearly documented in patient records.
- The nurse led assessment used a recognised scoring system of risk known as American Society of Anaesthesiologists (ASA). The service screened out any patients with an ASA risk score of four as this was above their risk threshold.Patients scoring ASA three were subject to further MDT discussion and to determine suitability to proceed.
- Staff followed the National Early Warning Score 2 (NEWS2) framework. NEWS2 was used to assess patients' clinical conditions and alert medical deterioration. Spire had set a target of 95% for completion of NEWS2, in February 2019 the surgical department was at 90%, March 2019 and April was at 100% with May 2019 at 85%.
- We were assured that the World Health Organisation (WHO) surgical safety checklist was being used consistently. This was a significant improvement since the last 2015 inspection. The service had a comprehensive audit programme which included local, regional and corporate audits. These were aligned to evidence-based practice and national guidance where appropriate. Where patient outcomes did not meet national targets, the unit introduced action plans to

improve, such as the venous thromboembolism assessments, 'WHO' safety surgical checklist, and unplanned return to theatre, or cancellations of procedure.

- World Health Organisation surgical safety checklists (WHO) were in place for all patients undergoing surgery. WHO checklists are a simple tool designed to improve the safety of surgical procedures. The service undertook audits and set a target of 95% on compliance. The latest audit reviewing staff practice and records had a rate of 100% compliance on an observational audit and 100% compliance on the documentation audit.
- Staff on duty during the inspection had a good understanding on recognising signs and symptoms for sepsis, the sepsis training compliance rate for nursing staff (excluding medical staff) was 95%.
- We reviewed the emergency and escalation policy and staff were able to demonstrate what actions they would take if a patient was to deteriorate and needed to be transferred to the nearest NHS acute hospital; we also reviewed two local NHS trust service level agreements (SLA) with Spire. The service level agreements provided assurance that patients requiring additional care such as intensive care would be admitted to a local NHS hospital able to meet their needs.
- Emergency pull cords and nurses call bells were available on wards and in toilets.
- During our inspection we observed the hospital's resuscitation huddle. This required all clinical bleep holders to meet at a dedicated base within the hospital. At the resuscitation huddle all staff were allocated a job during a resuscitation event, to ensure everyone knew what to do prior to any emergency scenarios.
- We saw the ward had an 'alert' folder, this was presented in their weekly planning meeting. The information provided was presented at the planning meeting for upcoming surgeries, details included patients who had allergies such as latex, nuts or patients who may be infectious or patients who were diabetic or severely anxious. All 'alert' case were planned and discussed on a weekly basis. We observed one meeting and found all staff discussed each individual cases and allocated patients to their best interest and the hospital.
- The surgical register in the operating theatre was completed and recorded procedures undertaken. Information included the names of surgeon and scrub nurse, the time each patient entered and left theatre, the patient's name and unique identifier as well as implants and swab counts. This enabled senior staff to check patients had received the appropriate support and who to approach when patients required follow up care or had concerns about their treatment.
- Should a patient need to return to theatre unexpectedly out of hours, there was a theatre team on call, supported by senior nursing staff, x-ray, pharmacist, physiotherapists and occupational therapists.
- The resident medical officer (RMO) provided the first response in an emergency. Staff told us that the RMO would review the patient quickly.

Nursing and Medical Surgical staff and Support staffing

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

- The hospital only undertook elective surgery which meant the number of nursing and care staff hours needed on any day could be calculated and booked in advance. Employed staff worked their contracted hours flexibly to cover the rota and any gaps were filled by bank or agency nursing staff or overtime.
- Spire used a dependency tool that was based on the shelford safe staffing tool. It was completed daily by the nurse in charge and then recorded against patient numbers including all admissions and discharges with each patient's dependency scored against set criteria. The number of both trained and untrained staff required was identified because of this score.
- During our inspection we saw the required numbers of qualified nurses were available to care for patients safely. Planned and actual staffing levels were on display.

- The hospital ensured they always had an appropriate mix of qualified and non-qualified (HCA) staff in all clinical departments to ensure safe staffing ratios. This was supported with the use of a safe staffing tool.
- The extended recovery unit (ERU) was based on a one to one nurse to patient ratio for a level one dependency, a ward-based model the patient does not require organ support (for example, they may need an Intravenous therapy, or oxygen by face). The nurse in charge told us these staff were supernumerary or carried a lighter case load to allow for any unexpected patient deterioration requiring a higher staffing ratio.
- Senior staff told us for additional support they could contact the clinical member of staff on call such as the clinical lead or matron for advice out of hours. The outpatient nursing team also utilised the safety cross to capture unexpected patient activity, along with theatre teams that worked following the association for perioperative practice guidelines with regards to minimum staffing requirements.
- Tools were used in conjunction with a red flag algorithm in line with National Institute for Health and Care Excellence (NICE) guidance. Additionally, variances relating to specific nursing needs was highlighted to the ward following a pre-operative assessment.
- A biennial review was undertaken for each consultant's practice by the hospital director, matron and medical advisory committee representative where appropriate. We found all records were up to date, information included numerous personal checks such as their general medical council pin, scope of practice documentation, Disclosure and Barring Service (DBS) status, mandatory training compliance with specific role additional training and appraisals. We saw the hospital was at 98.8% with practicing privileges compliance with mandatory documents.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. Consultants also arranged alternative cover from another consultant with practising privileges at the hospital, if they were not available. We saw evidence of this during our inspection. Based at the nurses' station there was a folder that provided staff with information on consultant cover.
- Each anaesthetist had agreed to be part of the anaesthetics cover group. This was kept as a copy by the theatre team and the wards. All consultants were responsible for contacting their preferred radiologist. There was a formal radiologist on call, and a list of telephone numbers was included in the on-call process paperwork. There were no reported concerns with accessing appropriate radiologist out of hours when required.
- Surgical consultants' and anaesthetists' workload varied dependant on patient demand and operation sessions were scheduled accordingly. A wide range of surgical staff were available which included suitably skilled nurses and operating department practitioners.
- Spire Little Aston had a medical advisory committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if they were deemed competent and safe to do so. The MAC met four to five times a year. We reviewed August 2018, December 2018 and February 2019 meeting minutes, and we found them to be robust, the agenda covered the hospital regulatory compliance, clinical reviews, practicing privileges, quality assurance, clinical services and hospital business reviews.
- The role of the MAC also included periodically reviewing existing practicing privileges and advising the hospital on their continuation. They gave examples where practicing privileges had been suspended or withdrawn because of concerns raised. This demonstrated that the MAC was an effective body for monitoring the competence of the consultants working at the hospital.
- The hospital had a resident medical officer (RMO) who provided cover on an on-call basis for the hospital 24 hours a day. The RMO worked for seven days and then had seven days off and were supplied by an agency. Staff told us that the RMOs were responsive and would come to assess patients when requested. During our inspection we saw at the safety huddle matron asking the RMO if they were rested prior to starting their shift to be sure they were not tired or called out overnight.

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.

- On the surgical ward, nursing documentation including care plans, risk assessments, observation charts and medicine charts were kept in a folder at the bottom of each patient's bed. This meant that they were easily accessible for staff providing care. Medical notes were kept securely in a key controlled cupboard behind the nurses' station or in a locked drawer.
- We looked at nine sets of patient records. Records we reviewed were updated daily with regular patient review by the consultant, with a detailed plan of care and thorough instructions for all staff to follow. Spire had a target that 80% of all patients' records should be fully signed and dated by their consultant daily, Spire Little Aston had achieved 84 % May 2019.
- We looked at the pre-assessment information in five patient records and saw that any clinical investigations undertaken were clearly documented, and patients' medical and social history was recorded prior to them being admitted for surgery, using the hospital robust criteria for surgery.
- Risk assessments were completed during pre-assessment appointments and then followed up on the ward to ensure the information remained up to date. We saw numerous examples of completed risk assessments such as self-medicate assessments for patients wishing to self-administer their own medication and venous thromboembolism (VTE) pre and post procedure assessments.

Medicines

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

- We saw medications were prescribed appropriately for pain control, this was in line with National Institute for Health and Care Excellence (NICE) Guidelines.
- Ward staff told us they would seek advice on medication from the pharmacy and the patient consultant team.
- Medicines administration records were well maintained and clear about the medicines prescribed and administered. We saw allergy wristbands in place to highlight patients were at risk.
- The hospital had an on-site pharmacy and pharmacists visited the ward on regular basis to check and re-stock the medicine supply. We saw pharmacists attending the morning huddle to discuss medicines to take home for those patients due for discharge.
- Staff had access to emergency medicines and these were stored appropriately on the emergency trolley. We saw medicines were intact and in date. We saw the log book was correctly completed.
- All medicine fridge temperatures including room temperatures we reviewed were within range.
- Pharmacy was open 9am to 5pm Monday to Saturday with on call support if needed.
- Controlled drugs required special storage and recording and were stored and monitored appropriately. This prevented them from being accessed or administered by people who were not authorised to do so.
- We reviewed prescription and medicine records and found them all to be legible, dated and signed, allergies documented and saw antibiotics were administered appropriately.

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.

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff were able to demonstrate good understanding around duty of candour (DOC). DOC is a regulatory duty that relates to 'openness', 'honesty' and 'transparency' and requires providers of health and social care services to notify patients or other relevant person(s) of certain notifiable safety incidents and provide reasonable support to that person.

- From December 2018 to June 2019, the hospital reported one incident which was classified as a never event for surgery. Details of the Incident involved an arthroscopic shoulder surgery, and the anaesthetist gave a regional block into wrong shoulder. A root cause investigation was robustly completed and shared with the CQC. We reviewed the hospital's duty of candour policy and found it to be in date with next review in September 2020.
- Staff had access to an electronic incident recording system. All staff with a log-in access could record incidents on the system. Each recorded incident was shared with managers who would then investigate or sign the incident off depending on the incident circumstances.
- Staff we spoke with were clear on how to raise and report incidents. Staff were aware of their responsibilities in raising concerns, recording safety incidents, and near misses.
- Staff told us that they were encouraged to report incidents, learning from incidents was shared at team meetings, staff members told us that "incidents are always a topic for discussions", Staff went on to tell us that any incidents that appeared to have trends and themes may result in some additional training to support staff and any immediate concerns would be escalated. One example given were around venous thromboembolism (VTE) assessments and the high risks in surgical patients.
- We saw the hospital carried out regular VTE assessments pre and post procedure. For May 2019 we saw 95% compliance with staff carrying out VTE assessments along with advice on discharge that included verbal and leaflet advice.
- We reviewed three root cause analysis (RCA) investigations in detail during our inspection and discussed them with senior management. Root cause analysis is an evidenced based, structured investigation process which uses tools and techniques to identify the true causes of an incident or problem, by understanding how a system failed. The RCAs were detailed and included relevant actions. We saw where recommendations had been raised as part of the RCA outcome, these had been implemented within the department.
- Matron told us that Mortality and Morbidity meetings took place monthly during their clinical effectiveness meeting, where they would discuss deaths that had occurred within their department. Investigation reports and further information were reviewed to identify any areas to improve.
- The service produced 48-hour flash reports. 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 hospital updated a scorecard each quarter that showed the outcomes for various clinical measures. It recorded there were low incidences of venous thromboembolism, falls or surgical site infections.
- Number of Clinical incidents by degree of harm with the surgical services in the reporting period of January 2018 and December 2018 was 802. No harm (658), low (89), moderate (54), severe (1), death (0) and total of non-clinical incidents reported was 182.

Safety Thermometer

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

- NHS safety thermometer took place one day each month. A suggested date for data collection was given but wards could change this however; it was stipulated that the data must be submitted within 10 days of the suggested data collection date.
- The hospital used a dashboard for individual services at the hospital to be used as a management tool, containing information about its performance against agreed targets such as use of agency staff, incidence of surgical site infection, slips, trips and falls and patient feedback.
- Staff were made aware of the hospital's performance and when improvements were needed action plans were in place and when needed actions were implemented. We saw the surgical ward had implemented the 'green cross system' on the ward

notice board to highlight how many falls and pressure ulcers had been identified each day, we saw none had been identified in June 2019. The tool allows teams to keep regular checks on harm and record the number of harms associated within surgical care. On display we saw up to May 2019 the hospital was at 100% for harm free care.

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. Staff protected the rights of patients' subject to the Mental Health Act 1983.

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Evidence based care pathways from established professional bodies such as the National Institute for Health and Care Excellence (NICE), World Health Organisation (WHO) and the National Patient Safety Agency (NPSA) were in use.
- The service used the Five Steps to Safer Surgery checklist from the NPSA, based on a World Health Organisation document which promotes the recording of staff briefing, sign-in, timeout, sign-out and debriefing, and is advocated for all patients in England undergoing surgical procedures.
- Staff were able to show us how they accessed clinical guidelines and local policies on their intranet page along with hard copies in a designated area within hospital.
- The service held handovers in a structured manner and away from patients. We saw handovers were consistent in their content and format and followed the Situation Background Assessment Recommendation (SBAR) model. SBAR is a technique that can be used to help standardise and prompt communication. Senior staff told us there were plans in place to implement consistency and evidence effectiveness of handovers.
- We saw the service ensured all patients received care in line with evidence-based guidance, including NICE guidelines and quality standards for surgery. This ensured all patients had effective care and treatment outcomes.
- We saw that the clinical effectiveness of procedures and compliance with clinical pathways and benchmarking with other Spire Hospitals was reviewed and assessed within the monthly clinical governance meetings.
- The service had processes to monitor deteriorating patients that were in line with National Institute for Health and Care Excellence guidance on managing acutely ill patients in hospital. We saw sepsis screening in line with the Sepsis Six pathway (a set of six tasks to be completed within an hour of identifying probable sepsis).
- NICE guidelines were centrally reviewed by Spire and were cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. We saw evidence through corporate key learning summaries and through departmental team meetings that changes in practice and guidance updates were discussed. For example, in the theatre team meeting, policies were discussed to ensure staff compliance with the latest guidance.

Nutrition and hydration

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

- Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- The management of 'nil by mouth' prior to surgery was discussed at the patient's pre-admission assessment. Protocols were in place to ensure that food and fluids were taken in line with consultant advice to ensure the safety of the patient. Data we reviewed showed that

advice was undertaken during pre-assessment in February 2019, theatre staff recording of dehydration times was at 65%, with March 2019 and April 2019 at 90% with May 2019 at 70%. This was a robust system to ensure all patients were hydrated up to the right time of surgery.

- Theatre staff told us they discuss their surgical list during morning safety huddles and their weekly planning meeting to inform the ward of the time the patient could continue to drink until, or any changes to the list would be discussed.
- Drinks machines, water fountains and snacks were available in the adjacent café area located in the main department of the hospital.
- Staff told us any dietary requirements were established during pre-assessment and then met on the day of procedure.
- Senior staff told us that if patients were insulin dependent or diet-controlled diabetics their treatment time was coordinated to maintain a normal blood glucose level.
- Records showed that patients were assessed for any risks of poor food and fluid intake or special dietary needs such as diabetes. Where risks were identified, plans were put into place to review the patient and obtain additional support with eating and drinking as needed. Patients were screened using the 'Malnutrition Universal Screening Tool'. The screening tool is a simple assessment that identifies if patients are at risk of poor nutrition. Patients who required additional specialist input received a referral, which could be made electronically to the dietitian with practising privileges whom staff could contact 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.

- The hospital audited pain scores and identified that on average 90% of patients had an assessment of their pain recorded, this was between February 2019 and May 2019.
- Staff tried to make patients as comfortable as possible during their procedure and post operatively. We spoke with seven patients who were all happy with the management of their pain and told us staff were very attentive and caring.
- Staff told us about the pain management forum that takes place quarterly, to discuss themes and patterns which involved discussions of complex cases such as patients with anaemia, patients on anti-coagulation and cardiac patients.
- We saw ward staff discussed pain relief and pain management plans with patients' and their relatives, relatives we spoke with told us staff managed their loved one's pain well.
- We saw patient records, that showed patients were prescribed regular pain relief with additional 'as when required 'pain relief. All pain relief were documented thoroughly and kept up to date.
- We saw analgesia was offered and given appropriately using the Five Rights of Medication Administration, one of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time. Inpatients' pain scores were checked and documented on the NEWS2 chart. Pharmacists counsel patients on analgesia and patient Information leaflets were available to provide clear instructions to patients.
- Patient's consultants were available to provide advice if patients complained of pain after surgery. Pain management advice was available 24 hours, every day.
- We saw from the discharge summaries we reviewed that pain medication was included in the discharge summary which was sent to the GP.

Patient outcomes

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

- 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. PROMs data for groin hernia repairs and knee replacements for the year 2018-2019 showed that the Spire Little Aston had below average responses from patients of 46% against hospital target of 70%. We reviewed the hospital action plan, which provided information on PROMs meetings every month, chaired by the bed manager and attended by the deputy matron, pre-assessment lead and administration team, ward manager and administrator manager. A Spreadsheet was maintained of compliance and analysis. Validation was the hospital priority. Monthly outcomes were published monthly on their clinical dashboard. PROMs meetings were recently changed to weekly.

- In October 2018, Spire Little Aston commenced a Robot-Assisted Joint Arthroplasty using robotic arm assisted technology, staff told us Little Aston were the second spire hospital to introduce this service. Senior managers told us that the stated benefits include faster functional recovery from surgery, less post-operative pain and reduced length of hospital stay in part due to the pre-operative planning that took place and the precision of the robotic arm, which minimised soft tissue trauma. We were told by the management team that research data were at an early stage in this field, therefore in order to develop an improved understanding of the outcomes using their orthopaedic surgeons at Spire Little Aston it was agreed by the team to undertake an audit using various time frames, pre-operatively, at discharge, six weeks post operatively and then six months post operatively.
- Between January 2018 to December 2018 the hospital reported eight unplanned readmissions.
- Between January 2018 to December 2018 the hospital reported a total number of 18 cases of unplanned returns to operating theatre which equates to a rate of 0.23% of patients.
- Between January 2018 to December 2018 the hospital reported a total number of 19 unplanned inpatient transfers to another hospital which equates to a rate of 0.24% of patients.
- Between January 2018 to December 2018 the hospital reported a total assessed rate of unplanned transfers (per 100 patient attendances) as 0.1.

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 told us that new staff to the ward, theatres or pre-assessments were given a tour of the premises on the first day. Orientation of the hospital took place for bank staff or agency staff who had previously worked at the hospital, this was to ensure any changes were shared with staff.
- Clinical staff were supported by a comprehensive competency assessment toolkit, which covered key areas applicable across all roles. Staff were also expected to pass a probation period depending on the skills of the staff. The hospital had a practice development nurse who supported nurses to develop and assess their competencies.
- The recruitment process ensured that staff had the right qualifications, skills, knowledge and experience to do their job when staff start their role.
- The perioperative care collaborative (PCC) had set out clear guidance for competencies of surgical first assistants (SFA). Surgical first assistants were assigned a consultant as a mentor. They also had a log book detailing the work they had undertaken which would be signed off by their mentor. We saw evidence of competency records for scrub practitioners who had gained additional competencies to act as surgical first assistants (SFA). Each member of staff had been signed off as competent by a consultant and had a mentor to ensure continued development. Spire at Little Aston currently have seven qualified SFA's, who have completed the university course programme and an additional four staff were waiting to complete.
- Ongoing staff competency was managed through a performance review process. Clinical staff were also expected to complete clinical professional development (CPD) to meet their professional body requirements. Staff we spoke with told us they felt supported to maintain CPD and engage with the revalidation processes.

- The role of the MAC was to ensure that consultants were skilled, competent and experienced to perform the treatments undertaken. The MAC representative told us any concerns identified with a consultant's competence would be managed accordingly.
- Consultant competencies were assured through the NHS annual appraisal and the general medical council (GMC) revalidation process. All consultants must have an annual appraisal by an approved appraiser to maintain practising privileges at Spire.
- There was a process in place within the departments of surgery services to monitor and arrange appraisal dates for staff. Staff told us their appraisals were helpful and a good way to raise any concerns, training and development requirements.
- Staff we spoke with told us they had an open discussion with their manager during their annual appraisal and were able to identify any training needs. Appraisal rates were at 100% in 2018, appraisals run from January to December.

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 worked effectively as a multidisciplinary team (MDT). All health professionals worked as one team to ensure patients' needs were met. All patients attending pre-assessments who didn't have capacity would have an additional care MDT meeting that allowed a decision to be made whether procedures were in the patient best interest.
- Specialist services were requested when required such as social services, psychological support and learning disability teams to promote an integrated approach to any health condition management. Staff also told us they had access to additional support from pharmacy, physiotherapists, and other specialist services. Other services provided support on an on-call basis.
- "Safety huddles" were held each day up to twice a day, so that information could be shared with all relevant staff involved in the care and treatment of patients. We observed two of these safety huddles where each patient was discussed, and decisions were made about further care and treatment.
- We observed medical staff, nursing staff, therapists and pharmacists working together as a team on the ward and in theatres. The whole multidisciplinary team-maintained records of care and outcomes.
- We observed two nurse's handovers during our inspection visit. The handover was structured and provided consistent information, and always contained relevant detail of patients' and their needs, including details of the operation, when patients are nil by mouth and any allergies. This meant that that nurses have enough information to mitigate any potential risk to all patients on the ward.
- Multidisciplinary team meetings were observed, and we found them to be very informative and robust. This ensured that patients' needs could be met across a range of treatments and therapies.
- We saw a noticeboard in the pre-assessment clinic on display in the waiting area, to show which members of staff were working at the clinic. All staff across the hospital wore a name badge and the spire identification lanyard.

Seven-day services

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

- Theatres were available 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday, the hospital operated on most Saturdays during the year and offered a six-day service.
- On-site pharmacy support was available 8.30am to 5.00pm Monday to Friday and 9.00am to 5.00pm on Saturdays. There was an out-of-hours pharmacy support with access available through the nurse in charge of the hospital.
- Friends and family were welcome to visit the ward anytime between 10am to 8pm every day.
- Pre-assessment facility clinics were open between 8am to 8pm Monday to Friday and Saturday 8am to 1pm.
- We saw hospital inpatients had seven-day access to diagnostic services. Staff could access CT scans, MRIs, ultrasounds and emergency plain films. Services were consultant led.

- Staff told us access to medical advice at night came from the hospital on call night team such as the matron or deputy matron, and the RMO could contact consultants if they needed to. Staff told us the hospital on call team and the RMO provided advice and assistance when needed.
- Theatres were available for any patient needing to return to theatre 24 hours a day, seven days a week if needed in emergency. We saw an on-call folder providing information on staff on call rotas, that included first assist scrub staff, a specially trained nurse who can directly assist surgeons in the operating room. Staff worked variable hours to accommodate surgeons.

Health promotion

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

- Information leaflets in the waiting room were available for patients to read. Leaflets detailed information about what to expect during the procedure.
- We saw leaflets on display for members of the public to pick up and read if they required additional contact numbers for support.
- We observed literature about a range of health conditions such as diabetes, chest conditions, heart failure, healthy eating, smoking cessation and healthy living and regular exercise.
- We saw posters on display specific to health promotion activities and infection prevention messages.
- We saw evidence within patient records that staff documented patient's weight in pre-assessment and again on admission to the ward and staff told us if people required support with their diet they were referred to dieticians.
- Staff across surgical services told us that they promoted self-care. Advice included encouragement to relieve pressure areas, dietary intake, and education around control of diabetes, smoking cessation, and falls prevention.
- Staff and patients told us about the joint school, a weekly class specifically aimed at patients undergoing knee and hip replacement operations. This weekly class was led by one of the senior nurses that promoted self-care. Nurses also spoke about pre-assessment clinics, theatre procedures and after care including how to administer injections and medications correctly. Nurses also invited the hospital physiotherapist to demonstrate exercises to help during the healing process post operatively. In addition, the lead pharmacist and occupational therapist discussed after care including how to administer injections and medications correctly throughout the patient's pathway and equipment requirements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- The senior manager in pre-assessment was able to demonstrate good understanding and innovative work around patients with cognitive impairment and nurses carried out double assessment and completed 'my health care passport' that covered all aspects of health and social well-being of patients.
- We observed nursing staff explain procedures to patients and gain verbal consent to carry out procedures. Patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding the treatment and care patients required.
- Consent forms we reviewed identified the procedure to be undertaken, any associated risks and documented the health care professional responsible for consulting the patient. They also recorded signatures from patients indicating that they were providing consent to undergo the proposed procedure.
- Where patients were confused or there was a question about their capacity to consent, medical staff undertook mental capacity assessments to determine whether they could make decisions relating to their care and treatment, this was assessed during pre-assessment clinic to determine whether a patient was suitable for treatment at the hospital.

Good

Surgery

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.

- To capture patient feedback, the hospital carried out a
- We saw examples of patient feedback relating to consultants and found them all to be positive. One patient said, “feel safe in their care, always takes care and shows time”. Another patient said, “extremely professional and retains a human touch”.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Patients told us they had no concerns about how staff maintained their privacy and dignity. For example, we observed staff closing curtains when providing personal care and interacting patiently and respectfully with an anxious patient.
- We found privacy and dignity was well maintained. Many of the patients we spoke with felt staff treated them with compassion and empathy. They felt well cared for and told us staff were responsive to their needs.
- We spoke with the hospital dignity champions, their aim was to look at their own departments, discuss with their colleagues to gain insight into how people felt when at their most vulnerable whilst in hospital and identify any improvements.
- Dignity champions also looked at ways of how they could communicate respectfully supported by the National Dignity Council. Patients had access to the Spire patient discharge survey to inform the hospital of their experience and the hospital used this feedback to learn and improve. Patient forums were established to review areas of concern raised and to give patients a voice. Little Aston actively promoted the ‘Declare your Care ‘campaign and encouraged patients to talk if patients had a concern
- We did not observe any breaches of single sex accommodation. Staff told us a breach of single sex accommodation would never happen because all patients had their own ensuite room.
- We observed a ward round and saw that all staff introduced themselves appropriately and that curtains or bedroom doors were closed to maintain patient dignity. We observed all staff knocking on doors to patients’ rooms and waiting for a response before entering.
- We saw support staff such as housekeeping staff, porters and administrative staff were friendly and engaging when speaking with patients and relatives.
- Patients told us drinks and snacks were offered regularly where appropriate to ensure patients were comfortable. The patient survey showed that 78% of patients were happy with the quality of the food and this was above the benchmark for the national spire average score.

Emotional support

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

- All the patients we spoke with praised staff for their responsiveness, friendliness and emotional support.
- Patients had access to support from clinical specialists. For example, the hospital had one specialist breast care nurse, a colorectal and stoma nurse specialist. The hospital employed a breast care nurse, but other specialist nurses had practice privileges at the hospital and could be contacted to provide patient support pre and post operatively and when requested.
- The hospital had a clinical psychologist with practice privileges who had regular clinics at the hospital and could provide counselling when needed.
- We saw and were told that staff had more time to spend with patients, getting to know them and understanding their anxieties or fears. We saw members of staff comforting patients on their way to theatre and in the anaesthetic room. Additionally, we saw staff providing emotional support to patients when they were recovering from an anaesthetic.
- Staff were offered counselling sessions if they required additional support.

Good

Surgery

- Patients told us that physiotherapists provided support when mobilising following surgery and that they were encouraging and supportive.

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 and relatives, we spoke with said they felt involved in their care. They said they were given opportunities to speak with the consultant looking after them and to ask questions. Relatives or carers are encouraged to stay overnight to reduce anxiety for patients living with dementia or with additional needs.
- We spoke with patients who had undergone surgery. They told us they had been given details about the operation and what to expect post operatively, many were positive about the joint school support.
- Patients told us they were pleased with their pre-operative assessment. They said they were given enough verbal and written information about their procedures and their questions were satisfactorily answered. We saw examples of information leaflets that were presented during their appointment.
- Relatives told us they were kept informed of any plans and treatment and told us staff were helpful and approachable.

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 support to the local people, for example we saw the hospital was planning an awareness open day for dementia care, that provided members of the public with useful information leaflets and fundraising opportunities.
- Patients were admitted on a planned basis for elective surgery this included private patients and NHS patients.
- The hospital had a large variety of patient information leaflets in several different formats and languages available, and the hospital website provided useful information to patients and their relatives.
- The hospital provided a face-to-face interpreter for patients if they did not speak English as their first language. We saw the hospital also had access to a translation line; staff we spoke with knew how to access this and said they used this translation line often.
- The hospital did not provide emergency care and all admissions were planned and arranged in advance**.**
- We saw during the morning safety huddle; senior staff were allocating a room in the hospital to be specifically used as a prayer room. We saw leaflets on guides to the custom of religious culture and practice that covered 18 religions, including a prayer box that had different prayer books and some religious symbols.

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.

- Patients with fluctuating capacity or those living with dementia were supported in line with good practice. Some adaptations were made to rooms to assist patients with their stay. Additionally, where patients were identified with additional needs such as dementia or learning disabilities they had visited the hospital prior to surgery to help them be familiar with the environment.
- The service used a "This is me" form for patients living with dementia. This was a simple form that provided details about the person including their cultural and

family background, events, people and place important in their lives, and their routine and personality. The form provided information to enable staff to know more about the patient and adapt to meet their needs.

- Fluid balance charts were consistently completed, and we saw that patients had access to drinks and snacks.
- Staff in all the areas we visited were able to describe specific arrangements for involving patients with special needs and their families, in planning and providing care and treatment. During our inspection we saw one patient with learning difficulties who had arrived for a walk about tour with their parent, to see the hospital, meet staff and speak with patients who had undergone the same procedure, followed by a full MDT meeting to discuss patients' best interests.
- The service had a Dementia box which included equipment and activities designed to stimulate and support the patient during their stay. All patients had a single room with ensuite toilet and shower facilities.
- Patients were seen by the resident medical officer (RMO) and their consultants before discharge, all treatments were communicated to the patients' GP by letter.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres. Equipment was requested if needed during pre-assessment clinics.
- Discharge arrangements were discussed pre-operatively. Patients told us that they were required to confirm that they had somebody at home to support their care before they could be discharged.
- The hospital had a chaperone policy, all patients were offered a chaperone if they wished. This request was documented in patients' medical notes if they required a chaperone.
- Large-print and Braille information leaflets and other documentation could be ordered as required for patients living with impaired vision.

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.

- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. Patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input from physiotherapists and pharmacists. Staff completed a discharge checklist, which covered areas such as medication and communication with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner.
- Admission times were staggered throughout the day so that patients did not have to wait for a long period of time once admitted to the ward. By staggering admission times, the hospital was able to ensure those patients with the most urgent needs were prioritised. For example, patients with diabetes were placed at the beginning of the theatre lists so that they had their surgery as quickly as possible.
- Pre-assessments and regular theatre planning meetings in place identified patient needs in advance and reduced the risk of inappropriate admissions or cancelled procedures.
- There was enough bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation.
- Between January 2018 to December 2018 the hospital reported a total number of 22 cancelled procedures for a non-clinical reason. Of the above cancelled procedures, the percentage of patients offered another appointment within 28 days of the cancelled appointment was 100%.

Learning from complaints and concerns

Good

Surgery

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 we spoke with told us that any "Thank you" and compliments to individual staff members were shared in monthly team meetings; staff handovers and an email would be circulated.
- Staff were aware of actions to take if someone wanted to raise a complaint or a concern, and they would seek support from senior staff if they were not able to resolve the complaint. We saw leaflets on display throughout the hospital with telephone numbers if patients or relatives wished to complain or share their compliment.
- The service had a proactive approach to handling complaints. They addressed concerns at a local level before they became a complaint. Staff told us that this proactive approach helped reduce the number of complaints and gave them opportunities to learn from these complaints.
- Complaints were reviewed at the monthly heads of departments meetings, governance meetings and MAC meetings where outcomes, lessons learnt and improvements on practice were discussed.
- The complaints procedure set out the three-stage process for the review of complaints, and appropriately referenced the adjudication services: The Independent Healthcare Sector Complaints Adjudication Service and the Parliamentary and Health Service Ombudsman.
- We saw on display for surgical services for May 2019 they received nine complaints, four compliments and three concerns. All staff we spoke with were aware of these figures. The service sets itself a target to respond within 20 days but aim for earlier response when possible, the response rate was above 90% within 20 days.

Are surgery services well-led?

Good

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

Leadership

Managers of all levels within the service had the right skills and abilities to run a service providing quality and sustainable care.

- The hospital director led the hospital and was supported by the head of clinical services. Leadership within surgical services was provided by the theatre manager who managed theatre activity and a clinical services manager and deputy matron managed nursing staff. A clinical governance manager reviewed clinical governance both within surgery and throughout the hospital.
- Staff and managers told us that unprofessional behaviours were challenged and addressed. All staff told us that the hospital was a friendly and caring environment and enjoyed working for spire. They told us that they would highly recommend the hospital to work for and promote the care and treatment the hospital provided.
- Staff we spoke with told us that after mandatory training sessions were completed, the registered manager met with staff for informal meeting including head of departments.
- There was an experienced senior management team (SMT) and a supportive medical advisory committee was well established. Senior managers told us that a member of SMT attends all departments team meetings to show support and to answer any questions and provide further information on outstanding actions.
- Senior nursing staff told us they felt they were being listened to by the management team and there was a real focus on patient safety.
- Staff spoke highly of their immediate line managers and felt well supported by them. Staff told us that both the hospital director and head of clinical services were visible and supportive, and they could approach them with any concerns.

Vision and strategy

The service had a vision of what it wanted to achieve and plans to turn it to action. Staff were aware of the vison and values and staff we spoke with were able to demonstrate the values within their role.

- Staff told us that Spire healthcare's vision was to be recognised as a world class health care business. That provided safe clinical care, and as a minimum, complying with the statutory and regulatory requirements of relevant registration bodies.
- The senior team told us of their 2019 hospital strategy and how it was developed with the involvement of all the hospital Heads of Department. This was also displayed in all departments which gave the hospital team clarity, focus and direction of the structure that follows Spire's national governance standards.
- The hospital strategic objectives for 2019 included: Deliver growth: by delivery of quality services through innovation, High Quality Clinical Care: by achievement of regulatory and quality regulations, having open engagement with local people: by listening and learning through hospital partnerships, colleagues, consultants and having patients in the heart of everything they do. Transparent offering: by having fair and open clinical governance and administrative processes.
- Vision and objectives had been cascaded to staff across the wards and theatre areas we inspected, and staff had a good understanding of these.
- Staff we spoke with felt engaged with the department's strategy, understood that there was a clear vision for the service and knew their role in achieving the best outcomes for their patients.
- Managers told us that they discussed the hospital's values during team meetings, recruitment interviews and staff appraisals. Staff told us

Culture

Managers at the unit promoted a positive culture that supported and valued their staff with shared values on patient care and improving the quality of care within their service.

- There was a positive culture of staff development and empowerment, which was supported and encouraged by all managers we spoke with. Some staff told us they had developed within their role, to which they are now senior members of the department.
- Staff told us that matron, deputy matron and the registered manager had 'an open door' policy, and felt they were able to raise their concerns anytime.
- Staff we spoke with said they had worked for Spire and at Little Aston hospital for considerable number of years and all said it was a good place to work and a good provider to work for.
- Staff told us, and we saw there was an 'open' culture that was not about blame. They were encouraged to report incidents, as it was an important learning tool.

Governance

The governance arrangements were clear and operated effectively and staff understood their roles and accountabilities.

- We found there was a system of governance meetings which enabled the escalation of information upwards and cascading information from managers to front-line staff.
- Wards and theatres had developed local action plans to monitor and improve their delivery of patient care.
- Spire Little Aston had a dedicated clinical governance team, including a risk and a health and safety lead. Standards and performance were measured through a monthly clinical dashboard. A quarterly governance report was produced and shared with all staff and the medical advisory committee.
- An electronic tracker was also in place to monitor internal and external alerts to ensure all actions were completed. The electronic reporting system was set up with a central support to include dashboards to monitor any themes or trends of incidents and associated risks.
- The risk register was set up with central guidance to ensure all risk were captured and visible to identify the hospital top five risks and then shared with all staff in each department. The hospital contributed governance data to the Spire organisation to provide additional oversight and external scrutiny of the service's performance. There was a clinical score card in place that highlighted areas for development and areas that the service was doing well in.
- There were several staff huddles to discuss staff activity and specific patients. There was a head of department huddle, led by the hospital director, at 9.15am each

morning. Any significant events that had taken place over the intervening 24hours were discussed. Each department, including theatres, catering, wards, and housekeeping were involved.

Managing risks, issues and performance

The service had a system in place for identifying risks, planning to eliminate and reduce risks and the ability to cope with expected and unexpected challenges within the service.

- During the inspection, we looked at the surgical department risk register and saw that key risks had been identified and assessed. Some risks also appeared in the hospital wide risk register. The risk register was reviewed at the monthly Risk Meeting attended by Registered Manager, Clinical Governance Lead, Senior Management Team members and Health and Safety Lead.
- There were regular audits and monitoring of key performance across the ward and theatre areas to monitor performance against hospital objectives. Information relating to performance was cascaded to wards and theatre managers. For example, cancellation of operations, which was analysed and reported at monthly clinical governance meeting.
- Findings from audits were shared with staff through a variety of means, such as team meetings, safety huddles, and information was provided on display boards. This was seen throughout the surgical services.
- Registered manager and the medical advisory chair told us that consultant's clinical practice was reviewed on a regular basis and in several ways. For example, through the monthly clinical dashboard produced by the clinical governance team that was discussed at the monthly clinical management group meeting, and at the monthly senior management team meeting. We saw meeting minutes to support this and we saw the clinical dashboard was displayed across each department at the hospital. High risks were automatically escalated to the central governance team.
- We saw there were six main clinical risks for surgery and 26 on the live register for the hospital. Main areas of concerns were around security, Brexit, file trackers and transferring deteriorating patients. We saw the hospital had action plans in place and were on track to meet these.
- A root cause analysis (RCA) investigation was undertaken following each serious incident or post-operative infection. The RCA detailed the investigations undertaken and actions to reduce the risk of further similar incidents in the future.

Managing information

Management collected, analysed, managed, and used information to support activities using secure systems with security to safeguard all processes in use.

- We observed the hospital weekly planning meeting that was held every Wednesday, we saw staff discussing the upcoming 10 days of admissions. We observed many good examples of how the departments worked well together to prioritise patients and their safety. One example was around a diabetic patient who required to be first on the list, all staff discussed the patient's medical history and best interest. We saw examples of bariatric patients; all staff discussed the equipment's availability. We observed discussions around moving the patient per the 'alert' to be able to support and respond to their needs.
- < > managers were responsible for cascading information upwards to the hospital management team. We saw information was shared during clinical governance meetings.
  Information on the number of incidents, complaints and general information for the public was displayed on notice boards in the ward and theatre.
- There was an adequate number of computers in the unit for staff to carry out their duties.

Engagement

Staff engaged well with patients, staff, and the public and local organisations to plan and manage appropriate services and collaborated with partners' organisations effectively.

- Theatres and ward staff, we spoke with told us they routinely engaged with patients and their relatives to gain feedback from them.

- The hospital engaged with the public through various mediums such as social media, charitable events and listening into action events.
- Staff we spoke to felt valued and that senior managers engaged with them. Staff spoke positively about the 'Inspiring People's Award' which recognised staff and patient compliments. Staff said they felt valued and these awards were given in person by the hospital director.
- We spoke with the registered manager who told us they work very closely with local charities. We asked how they decide on the charity to support; all staff voted for their chosen local charity and top three was chosen at random with a final vote. The current charity was their local hospice, Spire was involved with the charity forum monthly meetings involving members of the public, staff and the hospice.
- Spire Little Aston had recently started a patient experience group, where patients were invited to tell the management team about their 'Spire' experience.
- There were several up to date information posters on display boards for staff within the hospital. The clinical and quality leads took responsibility for keeping the boards up to date with useful information. This meant that staff could, immediately, be kept up to date. For example, the changes in practice to let staff know what's changed and how it affects them such as new 2019 NICE guidelines, revalidation, and spire newsletters.

Learning, continuous improvement and innovation

The service was committed in improving services by learning from things that have gone well and when things go wrong, promoting training, research, and innovation.

- We were given a copy of the hospital's business continuity plan which contained actions to be taken to ensure that patients and staff were kept safe and that the hospital's business could continue, where possible, in the event of an incident disrupting their facilities.
- Spire Little Aston commenced a Robot-Assisted Joint Arthroplasty using a robot in October 2018, staff told us Little Aston were the second spire hospital to introduce this service.
- We saw the hospital had an 'excellence' award for anaesthetist passport and safety work around the implementation of 'Stop before you Block', with additional stickers that were on display throughout the hospital. We saw the hospital carried out regular audits, we saw compliance data for April 2019 was at 88% and 80% in May 2019. This was a result of learning from the never event.
- We saw the hospital were ACSA accredited, an anaesthesia clinical services accreditation, a voluntary scheme for NHS and independent sector organisations that offers a quality improvement through peer review scheme based on a relevant and robust criterion set by professionals, for the profession.
- The hospital had implemented a new Pre-Operative Assessment Proforma (POA) checklist within pre-assessment to ensure written information was provided and patients understanding of the pre-op instructions. We saw the hospital carried out a POA documentation audit, the sample consisted of 10 patient records undergoing a general anaesthetic (GA) and we saw 96% of staff were compliant with mandatory completion of POA documentation.
- There was a strong focus on learning and improvement at all levels of the organisation. Spire had recently started to have regular meetings with local Healthwatch to connect further with the public and to promote continuous improvements to the service.
- All staff we spoke with told us there has been a significant improvement to their service since the 2015 inspection, examples given was the 'WHO' safety surgical checklist, the daily safety huddles including the 'resus huddle'. Staff went on to tell us that the safety culture has been the hospitals main focus.
- The registered manager told us that they were due for a visit regarding the hospital PROM's audit and "getting it right first-time" in August 2019 covering the orthopaedic service at the hospital.
- We spoke with the hospital Dignity Champions, their aim was to look at their own departments, discuss with their colleagues to gain insight into how people felt when at their most vulnerable whilst in hospital and

identify any improvements. Since this role had been established the team have implemented 'Knock before Entering' initiative and a poster throughout the hospital, patients we spoke with spoke highly of this initiative.

- Senior management told us of their three-year plan for Little Aston, their aim was to concentrate on the fabric of the building, quality of the services they provide and expanding the services such as the endoscopy unit, the
- The hospital has implemented a weekly anaesthetic clinic, which allows patients to have a face to face interaction with the anaesthetist prior to procedure if patients were deemed at risk. Additional clinics and questionnaires were also provided called the 'stopBang' that provided further assessments into sedation for patients with sleep apnoea or those patients who required further assessment into sleep patterns.
- We spoke with staff in the pre-assessment clinics who showed us a new design of a 'bare-non' disposable covers 'to use as an additional dignity coverage for patients, for example patient undergoing an electrocardiogram (ECG) who may not want to be exposed.

Good

Outpatients

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

Are outpatients services safe?

Good

We rated it as **good.**

Mandatory training

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

- The hospital had a rolling mandatory training programme for staff to update their skills, knowledge and understanding. The training period was each year and ran from January to December.
- Topics included health and safety, infection control, fire safety, information governance and equality and diversity, manual handling and safeguarding.
- Data provided by the hospital showed outpatients appointment staff had 100% compliance with mandatory training topics as of June 2019.
- Outpatient's clinical and other staff had reached between 86% and 91% compliance by that half way point in the year. Staff we spoke with during our inspection visit confirmed they undertook this training regularly and there was a system in place to prompt them when it was next due.

Safeguarding

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

- The hospital provided safeguarding training at level 2 and annual updates for staff, these topics were mandatory according to role and in line with the Intercollegiate guidance 2019.
- Data provided by the hospital showed as at June 2019 outpatient staff in all roles were up to date with or on target for safeguarding adults training at level 2 and level 3 competence. This included non-clinical staff. All nursing staff had level 3 competence in line with the hospital policy as they worked with children.
- Staff in all roles were up to date with or on target for safeguarding children training at level 2 competence. This included non-clinical staff.
- Reception staff and nurses, we spoke with were able to give us examples of how they might recognise signs of abuse in vulnerable adults and in children and described appropriate ways they would act on their concerns.
- We saw posters in patient's toilets with contact information for agencies that provided support to victims of domestic abuse. There was information on posters in the staff room about safeguarding procedures, interagency contact details and the government Prevent strategy.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises generally clean. They used control measures to prevent the spread of infection.
- The outpatient department had a protocol for patients presenting with infection. Nurses could contact the registered medical officer (RMO) if they were

concerned a patient had an infection. The RMO could refer to a consultant on site if anti-biotics were needed and a swab taken. Patients would be sent home with anti-biotics or admitted if appropriate. If they were sent home the hospital would contact them again within a few days with a view to seeing them again quickly.

- Quarterly audits were undertaken and for Q1 2019/20 the score across the hospital achieved the 95% target.
- The outpatients department was visibly clean, and the space was well organised. We spoke with two hospital housekeeping staff who told us outpatient areas were cleaned at night and they followed schedules of tasks.
- Patients toilets were clean as were all facilities for the use of staff on duty. Consultation and treatment rooms were clean and uncluttered. We saw wash basins, hand cleanser and paper towels in the treatment rooms.
- Equipment was labelled with stickers to demonstrate it had been cleaned and was ready for next use. There were stocks of single use equipment in treatment rooms, sharps bins and clinical waste bins to separate this from general waste.
- There were hand cleansing dispensers including at child height level around the department, although we saw no patients or visitors using them over the two days of our visit. We observed reception staff did not take an opportunity to prompt patients and visitors to do so.
- The hospital undertook staff hand hygiene audits quarterly. For quarter one (January to March 2019) the outpatient department scored 100% compliance.
- Nursing staff wore short sleeve uniforms and were therefore 'bare below the elbow' which is good infection control practice. We noted some consultants wearing suit jackets and ties when they went to the waiting areas to call their patients. The manager told us hospital policy was that they should remove jackets and roll back shirt sleeves and tuck in ties whenever they were examining or treating a patient. Patients we spoke with confirmed their consultants had done so that day.

Environment and equipment

The service had mostly suitable premises and equipment and looked after them well. However, the audiology room was small and crampt.

- The hospital had 15 outpatient consulting rooms and a procedure room
- We saw resuscitation equipment was to hand near the outpatient nurses station.
- Two locked and signed cupboards housed any hazardous substances and control of substances hazardous to health procedures were in place. A biohazard kit was available in the medicine's storage room to staff.
- We noted equipment; including fire safety equipment was clearly labelled with maintenance and test checks. A fault on the fire alarm system board was being investigated by engineers on the first morning of our visit.
- The outpatient area was ground level, generally spacious and well-furnished and decorated and displayed appropriate signage to assist patient and visitors.
- The audiology consulting room was very small and cramped with a large audio testing booth in one corner. It would not easily accommodate a patient using a wheel chair safely together with one other person beside the consultant. Medical staff told us consultations with children were particularly difficult to manage with their adult present. They said this had been raised with hospital managers over several years. Although the door had been recently sound proofed, this did not address the space restriction issue. We noted this room appeared to be in a poorer decorative order than other consultation and treatment rooms.

Assessing and responding to patient risk

- **Staff identified and quickly acted upon patients at risk of deterioration.**
- Outpatients were generally 'medically fit' patients. If a patient became acutely unwell the outpatient's services policy was to stabilise and stay with patients and call the emergency 999 service.

Good

Outpatients

- The outpatient department had a fully equipped resus trolley next to the nurse's station. This included paediatric equipment and we saw from records it was regularly checked.
- Sixty percent of nursing staff had up to date paediatric immediate life support training. Managers told us the remainder of the team of 13 were booked for their update training event during the summer 2019. This was in line with their training programme.
- The daily duty staffing board clearly identified staff members on duty with life support training including paediatric.
- The nursing team included one sick children nurse who could provide advice to colleagues when on duty.
- Sepsis information posters were on display for patients and sepsis pathway information was on display in the staff room. Sepsis was a topic on the intermediate life support course and the outpatient service had a screening tool within a deteriorating patient folder kept on the nurse's station.
- Outpatient staff could raise the hospital emergency team with an alert button. The manager told us this was tested every morning at 09.30 at different points around the hospital including outpatients. Each month the team were presented with a different emergency scenario and their response was assessed for improvement.
- For our detailed findings on processes in place to assess patient's condition, address risks and manage a deteriorating patient please see the Safe section in the surgery report.

Staffing

There are no nationally agreed standards or guidance for outpatient staffing levels however; **the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

Nurse staffing

- Levels of qualified nurses and health care assistants were planned in advance and reflected the pre-booked demand. Early shifts were planned as between three and five nursing staff (recent records showed mostly four) and the late shift was planned for four or five nursing staff (mostly four).This was based on longer and busier clinics in the late afternoon and evening.
- A sample of one recent month's data sent to us by the hospital showed May to June 2019 actual staffing levels generally matched planned staffing levels. For two early shifts staffing levels were higher than planned and for only one shift they were slightly lower than planned. For late shifts in that period four shifts were higher than planned and only, one shift was lower than planned.
- At the time of our inspection outpatient services had one whole time equivalent registered nurse vacancy and two whole time equivalent health care assistant vacancies. Managers told us they covered these shifts with overtime and internal bank staff. The hospital was recruiting to fill these vacancies.
- One agency nurse was being used at the time of our inspection. This nurse worked regularly for the provider and was familiar with the hospitals procedures and company policies.

Medical staffing

For our detailed findings medical staff please see the Safe section in the surgery report.

Records

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

- Patient records were in electronic and paper form.
- We spoke with nine patients who told us their records were available when they attended for their appointment. The outpatient manager confirmed notes 'were always' available when they were needed, and no audit programme was in place for this. The rare exceptions were reported as incidents.
- We reviewed five sets of patient records. Each patient had a complete set of documentation, with diagnosis and treatment plans and follow up arrangements in place and on record.
- Records were tidy, well ordered and readable.

- We saw records were available to nurses and consultants when they needed them but remained secure from casual view as they followed the patient through the department.
- There were systems in place to retrieve and return paper records to secure storage.
- Where consultants were seeing a patient also at a local medical centre, the hospital told us the medical records were transported by courier in a sealed blue bag. Two ties to seal the were placed inside for the return journey. We saw this happening in practice.
- Discharge summaries were shared with patient's GP's if the patient consented to this.
- A Spire single patient records audit which included quality and management of records took place quarterly. The most recent audit was completed in Q2 with 91% compliance. This was in addition to clinical records audits which were completed quarterly and reported via the clinical scorecard, such as NEWS scoring, pain scoring, risk assessments and consent.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. There were robust systems in place for safety and security of medicines.

- Private patient's prescriptions were issued by the pharmacy which was located next to the outpatient department. All prescriptions had a traceability number on them.
- Pharmacy staff signed out and counted prescription forms every morning and issued them to the consulting rooms. Doctors issued them to patients and entered details on the traceability record. Two copies were filed.
- There had been no incidents reported of lost prescriptions or error in the recording process.
- No controlled drugs were stored within the outpatient department. We saw other drugs were securely stored and there was an accounting and audit system in place for these. Drugs and consumables were all neatly organised and labelled.
- Drugs room and fridge temperatures were within range and records showed staff checked these on a daily basis to maintain it.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- The outpatient clinical nurse manager confirmed there had been no serious incidents or never events reported because of outpatient services in the 12 months prior to our inspection.
- The outpatient services used the hospital's electronic incident reporting system and staff were able to give us examples of recent reports they had made.
- All incidents in the outpatient's department went in the first instance to the manager for review and action. The manager maintained a system of 'red cards' for incident improvement, this included details of the incident, the outcome and monitoring of the learning from it.
- The manager told us outpatient services had recurring incidents during 2018 with errors in the labelling of blood samples by outpatient staff. This resulted in samples being returned and patients asked for a further sample. It was being addressed by an action plan at the time of our inspection.
- The most recent monthly Spire wide safety bulletin was on the notice board in the outpatient staff room, this included shared learning from incidents and good practice across the organisation's hospitals.
- Mortality and morbidity were a standing item on the outpatient staff meeting agenda and the monthly clinical effectiveness meeting attended by outpatient managers.
- Managers and nursing staff were able to explain their duty of candour (DoC). 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 reasonable support to the person.

- Staff confirmed the hospital's electronic incident reporting system prompted DoC process consideration from the rating of severity of harm from the incident. As the outpatient department had experienced no serious incidents we could not assess the quality of any root cause analysis.

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

- Outpatient services contributed to the hospital monthly safety dashboard.
- The current monthly hospital safety dashboard was on display in the outpatient staff room. Staff confirmed the safety dashboard was discussed in staff meetings.
- For our detailed findings on the hospital safety dashboard system please see the Safe section in the surgery report.

Are outpatients services effective?

Not sufficient evidence to rate

Currently we report on but do not rate outpatient services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- Outpatient's services followed the World Health Organisation (WHO) checklist for minor hand surgery procedures.
- We noted a set of up to date clinical briefings in a carrousel binder in the outpatient staff room for staff to easily refer to. The hospital audit programme was also on display and there was a range of planned audits specific to outpatient services for the current year.
- The hospital had recently developed its cognitive impairment adult framework (Alzheimer's society 2015) intended to guide clinicians in selecting the most appropriate cognitive assessment tool for the setting. Although the hospital's May 2019 policy included 'the outpatient phase' in the contents page, nothing appeared about this within the text of the policy.
- The April 2019 hospital safety update reported several changes had been made to the policy to include equipment suitability, clarity regarding ear, nose and throat, nasoendoscopy, and instructions on suitable environments for endoscopy via natural orifices.
- For our detailed findings on the hospital application of National Institute for Health and Care Excellence guidelines please see the Effective section in the surgery report

Nutrition and hydration

The hospital made available to patients enough food and drink to meet their needs.

- The hospital provided a restaurant/café on the ground floor of the building close to outpatient services. This offered a range of hot and cold food and drinks including meat free dishes.
- The outpatient service had a hot drinks machine and cold-water dispenser in the main waiting area.

Patient outcomes

- **Outpatient services were developing ways of monitoring the effectiveness of care and treatment but not yet using the findings to improve them.**
- The physiotherapy service recently began encouraging patients to record their immediate satisfaction level (FFT criteria patient experience questionnaire) with a therapy session on a tablet device as they left the department. The service could report patient satisfaction levels by therapist this way. This data the hospital sent us for May 2019 was from only 17 respondents. This was very positive with most patients scoring that they would be likely and extremely likely to recommend the service. This represented very low base line figures at this time with which to judge performance.

- Since 2016 the physiotherapy service had been working on establishing measurable patient outcomes from effectiveness of the Joint Schools (shoulder, hip and knee) run by the service.
- We saw for example, reports of shoulder class audits from 2017 to the end of 2018. By the October to December 2018 audit the service reported; 'the shoulder class was effective for the type of patients included in the class currently. However, after discussion it was decided that the shoulder pain and disability index (SPADI) outcome measure did not represent the meaningful goals of each individual patient. We therefore decided to: include an overall rating of how well the patient feels their shoulder is functioning overall; update the information provided to the patients as well as the class content to allow for easier progression of the exercises included and to aid in the compliance of the exercises at home'.
- Managers told us outpatient services were looking at ways it could measure other outcomes.
- The hospital had staff dedicated to the mandatory Joint National Registry data submissions and to patient reported outcome measures (PROMS). The hospital had achieved the Quality Data Provider Award for National Joint Registry for 2018 and 2019 for 99.5% compliance. PROMS were collected for hip and knee replacement and more recently for breast implants and cataract surgery. The PROMS committee met once each month.
- Staff told us the hospital collection percentage of PROMS data was not as high as others in the independent sector. Consultants did not look at the collective data so did not appreciate the potential benefits. There had been efforts over the past two to three years to improve awareness and interest, for example the hospital had managed to arrange a visiting expert speaker in the near future to address consultants. Key staff had been sent to a recent conference.
- Staff had identified the additional difficulty of getting patients to complete the PROMS questionnaires. This led to changes to the point in the patient pathway where they were asked to complete it.If a patient had not already completed a questionnaire by the time they attended joint classes in outpatients, they were now asked to register to do so then.
- It was too early to assess if this change had significantly improved the uptake.
- For our detailed findings on the hospital monitoring of patient outcomes please see the Effective section in the surgery report

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 monitor the effectiveness of the service.

- The staff appraisal year for the provider runs from January to December. Data from the showed by 1 February 2019, 33% of nurses and 33% of health care assistants within outpatient and diagnostic and imaging services had undertaken their annual appraisal. This represents a strong start to the year's programme.
- Agency staff undertook the hospital induction programme.
- The outpatient service ran a specific staff induction programme that included a supernumerary period of one month and competencies that had to be attained and assessed.
- Nursing staff confirmed they had specialist phlebotomy, trace test allergy (TTA), aseptic dressings and wound care skills and their competencies were up to date.
- The hospital reported it was supporting three of its physiotherapists to complete a Master of Science (MSc) qualification to enhance the expertise within the department.

Multidisciplinary working

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

Good

Outpatients

- Nursing staff told us they worked closely with consultants to support individual patient care plans.
- Consultants told us nursing, therapy, reception and administrative services were well run to support the team work needed to provide the clinics and manage the flow of appointments.
- Managers told us monthly clinical effectiveness meetings, attended by outpatient senior staff were multi-disciplinary. The pre-operative assessment sister would also trigger a multidisciplinary meeting when the hospital was expecting a patient with learning disabilities or living with dementia and outpatient staff would attend these.
- The hospital was actively involved in the local Partnership Assurance Group (PAG) which comprises representatives from local NHS and private providers who voluntarily come together to work in partnership with the key aim of securing care for patients which is both safe and of good quality. Meetings have a particular focus on safety performance and intelligence regarding staff and consultants and was established following a high-profile case involving poor consultant practice across multiple providers in the area
- All joint replacement patients took part in joint school which the hospital described as a bespoke training session run by an in-house lead nurse, pharmacist, physiotherapist and occupational therapist.

Seven-day services

- Outpatient's clinics were offered from 7.30 am to 9pm week days and on Saturday mornings. This ensured that there was availability of appointments outside of normal working hours.

Health promotion

- We saw leaflets on healthy weight and lifestyle were available to patients in the main waiting area.
- The hospital café offered salads and fresh fruit.
- For our detailed findings on the hospital health promotion please see the Effective section in the surgery report.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Capacity Act 2005.** They knew how to support patients who lacked the capacity to make decisions about their care.
- The five-key principles of the Mental Capacity Act appeared in the Spire patient passport, part of the hospital's cognitive impairment framework. Outpatient services staff we spoke with were able to tell us the substance of these principles and how they might apply them.
- Outpatient managers told us the practice around obtaining formal consent for procedures varied between consultants with some taking the patient's consent within outpatient clinics, after diagnostic tests when they chose their surgery date with the consultant. Consent was then checked again at the pre-operative process usually two or three weeks later. Where a patient wanted to consider their options prior to making a booking, a consent form was signed on the day of the operation by the consultant prior to any treatment.
- For our detailed findings on the hospitals approach to cognitive impairment please see the Effective section in the surgery report.

Are outpatients services caring?

Good

We rated caring as **good.**

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. For example;

- Every patient we spoke with told us staff in all roles were kind, attentive and interested in them.
- Patients responded on our comments cards as follows; 'the staff were all fabulous, especially the nurses (pre and post surgery)…I felt listened to'. 'The service could not be better, excellent. The staff were wonderful, made me feel so relaxed and comfortable, it was a pleasure to meet such a diligent and respectful staff. The staff were attentive to anything I

Good

Outpatients

said. It was a lovely, safe environment. Thank you'. 'I was very happy with the staff, very nice and friendly and very caring. Put me at ease. I was listened to, even if I am a chatterbox '.

- We observed patients being greeted warmly by reception staff, nurses and consultants. Any person who appeared to be unsure of where they were going was approached by a member of staff including the matron if she was passing.

Emotional support

Staff involved patients and those close to them in decisions about their care and treatment.

- Electronic imaging reports from diagnostic services were shared with patients during consultations.
- Patients told us, with their agreement; partners or relatives and friends were welcomed to participate in their consultation.
- One patient who completed a comment card on the physiotherapy service they received said, 'I received treatment for damage to my leg from a fantastic member of staff, outstanding care and attention to my needs with a great sense of humour during a very difficult period of my life'.

Staff provided emotional support to patients to minimise their distress.

- Nursing staff were able to provide us with a recent example of how they had engaged a patient's small children in role play within their treatment session as they could not be left unsupervised in the waiting area.
- Nursing staff were able to provide us with a recent example of how prior to their appointment, they had made a quiet room and some toys available to relatives of a small child who arrived distressed at anticipating a blood test.
- The hospital had a consultant psychologist for cosmetic surgery services. Outpatient staff told us they could access this service and refer any patient if necessary.

Are outpatients services responsive?

Good

Service delivery to meet the needs of local people

The hospital planned and provided services in a way that met the needs of local people.

- The hospital provided outpatient services for adults and children. Outpatient services offered appointments on weekdays from 7.30am to 9pm and on Saturdays from 7.30am to 2pm.
- Children were not treated at the hospital as inpatients but attended certain outpatient clinics such as audiology. Clinics saw only children who had been referred by their GP.
- The hospital provided services to privately funded patients and NHS funded patients. The majority of patients were privately funded.
- During March 2018 to February 2019 there were 43955 total number of outpatient attendances of which 1185 were children and young people between 0 to 18 years (these figures provided by the hospital are for outpatients and diagnostic and imaging services).
- There were 36268 attendances of patients who were between 18-74 years old and 6502 attendances were patients who were 75 plus years old.

Data from the hospital for 2018/19 showed outpatient clinics comprised the following activity:

- Ear, nose and throat (ENT) 3.53%
- Gynaecology 5.32%
- Cardiology 3.33%
- Orthopaedics 26.85%
- Urology 2.85%
- General surgery 5.88%
- Plastics 3.66%
- Neurology 1.25%
- Gastroenterology 1.90%
- Other 37.39%

Good

Outpatients

- The service offered a nurse led clinic in bloods, dressings and wound care.
- There was a physiotherapy and rehabilitation centre. The hospital had implemented a sports and musculoskeletal medicine consultant service within the physiotherapy department. It offered functional movement screening and joint schools for patient to attend before hip, knee and shoulder surgery.
- The cancer centre offered services for inpatient and outpatient care. This included holistic needs assessments, care planning and treatment summaries to GPs.
- Patients could access services provided by the hospital through an online patient appointments system. Spire GP and consultant on line booking was through the provider's own website. There was a direct bookings portal for insurance Companies.
- The hospital had a dedicated outpatient's appointment service. Booking staff told us each patient was booked into an initial appointment within 2-3 weeks of a GP referral. There were dedicated slots available for NHS patients and many consultants had mixed private and NHS clinics for example 28 out of 34 orthopaedic consultants saw NHS patients.
- For our detailed findings on the hospital planning and providing services that met the needs of local people please see the Responsive section in the surgery report.

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**.**

People could access the service when they needed it.

- The outpatient department was on the ground floor of the hospital near the main entrance and reception. It was accessible for people using mobility aides. Free car parking was available directly outside of and around the hospital building, with 10 dedicated disabled parking bays. The nearest public transport service was from a local train station by a taxi drive.
- Wheelchairs were available at the hospital door for patients use while visiting the outpatient services. The hospital had two accessible toilets for people with disabilities.
- The outpatient reception area had an audio loop system in place and reception counter at an appropriate height for seated patients. Bariatric seating was available for patients or visitors that needed it.
- The environment was appropriate, and patient centred. It was comfortable with sufficient space and seating. A further waiting room was available within the physiotherapy suite. There was also a play area for children in a corner of the main waiting area.
- The service was busy throughout the two days of our visit. Staff confirmed this volume of patients was usual. We noted there were insufficient toilets for outpatients to use. The three available single toilet rooms were located on the main passage way where people were constantly coming and going, and the toilet doors opened directly onto it. We saw people waiting outside these doors, including parents with prams and small children. This compromised people's privacy and created a bit of obstruction on the passage way.
- The main outpatient waiting area was calm and well organised and although the service was continually busy, everyone we saw was able to take a seat. Nurses and consultants came into the waiting area personally to call, greet and collect their patients.
- Patients were able to book in and get directed from the main and the outpatient reception when attending pre-operative and cancer services. This was so they were not left to find the area they needed.
- Nursing staff told us they rarely saw patients who were specifically vulnerable such as those with autism or learning disabilities. They did see some patients who were living with early stages of dementia or other cognitive impairments.
- Outpatient staff were aware they could seek advice and support from the hospital dementia champion whose role was to promote multidisciplinary team working for patients living with dementia.

Good

Outpatients

- Patients we spoke with said the consultant or nurse they saw had given them sufficient time to ask questions and repeated information if necessary. There were patient health information leaflets available in the main waiting area.
- There was a 'quiet room' indicated on the clinic board each day where patients could wait if they found busy environments distressing or needed emotional support before or after a consultation or treatment. The outpatient reception desk was well staffed, and receptionists or nursing staff were able to fetch patients from the quiet room or the café if necessary.
- Staff had access to the interpreter service for patients either by phone or face to face if arranged in advance.
- For our detailed findings on referral time to treatment and access to cancer outpatient services please see the Responsive section in the medicine and the surgery report.

Access and flow

People were offered appointments within a reasonable time of referral and seen on or near the time of their appointment at the service. Staff kept patients informed if appointments or clinics were delayed.

- When we arrived unannounced for our inspection we found all outpatient clinics were running as scheduled and consultant and nurse led clinics were running to time.
- The outpatient service had recently audited its adult and paediatric waiting times within the department for a sample of 117 patients. This showed 52% were seen early or on time; 37.7% were seen within 15 minutes and 10.3% were 'other'.
- Each of the nine patients we spoke with across the two days of our visit told us they were not kept waiting more than a few minutes for their appointment when they arrived for their clinic.
- Local managers told us where clinics were delayed or had to be postponed it was usually due to consultants being unavoidably delayed by their NHS trust duties elsewhere. Nursing, clerking and reception staff confirmed patients were contacted in advance where possible to rearrange appointments or offer a different consultant. If patients had already arrived staff offered them choices of waiting, seeing another consultant where possible or re scheduling an appointment.
- The hospital had recently started incident reporting clinic cancellations. Data for the middle of April to the middle of May 2019 showed eight incidents of clinic cancellations involving a total of 28 patients (one incident did not state the number of patients affected). None of these were cancelled on the day of the appointment. The hospital had rated each one as 'avoidable'. This data was scheduled for discussion at the July 2019 clinical effectiveness meeting where an action plan for improvement was to be agreed.
- Referral to treatment times between May 2018 to April 2019 were as follows:

  Admitted patients (all specialities), percentage admitted with 18 weeks, average 73.6%. The registered manager pointed out that these figures were relatively low because of orthopaedic work they were doing to support a local trust. They carried out 25-30 hip and knee replacements which have been on long waiting lists at the trust, which carried on to Spire figures.

  Non-admitted patients (all specialities), percentage treated within 18 weeks, average 91.5%.

  Incomplete pathways (all specialities), percentage waiting less than 18 weeks, average 92.9%

  For our detailed findings on access to services and flow through services please see the Responsive section in the surgery report.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- Outpatients were made aware of the hospital's complaints and concerns procedures through several methods including through the hospital web site, posters within outpatient services and leaflets.
- The hospital overall reported it had received 81 complaints from February 2018 to March 2019.

Good

Outpatients

- The outpatient manager talked us through an example of a recent outpatient complaint through the electronic recording procedure. This was about a procedure delayed due to staff sickness at that time. The service apologised and concluded more effective communication could have avoided the grievance.

Are outpatients services well-led?

Good

We rated well-led as good.

Leadership

The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.

- The outpatient's services manager was a nurse, and a member of the head of department team who reported to the deputy matron. The matron was a member of the senior management team.
- Leaders were visible and outpatient staff confirmed they were approachable.
- Outpatient services were managed by clinical staff who reported to the deputy matron. The hospital's matron's office was within the outpatient waiting area.
- Staff we spoke with told us the leadership of the outpatient services was good.
- For our detailed findings on leadership within the hospital please see the Well Led section in the surgery report.

Vision and strategy

The provider had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

- The hospital vision was 'to be recognised as a world-class healthcare business and to be the first choice for private healthcare for patients, consultants and GP's in the West Midlands'.
- For our detailed findings on the service's vision and strategy please see the Well Led section in the surgery report

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Each of the nine patients we spoke with said they felt confident the service would be honest and open if it made any mistakes with their care and treatment.
- We saw a poster in the outpatient staff room detailing the role and contacts details of the hospital 'freedom to speak up guardian'. This is a member of staff any one can go to if they have concerns about quality and patient safety and feel they cannot share them with their manager.
- We noted in the outpatient's staff room a poster offering staff a few simple steps of a strategy for not taking home the stress and worry of a working shift, called 'before you go home'.
- Staff we spoke with across a range of roles told us they felt proud to work in the hospital and were committed to be the first choice for private healthcare and GPs in the West Midlands.
- For our detailed findings on culture within the service please see the Well Led section in the surgery report

Governance

The provider used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. For example;

- The outpatient manager and staff nurses contributed to the hospital governance structures and arrangements. The outpatient manager convened bi-monthly team meetings. They attended the monthly head of department meeting including the clinical effectiveness committee, the quarterly clinical governance meeting that reported to the medical advisory committee (MAC) and the resuscitation and critical care quarterly meeting.

- The hospital told us the administration manager had started to use the electronic incident reporting system in April 2019 to log and monitor clinic cancellations by consultant within four weeks of the cancellation. This was to identify and report on any patterns that could be addressed with the senior management team.
- For our detailed findings on the governance arrangements within the service please see the Well Led section in the surgery report.

Managing risks, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

- The outpatient manager contributed data to the hospital clinical score card and dashboard populated by the clinical governance lead nurse.
- Heads of department including the outpatient manager attended an incident report 'huddle' each Thursday morning with the clinical governance lead nurse.
- When we arrived unannounced for our inspection visit on Tuesday morning we saw the end of an outpatient safety 'huddle' held prior to and reporting to the hospital wide safety meeting at 9am each day.
- We saw up to date information on the outpatient staff governance notice board. This included the top five hospital risks. The outpatient services risk register was managing two 'amber 'rated risks at that time; blood sample mislabelling and consultants updating patient records. The manager told us these were reviewed each month with the clinical governance lead nurse.
- For our detailed findings on the systems in place for management of risks please see the Well Led section in the surgery report.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- Outpatient services were beginning to collect patient satisfaction data and metrics around waiting times within the department and clinic cancellations.
- Staff were committed to recording any safety or quality incidents and near misses.
- For our detailed findings on the systems in place for collecting, managing and using information to support activities please see the Well Led section in the surgery report.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

- The hospital wide staff survey results were posted in the outpatient staff room. Hospital wide feedback for improvement from the staff survey showed a common theme where better understanding of the resource needs of departments was required from the senior management team. The team scored highly for staff saying they could rely on colleagues in their team to be there for them if they needed help or support and for feeling valued by their colleagues.
- Consultants ran a programme of workshops with GP's to keep them up to date with clinical procedures available at the hospital.
- The hospital was beginning to set up patient focus groups, but we heard no specific plan for outpatient experience.
- For our detailed findings on the systems in place for engagement please see the Well Led section in the surgery report.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong.

- To address the incidents within the outpatient services of repetitive human error with labelling blood samples the hospital had created two dedicated phlebotomy health care assistant roles to focus on these tasks.
- The physiotherapy department was a pilot site for an electronic delivered patient reported experience measure. The final version was implemented in the department in November 2018 and provided monthly feedback through the governance structures.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had Dignity Champions, their aim was to look at their own departments, discuss with their colleagues to gain insight into how people felt when at their most vulnerable whilst in hospital and identify any improvements.
- Dignity champions also looked at ways of how they could communicate respectfully supported by the National Dignity Council.
- Patients had access to the Spire patient discharge survey to inform the hospital of their experience and the hospital used this feedback to learn and improve.
- Patient forums were established to review areas of concern raised and to give patients a voice.
- Little Aston actively promoted the 'Declare your Care' campaign and encouraged patients to talk if patients had a concern.
- During our inspection we observed the hospital's resuscitation huddle. This involved all clinical bleep holders to meet at a dedicated base within the hospital. At the resuscitation huddle all staff were allocated a job during a resuscitation event, this was implemented to ensure everyone knew what to do prior to any emergency scenarios.
- The service produced 48-hour flash reports. 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.
- Staff in all the areas we visited were able to describe specific arrangements for involving patients with special needs and their families, in planning and providing care and treatment. During our inspection we saw one patient with learning difficulties who had arrived for a walk about tour with their parent, to see the hospital, meet staff and speak with patients who had undergone the same procedure, followed by a full MDT meeting to discuss patients' best interests.
- We spoke with staff in the pre-assessment clinics who showed us a new design of a 'bare non-disposable' covers to use as an additional dignity coverage for patients, for example patient undergoing an electrocardiogram (ECG) who may not want to be exposed.
- The hospital was actively involved in the local Partnership Assurance Group (PAG) which comprises representatives from local NHS and private providers who voluntarily come together to work in partnership with the key aim of securing care for patients which is both safe and of good quality. Meetings have a particular focus on safety performance and intelligence regarding staff and consultants and was established following a high-profile case involving poor consultant practice across multiple providers in the area.
- The chemotherapy suite achieved 5* Macmillan Quality Environment Mark in 2018. (This is a framework for assessing whether cancer care environments meet the standards required by people living with cancer.)
- The lead chemotherapy nurse was a member of the local Cancer Alliance (an expert advisory group run by NHS England.) This enabled the service to be kept up-to-date with local clinical guidelines, Cancer Alliance updates and competency frameworks.
- The breast care specialist won a national Spire 'Inspiring people award' for setting up the, 'Living with and Beyond Cancer Group'. The group was jointly facilitated by Consultant Clinical Psychologist and Clinical Nurse Specialists in cancer. The group aimed to help patients prepare for their future post diagnosis, identified their concerns and supported their needs.

Outstanding practice and areas for improvement

- The hospital had achieved the Quality Data Provider Award for National Joint Registry for 2018 and 2019 for 99.5% compliance.

Areas for improvement

Action the provider SHOULD take to improve
The provider should:

- Ensure the endoscopy service apply a consistent approach to decontamination processes and hand hygiene.
- Ensure all staff are aware how to assemble sharps boxes correctly.
- Consider completing the hospitals policy for its Cognitive Impairment Adult Framework to include 'the outpatient phase' as indicated as intended by the contents page.
- Consider how more accessible accommodation could be provided for the audio clinic.
- Consider how more patient toilets could be provided for outpatient services and privacy improved.
- Consider how front-line outpatient staff could encourage patients and visitors to cleanse their hands.
- Consider updating the flooring in room 63 (chemotherapy suite) to meet HBN 00/10- part A (flooring).