Spire Leeds Hospital

Quality Report

Jackson Avenue
Leeds
West Yorkshire
LS8 1NT
Tel: 0113 269 3939
Website: www.spirehealthcare.com/leeds

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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?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Spire Leeds Hospital is operated by Spire Healthcare Limited. The hospital has 88 inpatient beds. Facilities include eight operating theatres, an eight-bedded level two critical care unit, a chemotherapy unit, outpatients' departments, an eight-bedded children's ward and diagnostic and imaging facilities.

The hospital provides surgery, including cosmetic surgery, medical care including chemotherapy, high dependency care for adults, services for children and young people, and outpatients and diagnostic imaging. We inspected all these services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection from 10 to 12 January 2017, along with an unannounced visit to the hospital on 24 January 2017.

Summary of findings

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

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

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

We rated this hospital as good overall.

We found good practice in relation to surgery, medicine, critical care, children and young people and outpatients and diagnostics:

- There were sufficient qualified, experienced and skilled staff to meet people's needs in most areas. The service managed staffing effectively. Staff teams and services worked well together to deliver good quality care.
- The hospital had systems and processes in place to protect people from avoidable harm. There were systems for incident reporting. Staff knew how to use these and learning was shared to prevent reoccurrence.
- We found care and treatment supported good patient outcomes and was based on the best available evidence. There were clear pathways of care and staff were able to recognise and respond to warning signs of deteriorating health.
- The service met national indicators for referral to treatment (RRT) waiting times. The service worked closely with local commissioners and NHS providers to meet the needs of the local population. The service considered the individual needs of people in some areas, including those living with dementia and those with learning disabilities.
- Senior managers were visible, approachable and promoted a fair culture. Staff felt listened to and said the hospital was a great place to work. There was a clear vision and strategy. Staff were fully engaged with changes in the hospital and patients were encouraged to suggest improvements.

There were governance systems in place to ensure oversight of quality, performance and management of risks.

- Radiology services were able to access electronic images held by other healthcare providers without any delays and reducing the need for re-imaging.

We found areas of outstanding practice in relation to caring:

- All staff demonstrated a very caring approach to their patients. We saw all patients were treated with dignity and respect and feedback from patients was consistently positive. The approach to care was patient-centred and all staff demonstrated a high level of commitment to ensuring patients had a positive experience. We heard of numerous examples where staff had gone the extra mile to ensure patients had a positive experience.
- We saw staff in endoscopy had sourced special theatre shorts for patients undergoing endoscopies and colonoscopies to maintain patients' dignity as much as possible.

We found areas of outstanding practice in relation to responsiveness and well-led in medicine:

- Partnership working ensured patients could access counselling, holistic therapist, cosmetic services, palliative and pain services as well as hospice care to meet all of their individual care needs.

There were areas where the provider should make some improvements, to help the service improve. These were:

- The provider should ensure the safer steps for surgery, which includes the WHO checklist, is consistently adhered to.
- The provider should ensure the senior management team and the medical advisory committee take note of actions and matters from other groups, such as the paediatric steering group, within the hospital.
- The provider should ensure there is a robust process for document control for documents produced at the hospital.

Summary of findings

- The provider should ensure that appropriately trained staff undertake incident investigations.
- The provider should ensure audits or checks of the National Early Warning System (NEWS) include correctly calculated scores.
- The provider should review the process for recording and sharing learning from near miss incidents.
- The provider should continue to implement measures to improve fasting times for patients.
- The provider should risk assess situations where one registered children's nurse is caring for children on the ward.
- The provider should review the chaperone policy and the admission and discharge policy in relation to children to ensure the requirements are clear for chaperones and age of children admitted.
- The provider should monitor did not attend (DNA) rates and have a robust system for recording and following up children who did not attend appointments.
- The provider should ensure that all records are completed in line with hospital and professional standards including the provision of care plans for patients identified at high risk of falls or developing pressure ulcers.
- The provider should review their local audit programme in the outpatient's department.

Ellen Armistead

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	Outstanding ☆	Medical care services were a small proportion of hospital activity. The main service was oncology. Some of the services were delivered on the same wards as surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as outstanding because it was outstanding in caring, responsive and well-led and good for safe and effective.
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, responsive and well-led. We rated caring as outstanding.
Critical care	Good ●	Critical care services were a small proportion of hospital activity. The hospital had an eight-bedded high dependency unit providing level 2 care. The main service was elective post-operative recovery. 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.
Services for children and young people	Good ●	Children and young people's services were a small proportion of hospital activity. The main service was elective surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led.
Outpatients and diagnostic imaging	Good ●	Outpatients and diagnostic imaging was a large proportion of hospital activity. We rated this service as good because it was safe, responsive and well-led. We rated caring as outstanding. We inspected the effectiveness of the service, but did not rate it.

Summary of findings

Contents

Good

Spire Leeds Hospital

Services we looked at

Medical care; Surgery; Critical care; Services for children and young people; Outpatients and diagnostic imaging;

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Background to Spire Leeds Hospital

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

The hospital opened in 1989 and has been under varied ownership during that time. Since 1 October 2010, the hospital has been in the ownership of Spire Healthcare.

The hospital has had a registered manager in post since 1 October 2005. The hospital director has been in post since 2005.

The hospital also offers cosmetic procedures such as dermal fillers. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, and specialist advisors with expertise in surgery, theatre management, paediatrics, radiology, out patients' management, medical nursing and governance. The inspection team was overseen by Cathy Winn, Inspection Manager.

Information about Spire Leeds Hospital

The hospital had two mixed gender adult wards, one for day cases with 18 beds and one for overnight inpatient stays with 38 beds; a critical care unit (level 2 care) with eight beds; a children's ward with eight beds; an oncology day unit with six day case chairs and a large outpatients' area, including physiotherapy.

Outpatients covered a wide range of specialities. The highest activity was orthopaedics (29%), general surgery (14%), plastic surgery (10%) and ear, nose and throat (ENT) at 5%. The hospital saw children from babies (10kgs and over) to age 18 years. In outpatients, 6% of the activity was related to children's attendances.

The hospital also provided a range of diagnostic and imaging radiology services including digital radiography, digital mammography and ultrasound. There was also magnetic resonance imaging (MRI) and computerised tomography (CT) scanning.

There was on site pathology services providing pathology and blood transfusion services to other hospitals in the group in the area.

Spire Leeds hospital is registered to provide the following regulated activities:

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

During the inspection, we visited outpatients including the physiotherapy department and radiology departments, Wards 1 and 2, the critical care unit, the children's ward, the operating theatres including endoscopy and the oncology day unit. We spoke with 92 members of staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We held focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed members of the senior management team and the chair of the medical advisory committee. We spoke with 22 patients and seven relatives. We reviewed ten emails from patients regarding their recent care and treatment at the hospital. We also received 47 'tell us

Summary of this inspection

about your care' comment cards which patients had completed prior to and during our inspection. We also reviewed 66 sets of patient records including 14 medication administration charts.

There were no special reviews or investigations of the hospital ongoing by the CQC at the time of the inspection. There had been one unexpected death which occurred in 2016. This was being reviewed by CQC and the inspection gave an opportunity to follow up on the action plan, which had resulted from the incident.

The hospital has been inspected four times; the most recent inspection took place in December 2013, which found the hospital was meeting all the standards of quality and safety it was inspected against.

Activity:

- In the reporting period June 2015 to July 2016, there were 10,935 inpatient and day case episodes of care recorded at the hospital; of these 40% were NHS-funded and 60% were other funded.
- Twenty per cent of all NHS-funded patients and 27% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 76,053 outpatient attendances, including children, in the reporting period; of these 71% were private or other funded and 29% were NHS-funded.

Over 300 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked a one week on and one week off rota. There were 70 employed registered nurses including registered children's nurses, 29 operating department practitioners and care assistants and 118 other staff including receptionists, catering and administration staff. Bank staff were also employed. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety in the 12 months prior to our inspection:

There had been no never events reported. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

There had been 645 clinical incidents reported. These were rated as no harm (497), low harm (80), moderate harm (61) and seven were severe harm including expected and unexpected deaths.

There had been no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) and no incidences of hospital acquired Meticillin-sensitive Staphylococcus aureus (MSSA). There had been no incidences of hospital acquired Clostridium difficile (C.diff) and no incidences of hospital acquired E-coli.

Fifty-nine complaints had been received by the hospital.

Services accredited by a national body:

- Sterile Services - ISO13485:2003 EN ISO13485:2002 accreditation valid until March 2019.
- Joint Advisory Group on GI endoscopy (JAG) accreditation applied for – inspection due in April 2017.
- The pathology department was accredited with the United Kingdom Accreditation Service (UKAS).
- Macmillan quality environment mark (MQEM).

Services provided at the hospital under service level agreement:

- Cytotoxic drugs service
- Interpreting services
- Security
- Radiation protection service
- Cataract surgery
- Maintenance of medical equipment
- RMO provision
- NHS care and treatment and organ retrieval
- Multidisciplinary teams for cancer patients
- Transport services
- Medical secretary 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

We rated safe as good because:

- The service showed a good track record in safety. There had been no never events. Most incidents reported resulted in low harm. Staff understood their responsibilities to raise concerns and report incidents.
- Lessons learnt from incidents were shared with staff and we saw evidence of changes in practice to prevent reoccurrence.
- There were sufficient qualified, skilled and experienced staff to meet people's needs in adult areas. The hospital had introduced a dependency tool to ensure staffing levels in adults areas were in line with patient's needs and national recommendations.
- The hospital was visibly clean and we observed staff complying with infection control policies. No cases of hospital acquired infections had been reported. Surgical site infection rates for orthopaedic surgery were below the rate of other independent acute hospitals.
- Staff were 100% compliant with all mandatory training topics.
- Systems and processes in medicines management, patient records and the monitoring, assessing and responding to risk were reliable and appropriate.

However:

- The five steps for safer surgery safety checklist based on the World Health Organisation (WHO) checklist was not consistently performed or embedded in practice.
- The hospital used different systems for recording 'near miss' incidents. There was potential for missed opportunities for wider sharing of learning.
- Patients identified as high risk of falls and at risk of pressure ulcers did not always have written prevention care plans in place.
- Some equipment in theatre was rusty and the theatre doors did not close properly. The hospital had a refurbishment plan in place for 2017 to address these issues.
- The policy for chaperoning children for consultations was unclear which meant children might not be chaperoned by an appropriate person.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Policies and procedures and care and treatment were planned and delivered in line with current evidence based guidance. These were all easily accessible to staff.
- The service participated in some local audit and audit within Spire Healthcare. Clinical score cards were used to monitor compliance and effectiveness.
- Staff received a high level of support to maintain and develop their professional skills and knowledge.
- Staff assessed patients' nutritional and hydration needs and met these in a timely way. Pain relief was offered in a timely manner and staff checked its effectiveness.
- All staff had received an appraisal.
- Staff teams worked together effectively to deliver patient centred care. We saw evidence of effective multidisciplinary team working between allied health professionals, nursing staff, medical staff and administration staff.

However:

- Patient fasting times prior to surgery were not in line with national best practice guidelines, which meant patients were starved for longer than necessary periods. The wards were aware of this and making changes to improve performance.
- Very few local audits were taking place in outpatients.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Staff always considered patients' individual preferences and needs. They were motivated and inspired by leaders to deliver high quality, person-centred, holistic care and treatment.
- There was a clear person-centred culture where staff focussed on patients' emotional needs and helped them cope with their care and treatment.
- There were many examples of staff doing more than was expected for patients to ensure they had a good experience.
- Feedback from patients and relatives was consistently very positive about all aspects of care. Care had exceeded their expectations as they had been kept informed of their treatment and progress and were involved in the decisions made.
- Patients and relatives said communication was better than other hospitals they had attended and they had been put at ease by the staff.
- All staff consistently communicated with patients in a kind and compassionate way, promoted their dignity and respected their privacy.

Summary of this inspection

- Patient satisfaction surveys showed 100% of patients were extremely likely or likely to recommend the hospital.
- Patient-led assessments of the care environment (PLACE) for privacy, dignity and wellbeing within the hospital scored higher than the England average.

Are services responsive?

Good

We rated responsive as good because:

- Care and treatment was planned and coordinated with other services. Access to care and treatment was managed effectively to take account of peoples' individual needs.
- Unplanned admissions to critical care, transfers out to NHS acute hospitals and unplanned returns to theatre were not high when compared to other independent acute hospitals.
- From July 2016 to December 2016, the hospital met national indicators for referral to treatment (RTT) waiting times.
- Staff took account of the different individual needs of people using the service, including those living with dementia.
- The hospital responded to complaints in a timely manner, involving the patient and their families when appropriate. Learning from complaints was used to improve the quality of care.

However:

- Accessibility for patients with disabilities in the outpatient's department could be improved.

Are services well-led?

Good

We rated well-led as good because:

- There was clear nursing leadership within services to lead effectively. Staff had confidence in the leadership and could relate to the hospital's strategy, vision and values.
- There was a supportive and open culture at the hospital. Senior managers were approachable and valued staff's opinions. Staff felt able to raise concerns and were confident that they would be dealt with appropriately.
- There were high levels of staff and patient engagement and satisfaction. Actions were taken as a result of patient feedback.
- Staff spoke positively about the culture at the hospital and were proud of the job they did.
- Staff felt supported in their roles and were committed to delivering high quality care and treatment to patients.

However:

Summary of this inspection

- We saw examples where information regarding document control on key documents was absent or incomplete.

Outstanding ☆

Medical care

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are medical care services safe?

Good ●

We rated safe as good.

Incidents

- The hospital reported no expected or unexpected patient deaths related to medicine from July 2015 to June 2016.
- The hospital reported no never events related to medicine from July 2015 to June 2016. 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. We saw in the quarterly governance report for quarter two, from April 2016 to June 2016 there had been one incident of a bacteraemia (blood infection) in an oncology patient requiring readmission and treatment. We saw there had been one medication error, which had been reported in August 2016.
- We saw these had been reported as serious adverse events and had been appropriately investigated using root cause analysis (RCA). We saw duty of candour had been applied and patients were kept informed in both incidences. The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support.
- The hospital used an online software system for reporting incidents. Staff in oncology and endoscopy could describe the process for reporting incidents and gave examples of occasions when they had done this.
- Staff we spoke with told us they received key messages and learning from incidents in a number of ways such as through newsletters and team meetings. We saw evidence in meeting minutes that lessons from incidents were cascaded to staff.
- Staff also told us they received an email if any immediate action was necessary following an incident.
- Staff we spoke with were aware of the duty of candour regulatory duties and described their responsibilities relating to it.
- Staff in endoscopy and oncology gave us examples of the types of occurrences they would consider reportable incidents and near misses. These included medication errors and equipment failures.

Clinical Quality Dashboard or equivalent

- See information under this sub-heading in the surgery section.

Cleanliness, infection control and hygiene

- We saw that all clinical areas were visibly clean and tidy.
- We saw staff adhered to the 'arms bare below the elbows' policy and we saw staff wash their hands appropriately after patient contact.
- In the endoscopy unit, we saw personal protective equipment (PPE), including disposable aprons, gloves, theatre hats and masks were available to staff decontaminating endoscopes.
- We saw alcohol hand sanitiser available throughout clinical areas and in patient bedrooms to enable staff and visitors to decontaminate their hands.

- The hospital audited staff compliance with expected use of hand hygiene sanitiser as part of its infection prevention and control (IPC) programme. Audits in the oncology unit in February 2016 showed the area was compliant with expected use.
- Hospital managers told us they were reviewing this type of audit and had started implementing observational audits of handwashing as a more appropriate measure of compliance.
- We saw infection prevention and control (IPC) issues were discussed at team and governance meetings and advice and guidance concerning IPC was sought appropriately.

Environment and equipment

- We checked equipment in the endoscopy and oncology areas and found evidence of electrical testing and regular maintenance. Maintenance contracts were in place and staff told us the company responded quickly if anything needed repair.
- Staff told us they had access to all the equipment they needed.
- We saw endoscopes were washed and decontaminated on site and the endoscopy unit had a fully equipped room for staff to be able to do this.
- Staff in endoscopy told us the endoscope storage cabinet was regularly maintained and fully fitted with alarms. The staff told us a more efficient washing system was currently being installed.
- We found there were processes in place to quality assure the cleaning of scopes and there had been no problems to date. Staff explained what they would do if a protein test came back indicating a scope had not been properly decontaminated and showed us scope use was fully traceable, through an IT system as well as inpatient records.
- Washers were tested weekly for microbes and staff told us there was a clear escalation policy if a sample came back positive.
- We observed records of protein tests, traceability records and maintenance logs.
- The oncology unit was fully compliant with a waste audit on 07 November 2016.
- The sharp's bin audit in May 2016 showed the oncology unit was 87.5% compliant due to a bin being unlabelled.
- We saw correct segregation and handling of waste including cytotoxic waste. Staff we spoke with could describe the process for dealing with a spillage of cytotoxic drugs and spill kits were available.
- The endoscopy unit was situated in the main theatre area and accessed the main theatre resuscitation trolley. There were alarms in place to raise a cardiac arrest call and staff told us theatre staff would respond immediately.
- There were emergency call bells in the oncology unit and a resuscitation trolley was available. We saw records indicating the trolley and equipment were checked regularly.

Medicines

- We saw medicines including controlled drugs were safely stored in locked cupboards in the oncology and endoscopy units.
- Chemotherapy medicines were delivered to the hospital already prepared. These medicines were only released to the department after an appropriately trained member of the pharmacy team had checked them.
- We saw evidence that medication incidents and near misses were reported as incidents in the oncology unit.
- We saw there was a process in place to ensure safety of cytotoxic medicines through ordering, receipt, storage and administration. The processes minimised and managed the associated risks of these drugs. Ordering and checking on receipt was undertaken by a pharmacist, who checked all individual treatments received against recorded treatment plans. Processes were in place to return unused drugs to the provider if a patient treatment was unexpectedly cancelled or changed and the medicine could not be used before its expiry.
- We saw records indicating medication reconciliation took place. Drugs were logged in to and out of the storage area when they were received and when they were taken to the oncology unit for administration.
- The nurses told us there were always two nurses present when chemotherapy was checked and administered. This was in line with good practice guidance.
- We saw in endoscopy and oncology staff undertook daily monitoring of room and fridge temperatures. Staff were able to tell us what actions needed to be taken if temperatures went outside of recommended range. We saw records were completed to demonstrate these checks happened daily when the units were open.

Medical care

Records

- We saw records on the oncology unit were a mixture of paper and electronic records following the recent introduction of two IT systems to standardise care and delivery of chemotherapy. We observed an oncology admission assessment was undertaken using a paper based pathway and some of this information was entered onto an electronic system to enable multidisciplinary notes and chemotherapy treatments to be recorded. Staff and managers recognised that this practice held minimal risk as staff had access to all parts of the records at all times. The hospital was working towards implementing a single patient record.
- We saw the pathway used for oncology patients included a number of risk assessments such as nutrition, venous thromboembolism (VTE) and risk of pressure damage.
- We saw notes were stored securely in all areas we visited.
- We reviewed five sets of records of patients who had accessed the breast care service. All notes were fully completed, legible and contemporaneous. We saw evidence of two-stage consent, which was completed in all instances.
- Endoscopy staff maintained manual tracking and traceability records of the endoscopes. Each entry logged the patient details, the procedure carried out and the endoscope used.
- We looked at four electronic and two paper records on the oncology unit and found risk assessments were completed fully and consent was obtained in all cases.
- We saw oncology pathways were holistic covering treatment, risk assessments, pain, side effects and services and therapies to help patients cope emotionally with their condition and potentially altered body image.
- We looked at five sets of records on each of the two wards and found they were completed to a high standard. We saw two of these records were for post-operative endoscopy patients and these contained traceability stickers for the scopes used.

Safeguarding

- See information under this sub-heading in the surgery section.
- All staff we spoke with understood their roles and responsibilities with regard to protecting vulnerable adults and children and knew how to escalate any safeguarding concerns. All staff could correctly identify the hospital's safeguarding lead.
- All staff in the oncology and endoscopy units were up to date with adult and children's safeguarding level three training.
- Female genital mutilation (FGM) was included in the hospitals safeguarding training. Staff were aware of FGM and understood their responsibilities to report any cases.

Mandatory training

- See information under this sub-heading in the surgery section.
- All staff in endoscopy and oncology were fully compliant with mandatory training.

Assessing and responding to patient risk

- The nurses completed an oncology nursing assessment as part of a specifically designed care pathway for oncology patients. Patient assessment included information about the risks of chemotherapy and how these risks were managed.
- A patient having an endoscopy may have the procedure carried out under sedation. Endoscopy staff ensured medicines were available in case a patient had an adverse reaction to sedation.
- In the oncology unit, emergency medicines, including extravasation kits were available for use. An extravasation kit is equipment used to remove an intravenous (IV) drug or fluid that has leaked from a vein into the surrounding tissue. Staff were aware of the procedure for managing extravasation and the procedure to follow.
- Anaphylaxis kits for treating a severe allergic reaction to medicines or treatment were accessible to both endoscopy and oncology. The kits had the contents clearly marked and were in date.
- Chemotherapy spillage kits were available in the oncology department.
- The lead nurse in oncology had developed a comprehensive information booklet for patients attending for chemotherapy and a pocket guide for patients regarding mouth care to prevent infections and manage any oral symptoms arising as a side effect from medication.

Outstanding ☆

Medical care

- The hospital used the National Early Warning System (NEWS) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We found this was appropriately used in the oncology unit. We saw there were protocols in use in endoscopy, which identified types of patients who needed additional monitoring during their procedure.
- Staff in oncology were aware of extravasation (fluid leaking into body tissue) and adverse reaction to chemotherapy and were able to tell us what actions they needed to take in these situations.
- Blood samples were taken from chemotherapy patients for toxicity levels prior to each treatment, in accordance with clinical guidelines and to reduce the side effects and harm from cytotoxic medications.
- The hospital used a neutropenic sepsis pathway and ward staff and the registered medical officer (RMO) had access to this on the wards, out of hours and at weekends. Oncology patients had direct access to the service 24 hours a day and were admitted to the ward for symptom control or if complications such as sepsis occurred. Staff told us there was always an oncologist on call at weekends and they knew who this would be each week. The ward staff had access to a triage tool to help them determine if a patient needed to come to the hospital for assessment.
- Medical and nursing staff in endoscopy completed the five steps for safer surgery safety checklist based on the World Health Organisation (WHO) checklist. We observed one procedure where this was used appropriately and saw completed checklists in two other records.
- Staff in endoscopy were aware of the risks associated with endoscopic procedures and were able to tell us what actions they would take should an emergency arise. There was a bleep holder for resuscitation calls. The resuscitation trolley and assistance came for the main theatres, which was adjoining the endoscopy unit.
- Emergency drugs and anaphylaxis boxes were available in the endoscopy and oncology units. There were different coloured anaphylaxis boxes for adults and paediatrics.
- Oncology patients were given clear information regarding signs and symptoms of sepsis. They were advised to immediately contact the department if open or the hospital ward if these were experienced. Patients were admitted directly to the ward for emergency treatment of sepsis or for symptom control if necessary. Ward staff could contact the consultant directly in hours or out of hours for advice on emergency treatment.
- Refer to surgery for details of emergency transfers to other providers.

Nursing staffing

- The ward staffing arrangements are reported in the surgery core service report.
- Ward managers told us they were able to plan staffing around booked activity and were able to adjust staffing levels according to relatively predictable patient needs and acuity.
- Within oncology, we saw from rotas there were always at least two registered nurses on duty, which was in line with National Cancer standards and acute oncology guidelines.
- Staff worked annualised hours and this helped with flexibility to cover busier periods or when there was sickness or absence.

Medical staffing

- See information under this sub-heading in the surgery section.
- The RMO on duty or the nursing staff could access the on-call consultant if a patient contacted the hospital ward for help, advice or if they needed admission out of hours.
- There was a consultant on-call 24 hours seven days a week.
- Staff told us they always knew which consultant to call and the oncologists cross-covered for each other's holidays and other absences.

Emergency awareness and training

- See information under this sub-heading in the surgery section.

Are medical care services effective?

Good ●

We rated effective as good.

Evidence-based care and treatment

- We saw staff had access to evidence based policies and pathways and staff told us they kept up to date through local, regional and national networks.
- The oncology staff and breast care nurses had links into specialist forums and attended relevant events and conferences when they could. They had established good relationships with local partner organisations as a means of keeping up to date with advances in practice and for professional support and advice when needed.
- Staff told us they received bulletins from the Spire healthcare office, which highlighted new NICE guidance, national patient safety agency (NPSA) alerts and updated corporate policies.

Pain relief

- We saw nurses discussed pain with patients when assessing them prior to commencing treatment.
- Nurses monitored a patient's pain using a numerical pain scale. We observed staff closely monitored patient's pain levels during a procedure and provided appropriate support.
- Patients were also given information about pain relieving medications and other ways to promote comfort or manage side effects of treatment.
- We saw nurses in the oncology unit asked about patients' comfort regularly.
- Staff offered patients undergoing a gastrointestinal endoscopy a throat spray to reduce discomfort and / or intravenous sedation, to minimise any discomfort or pain.
- Specialist nurses told us one of the hospices was offering Spire staff an update regarding palliative pain management. The hospital was hoping to develop links with the pain management team at the local NHS trust for advice and support if needed.
- A consultant told us they routinely used carbon dioxide for procedures, to inflate the bowel, in preference to air, as this was better for patient comfort as it dissipated more quickly following the procedure.
- Nitrous oxide was available for patients in the endoscopy treatment if procedures were particularly distressing and painful.
- Medical staff performed colonoscopies under intravenous sedation if necessary.

Nutrition and hydration

- Nutritional needs of patients were assessed as part of a patient's pathway assessment prior to commencing chemotherapy.
- The oncology staff offered patients food and refreshments throughout the day. The catering team prepared meals on-site and catered for special dietary needs such as gluten intolerance, vegetarian options or halal meals.
- Senior managers said that if a patient required a nutritional assessment, this service was available as a same-day referral.
- We observed administrative staff asking patients if they would like any hot or cold drinks.

Patient outcomes

- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS.
- The hospital did not have Joint Advisory Group (JAG) accreditation for endoscopy services at the time of our visit. However, we saw the unit had prepared and submitted evidence to JAG and was awaiting a visit in April 2017 to decide whether the accreditation could be awarded. The lead nurse we spoke with told us of the preparatory work for the accreditation, including the implementation of an electronic reporting system and was confident that JAG accreditation was a realistic target.
- The hospital was an accredited Bowel, Breast and Gynaecology Cancer Centre.
- The hospital's accreditation submission for breast services on 31December 2016, showed that 85% of patients had received the triple assessment of consultation, needle biopsy and imaging all at one visit. The audit also looked at numbers of clinics offered, types of cancers seen and operations performed.
- The service submitted information to the national cancer registry.
- Oncology patients were discussed in a multidisciplinary team (MDT) meeting at a local NHS trust, and this provided opportunity for peer review and benchmarking.
- Audit information presented in the April 2016 to June 2016 quality governance report showed 93% of breast cancer cases were discussed at the multidisciplinary team.

- The hospital had been awarded the Macmillan Quality Environment Mark (MQEM).
- The hospital had a clinical audit programme and participated in national audits where relevant. The clinical audit timetable showed planned audits for; oncology neutropenia sepsis tool, oncology treatment plans, UK oncology nursing society (UKONS) and oncology triage.
- Patients underwent an MRI scan following two cycles of adjuvant treatment to see if the treatment was working.
- The hospital audited against policy compliance. A key performance indicator (KPI) clinical scorecard was used to measure and benchmark services to monitor performance and encourage improvement. Areas achieving a red or amber rating had action plans developed to ensure improvement.

Competent staff

- Staff and consultant appraisal was 100% in the last 12 months.
- Staff told us the hospital was very supportive of continuing professional development. They were supported with training and able to attend specialist conferences where relevant.
- Both breast care nurses had undertaken a breast care accredited course and the registered nurses in oncology had undertaken specialist training.
- Oncology and breast care nurses told us they could access training through links with partner organisations such as the local hospices and a local provider of complementary therapies. Staff told us when the local provider of complementary therapies had speakers at their meetings they opened up the sessions to Spire Healthcare staff.
- Staff told us medicines management competency was reviewed and assessed annually.
- Both breast care nurses had undertaken a breast care accredited course and the registered nurses in oncology had undertaken specialist training.
- The hospital had recruited another clinical nurse specialist to provide care for cancer patients on pathways other than the breast cancer pathway.
- The hospital had sourced advanced communications training for the oncology nurses and clinical nurse specialists.
- We saw new members of staff on the oncology unit received an induction and training and support from an experienced member of staff until they had been assessed as competent.
- Staff told us any issues with competence or non-compliance with providing evidence of competence, registration and indemnity required for practicing privileges was treated seriously and overseen by the medical advisory committee. We saw the hospital withdrew privileges from consultants who did not meet their requirements.
- The lead nurse for oncology had prepared an information folder as a resource for ward staff who may take calls from oncology patients out of hours. The folder contained a neutropenic sepsis pathway and triage tool. The oncology nurse had provided training to ward staff regarding the use of this pathway and tool.
- Staff in oncology had received competency-based training regarding administration of blood transfusions and the lead nurse was intending to become a trainer for other hospital staff.
- Staff in the oncology unit had been trained to safely handle and administer cytotoxic medicines and appropriately manage extravasation (leakage of intravenous medications into the tissue).
- The staff we spoke with had received anaphylaxis training and knew what to do if allergic reaction occurred.

Multidisciplinary working

- We found evidence of effective multidisciplinary working and pathways from audits and in the records we reviewed. Administrative, ward, endoscopy and oncology medical and nursing staff worked well together to ensure patient pathways were effective and patients had the best experience possible. The hospital also employed specialist nurses who worked closely with the oncology nurses, ward staff and doctors to ensure effective support for patients throughout their pathway.
- Nurses told us about good working relationships and direct referral pathways to local hospices, palliative care, pain specialists, lymphoedema services, breast physiotherapy and cosmetic services such as wig services and specialist providers of underclothing and prostheses for patients with breast cancer.
- All patients with cancer were referred into MDT meetings, which were usually held at one of the local

NHS hospitals. The patient's lead consultant and the specialist nurse (for example the breast care nurses) attended these meetings to discuss each patient's diagnosis, treatment and progress. The multidisciplinary team provision from the NHS trust was governed by a service level agreement (SLA).

- Patients' cases were referred into the MDT and discussed at diagnosis, following surgery and during oncology treatments.
- Staff told us how they linked with other independent healthcare providers, such as those providing radiotherapy and chemotherapy at home, to ensure patients' individual pathways were seamless.
- Staff were able to refer oncology patients to a clinical psychologist.

Seven-day services

- See information under this sub-heading in the surgery section.
- Patients from oncology and endoscopy were able to contact the hospital out of hours via telephone if they wanted to discuss any concerns or report any adverse side effects.
- Direct admission could be arranged at any time, 24 hours a day, seven days a week, if a patient's symptoms required this.

Access to information

- All staff had access to policies, procedures and guidance through the hospital intranet.
- Multidisciplinary team meetings held off site were able to access relevant results, x-rays, referral letters and last consultant letter as these were scanned and sent to the relevant administrator via secure email.
- The lead consultant and specialist nurse where relevant were always present at the MDT meetings, and were therefore able to give other information verbally.
- Patients received a discharge letter, which included the reason for their endoscopy procedure, relevant findings, and if any changes were required to existing medication. The letter also contained information regarding potential concerns and what to do if the patient had concerns, as well as details of follow up. A copy of the letter was sent to the GP and a further copy placed in the patient's medical records at the hospital. Letters to GPs for oncology patients were generated at point of discharge.
- Patients were discharged with advice leaflets about managing common problems after specific procedures and contact details for the ward if they needed any further advice.
- Staff told us ward staff could telephone the lead nurse for endoscopy or oncology if they needed advice out of hours, or the consultant on call.
- We saw ward staff had access to information folders prepared by the endoscopy staff and the oncology staff so they could refer to these if patients called out of hours to request advice. The endoscopy folder contained information about bowel preparation and fasting for scoping procedures. The oncology folder contained information regarding frequently asked questions, the neutropenic sepsis pathway and a triage tool to help determine if a patient needed to attend the hospital for assessment. Both folders contained antibiotic guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty

- Training records showed all staff had received training regarding mental capacity.
- We saw in medical records we reviewed that consent was a two-stage process and there was good documentation showing risks, possible complications and benefits were discussed. Consent was fully and correctly completed in all of the records we reviewed.
- We observed oncology patients were given detailed information to enable them to make informed choices and patients were asked for permission before nurses proceeded with any observations or interventions.
- We saw consent was checked in the endoscopy room as part of the five steps to safer surgery checklist.

Are medical care services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- One of the core values of the hospital was "Caring is our Passion" and we saw staff consistently demonstrating this throughout their patient care and efforts to improve patient experience.

Outstanding ☆

Medical care

- We found staff at all levels treated each other with high regard and in a caring manner; staff believed that this set the ethos for how staff treated patients.
- We found that staff at all levels and in all roles were caring and compassionate in their interactions with patients and treated them with dignity and respect at all times.
- Staff spoke compassionately about their patients and had a clear understanding of the impact that a person's condition and care had on their wellbeing and on those close to them, both emotionally and socially.
- We found relationships between people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
- Oncology staff told us, the majority of the time, the same nurse cared for the same patients at each visit. They said this enabled them to build relationships and they were able to recognise how patients were feeling either before, during or after treatment.
- We witnessed a holistic approach to patient care, with patients and their relatives being spoken to with respect at all times and in a manner they could understand
- We reviewed seven feedback cards from patients all of which were extremely positive. Patients told us staff were very caring, and treated them with kindness and respect. Words such as 'exemplary' and 'excellent' were used to describe staff at all levels.
- Feedback from patients who had endoscopic procedures was on display and this was extremely positive. Patients said staff made them feel at ease and made the procedure as pleasant as it could be.
- Patients told us staff always had time for them and they felt they "were in safe hands".
- We saw staff were attentive to patients' needs and comfort throughout treatments and considerate of potential body image changes.
- We found that the ethos of caring and compassion was reflected in the way services were planned and delivered throughout the hospital and at every stage of the patient journey. For example, the hospital provided access to telephones and Wi-Fi so patients could contact family or friends at any time if they wanted to.
- We saw staff in the oncology unit were concerned about patients' needs and well-being and gave encouragement to bring things to distract them while undergoing treatments.
- We saw staff in endoscopy had sourced special theatre shorts for patients undergoing endoscopies and colonoscopies to maintain patients' dignity as much as possible and had sourced and placed do not disturb signs on the treatment room doors to stop other theatre staff entering when a patient procedure was underway.
- We observed staff introducing themselves to patients and found they took patient feedback seriously and took action when appropriate.
- We saw staff adapted their communications to the needs of patients and spent time answering any questions they had.
- Feedback from the breast care nursing survey 2016 of patient experience was extremely positive in the areas of care and compassion provided by the breast care and oncology nurses. All patients (100%) rated the overall support from staff as very good on a scale of one (poor) to 10 (very good).
- The hospital's patient satisfaction survey in November 2016 showed 93% of patients were extremely likely to recommend the hospital and 6% were likely to recommend the hospital.
- In the same survey, 94% of patients felt the care and attention they received from nursing staff was excellent, 99% felt they were given enough privacy when discussing their care and treatment, 100% felt they were treated with respect and dignity while in hospital and 95% felt involved in decisions about their care and treatment.
- We spoke with patients and their relatives and friends. One patient told us they had changed their location of treatment from homecare to the oncology unit, as they were so impressed with the level of care the staff showed when they attended the unit for insertion of an intravenous device.
- Another patient and their friend told us the staff were very caring, knowledgeable and trustworthy. The staff welcomed her friend who came to help pass the time while having treatments.
- We found that staff took into account patients' preferences and personal choices when arranging their care and treatment and that patients were an active partner in planning their care. For example, we heard a consultant arranging a suitable time of appointment for an elderly patient who lived many miles from the hospital to ensure she was travelling during daylight hours and would be home before dark. Staff told us they had suggested to this patient that they might like to be

referred to another service that could provide follow up appointments nearer home. The patient had chosen to continue her follow up care and appointments at this hospital and with this team for as long as she was able, even though this meant her travelling a long distance for her care.
- Caring was evident in the way the staff worked together and with other agencies and providers to ensure the patient received holistic, personalised care.

Understanding and involvement of patients and those close to them

- We saw staff giving patients relevant information, both verbal and written so they could make an informed decision about their care and treatment.
- We observed that explanations and information was given in a way patients could understand and that nurses checked patients had understood the information they had been given. Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment
- Patients in the oncology unit told us staff kept them informed about their care, involved in any decision-making, and listened to them. Patients told us there had been sufficient time at their appointment for them to discuss any concerns they had.
- Patients were supported to involve their close relatives if they wished.
- Information was displayed and given to patients to take away to reinforce verbal information they had been given.

Emotional support

- We observed oncology nurses explaining to a new patient what support was available through the hospital and from other partner organisations. We saw how patients were advised about complementary therapies and cosmetics available to help with aspects of coping with altered body image.
- Breast care specialist nurses were available to offer emotional support to patients if needed. We saw these staff made themselves available to patients at points throughout their pathway. Patients were able to contact them up to five years after leaving the service if they had any subsequent concerns or questions.
- We observed a nurse initiating a pathway for chemotherapy with a patient who had recently been given the news they had cancer. The nurse demonstrated perception by eliciting what the patient already knew and how they felt. She invited the patient to communicate how much information they wanted and gave information in a way the patient could understand. The nurse demonstrated empathy and gave the patient opportunity to ask questions and be involved in choices regarding care planning.
- Patients were able to access psychologist support if needed.
- We observed signs prompting patients to request a chaperone if they would like one present when examined.

Are medical care services responsive?

Outstanding ☆

We rated responsive as outstanding.

Service planning and delivery to meet the needs of local people

- The service offered a range of oncology treatments, palliative treatments and care. We found the service was flexible, provided informed choice, continuity of care and was tailored around patients' individual needs.
- Medical care was provided at the hospital for private, insured and NHS patients. Oncology was the largest medical service. The hospital worked in partnership with the local NHS trust's regional cancer centre, local hospices and other independent providers to ensure a full range of services was provided to meet the patients' holistic needs.
- There was a service level agreement (SLA) in place to ensure cancer patients were discussed at the NHS trust's MDT meetings.
- The medical service offered consultation and treatment for oncology patients who were referred as new patients and follow up patients. There were six day-care chairs available within the oncology unit.
- Endoscopy services had provided waiting time initiative lists for a local NHS trust, although this source of referrals had recently been withdrawn as Joint Advisory Group (JAG) accreditation was not in place. The hospital staff had worked hard to meet JAG requirements and they were due to have their accreditation visit in April 2017.

Outstanding ☆

Medical care

Access and flow

- We found that oncology patients could access services in a way and at a time that met their needs.
- Between July 2015 and June 2016, the hospital had treated 980 oncology, (predominantly chemotherapy), 118 uro-gynaecology and 69 haematology patients. These were the largest medical specialities treated at this hospital.
- Between July 2015 and June 2016, the hospital had undertaken 1,326 upper gastro-intestinal and colorectal procedures, including endoscopies and colonoscopies.
- The hospital saw new patients and follow-up patients with cancer.
- Staff told us people were usually seen within one week of referral.
- The breast cancer quality survey 2016, indicated 100% of patients were seen within one week of referral, the service consistently exceeded the national cancer waiting time standard.
- There were one-stop clinics for patients with breast cancer so they could receive imaging and needle biopsy at the same visit as their consultation appointment; 85% of patients requiring triple assessment received this during their first visit and 100% of patients with symptomatic invasive cancer received the diagnosis within three working days of their initial assessment.
- Staff told us on occasions patients needed to return for diagnostic imaging but this was arranged at the patients' convenience and was usually the following day.
- The hospital was able to offer same day diagnostic radiology services.
- Cancer patients were followed up post treatment for five years. Breast care nurses told us that patients were encouraged to contact them at any time following their treatment for advice, support or signposting. We found evidence of post treatment follow up recorded in breast care records.
- Follow-up patients could ring to make an appointment and this was made within a day or two of calling. We heard a nurse in the oncology unit giving support and advice to a follow-up patient who had telephoned the unit and arranging an appointment for them to see the consultant.
- Staff told us how they worked with other providers to ensure patients were treated holistically. There were referral pathways in place to NHS providers, other independent providers including providers of healthcare at home and hospices for patients who were nearing end of life or required specialist palliative input.
- The hospital had taken action to stagger admission times to reduce time spent waiting for procedures.
- The endoscopy staff had made a business case for a secure endoscope trolley to improve the flow of endoscopy lists.

We heard telephone conversations between staff and patients where staff went out of their way to arrange appointments to suit patients working patterns and other individual needs.

Meeting people's individual needs

- We found the staff in this service had a proactive approach to understanding and meeting the needs of their patients.
- The nurses aimed to follow patients through their whole pathway from pre-assessment to treatment and through follow up care to be best able to assess and meet their individual care needs. This also enabled nurses to get to know family members and assess their care needs and provide support to them too.
- We saw there was clear and accessible information on admission and discharge for patients in oncology and endoscopy.
- The hospital provided translation services for languages other than English, hearing loops, British Sign language interpreters and patient information in braille.
- We witnessed the oncology unit's usual interpreter visit the department to inform staff that they were away for a few weeks and to ensure they had details for contacting the person covering in their absence.
- The catering department provided a range of food choices to meet individual's dietary needs and preferences. Food and drink was available at any time of day if a patient requested it.
- Staff we spoke with had received dementia awareness training and had an understanding of adjustments that may be needed for people with a learning disability.
- Staff told us a small number of patients had chosen the hospital as their preferred place of death in the last year and how these requests had been accommodated.
- Staff gave patients information about wig and cosmetic services and an independent provider who provided

free complementary treatments if they wanted to access them. We heard staff describe these services to patients to ensure they knew what the benefits were of accessing them and what help the other providers could give.
- Staff offered specialist treatment to patients who were concerned about hair loss as a side- effect of chemotherapy.
- Patients were discharged with advice leaflets about managing common problems after specific procedures and contact details for the ward if they needed any further advice.
- We saw breast care staff had changed the carrier bag they gave to breast cancer patients with information in it, as patients had felt the original bag identified their diagnosis to others from the wording on it.
- Partnership working ensured patients could access counselling, holistic therapist, cosmetic services, palliative and pain services as well as hospice care to meet all of their individual care needs.
- All areas were wheelchair accessible. Other environmental considerations have been reported in the surgery core service section.

Learning from complaints and concerns

- There were no complaints from patients specifically for the medical service.
- Staff we spoke with were aware of the complaints policy and felt empowered to try to address patients' concerns immediately.
- Staff were able to tell us about complaints received about their service and could tell us of changes they had made as a result.
- Staff told us and we saw from minutes of meetings that complaints, outcomes and learning were discussed at governance and staff meetings.
- We saw complaints were treated seriously and staff we spoke with viewed complaints as an opportunity to learn and improve the service they provided.

Are medical care services well-led?

Outstanding ☆

We rated well-led as outstanding.

Leadership and culture of service

- We saw strong leadership of the service from the hospital director who was supported by the hospital matron and heads of departments. The oncology department and endoscopy unit each had a senior nurse in post to lead the service provision on a day to day basis.
- We found the lead nurse for each department was very involved in the development and performance monitoring of their service.
- All staff spoke highly of the senior management team and felt they were visible, approachable and committed to delivering excellent quality services and patient experience.
- Staff we spoke with told us they were confident to challenge staff at any level, medical or nursing, if they were concerned about poor behaviours or practice. A member of staff gave an example of when she had done this and how this had been handled.
- Staff told us they felt the management team and clinicians responded appropriately and proportionately to concerns and took appropriate action, including capability and disciplinary action when necessary.
- We saw department leaders had worked hard with their staff to make improvements for the patients they care for.
- Staff told us they were very proud to work for the hospital and it was a friendly supportive place to work. We saw positive working relationships between staff. Due to the small size of the service, everyone knew each other's names and we observed friendly interactions between staff from all departments in the hospital.
- Staff told us the hospital was supportive of professional development and staff accessing accredited courses in their specialist fields.
- Staff felt the hospital had an open culture and they were encouraged to raise concerns and report incidents and near misses. Staff told us they were confident to raise concerns and gave examples of when they had done so.

Vision and strategy for this core service

- All staff we spoke with could describe the hospital's vision to be the flagship hospital within the Spire Healthcare group. All staff wanted to improve services for patients and gave examples of where they had made improvements.

- Although there was not a written strategy for each of the units, the nurse leaders in each of the areas we visited had a vision for improvements they wanted to make and could give examples of recent improvements they had made.
- The endoscopy department's vision was to attain Joint Advisory Group (JAG) accreditation for its endoscopy services and to be able to attract NHS endoscopy work.
- The breast care nurses wanted to develop a more suitable area for breaking bad news and to improve educational resources for patients.
- The oncology lead wanted to improve patient information and ensure the staff and department maintained up to date knowledge and expertise.

Governance, risk management and quality measurement

- The governance processes and ways in which quality is measured are the same throughout the hospital and these are reported in the surgery core service section.
- We saw up to date risk assessments and mitigations in each of the clinical areas we visited and staff were aware of the highest risks in their area.
- We saw from meeting minutes staff and consultants delivering medical care attended staff and governance meetings including the medical advisory committee.

Public and staff engagement

- Staff told us the hospital senior management team held regular staff forums to share information and discuss challenges and strategies.
- Staff we spoke with were engaged in the future of their services and the desire to be excellent providers of care.
- Some staff we spoke with were proud to have received recognition from their colleagues and managers for good work and achievement. Other staff had nominated colleagues for recognition.
- All staff we spoke with felt valued by the hospital, their line managers and the senior management team.
- We saw staff valued patient feedback and the hospital had recruited volunteers who had previously been patients.
- We saw 'you said we did' posters in endoscopy, which told patients about improvements made following their feedback. Improvements made included:
- consent being obtained from patients in clinic instead of just prior to endoscopic procedures
- ensuring pain expectations were discussed with patients before each procedure and included in the information leaflets patients were given on admission
- staggered arrival times to reduce waiting between admission and procedure.

Innovation, improvement and sustainability

- We found the service was encouraged to be innovative and strive for improvement. Staff gave us a number of examples where they had or were working towards improvements for patients.
- The oncology department had developed a comprehensive information booklet for patients accessing their services and a pocket guide for oral health to help prevent infection and enable patients to prevent and manage soreness in the mouth.
- The breast care nurses had developed a 'survivorship booklet' for breast cancer patients, to help them come to terms with their condition and treatment and the emotional impact of having and surviving cancer, and wanted to roll this out through their professional networks to other independent providers.
- The breast care nurses were also developing the use of electronic tablets as a teaching aid to demonstrate reconstruction techniques and outcomes to women undergoing surgery as part of their treatment for breast cancer.
- One of the Breast Care Nurses was nominated in 2016 for Yorkshire Inspirational Person of the Year by a patient.
- Spire Leeds Hospital were the first independent hospital in the UK to achieve Macmillan accreditation for cancer services.

Good

Surgery

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

Are surgery services safe?

Good

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

For example, in this section we cover the hospital's arrangements for dealing with risks that might affect its ability to provide services (such as staffing problems, power cuts, fire and flood) in the overall safety section and the information applies to all services unless we mention an exception.

We rated safe as good.

Incidents

- 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. There were no never events reported from July 2015 to June 2016.
- We reviewed incident data provided by the hospital. Between November 2015 and November 2016, 280 incidents were reported within surgery services. Of these, 173 caused no harm, 63 minor harm, 42 moderate harm and two severe harm.
- Between July 2015 and June 2016, there were five expected inpatient deaths and one unexpected death, which was an unplanned transfer to an acute NHS trust. The five inpatient deaths were related to oncology patients and staff reported they had chosen the hospital as their preferred place of death.
- We reviewed the root cause analysis (RCA) investigation relating to the unexpected death. A RCA is a structured method used to analyse incidents. The RCA had not been completed by staff with the appropriate training. Recommendations from the RCA included creating a management on call flow chart, reviewing the ward dependency staffing tool, reviewing of the critical care transfer policy and for the resident medical officer (RMO) to complete an evening ward visit to review patients. However, the RCA had not identified the incorrect calculation of the National Early Warning System (NEWS) score or the level of communication between the nursing and medical staff.
- We found gaps in the RCA and the subsequent action plan and had requested this was reviewed by the senior managers. A more robust plan had been developed as a result of this review.
- We saw evidence of lessons learnt from the unexpected death during the inspection. The hospital had introduced a dependency tool to assist in planning nurse staffing levels on the ward. There was a senior manager's on call flow chart displayed in ward areas and the RMO completed an evening review of patients. The critical care transfer policy had also been reviewed. However, audit of NEWS charts did not include checking the correct calculation although senior managers informed us this was planned for 2017.
- Three incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism

occurred from July 2015 to June 2016. For each VTE a RCA investigation was completed. We reviewed the RCAs and found the appropriate risk assessments had been completed.

- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the hospital's electronic reporting system. Staff we spoke with were able to describe the process of incident reporting.
- Staff understood their responsibilities to report safety incidents. However, if staff identified a near miss this was not reported on the hospital's electronic reporting system, but was recorded on a near miss event log. Although local action was taken, there were potential missed opportunities for wider organisational learning.
- We saw from meeting minutes a detailed review of incidents was a standard agenda item on the clinical governance committee minutes.
- Any lessons learnt from incidents were shared via team meetings, staff newsletters or by the ward sister to individual staff. Both wards had an incident file containing summaries of incidents and lessons learnt. There was a signature sheet for staff to confirm they had read the incident summaries. We saw examples of incidents from other Spire hospitals, which enable sharing of learning across the whole Spire group.
- We reviewed the theatre newsletter from 25 November 2016 and saw evidence of discussion about lessons learnt from incidents. Staff on the ward gave examples of lessons learnt including the introduction of intentional rounding following incidents of patient falls.
- We saw monthly incident management bulletins displayed on ward two, which showed the top three incident trends within the hospital.
- Staff we spoke with were aware of the requirements of the duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support. Staff knew about being open and honest with patients and families when things went wrong. We saw evidence of the duty of candour being implemented including the letter sent to the patient and discussions with the patient.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital collected and submitted data to the NHS safety thermometer. Results showed 100% harm free care between December 2015 and December 2016 with the exception of June 2016 (84%) and September 2016 (95%).
- The hospital used a clinical scorecard, which measured a number of key performance indicators reported every quarter. Results were benchmarked and tracked against the hospital group performance targets, so the information could be used for quality improvement.
- The hospital audited a range of indicators on their clinical scorecard and presented the results quarterly. Examples of the indicators included VTE risk assessment compliance, theatre starve times, effective discharges, NEWS, pain score, surgical site infections in hip and knee arthroplasties, unplanned return to theatre and critical care transfers. These were reviewed at the hospital's clinical governance committee and results were displayed in clinical areas.
- There were no incidences of pressure ulcers reported from July 2016 to September 2016.
- There were 2.9 patient falls per 1000 bed days recorded from July 2016 to September 2016. This was above the Spire target of less than two. The hospital was to display 'call don't fall' posters in patient rooms to prompt patients to ask for assistance.
- Venous thromboembolism assessments showed 100% compliance in the reporting period July 2015 to June 2016. This was better than expected when compared to other independent hospitals.

Cleanliness, infection control and hygiene

- The hospital had an infection prevention and control (IPC) lead and a team of IPC link workers in clinical and non-clinical areas.
- The infection control committee held quarterly meetings and the group reported to the clinical effectiveness and clinical governance meetings.
- The hospital reported zero cases of hospital acquired Meticillin resistant Staphylococcus Aureus (MRSA) and hospital acquired Clostridium Difficile (C. diff) in the reporting period July 2015 to June 2016. During the same reporting period, no incidences of Meticillin-sensitive Staphylococcus Aureus (MSSA) or E. coli were reported.

- Wards and departments were visibly clean. Housekeeping staff completed cleanliness checklists on the wards. We saw evidence of completed cleaning checklists in theatres, anaesthetic room and scrub room.
- Alcohol hand gel was available at the entrances to the hospital and in the inpatient and surgical unit. We observed staff using hand gel between patient contacts and all staff were compliant with 'arms bare below the elbows' policy.
- The hospital had changed its method of auditing hand hygiene. In June 2016 the hospital introduced observational hand hygiene audits, results from quarter three showed staff were 95% compliant, however, it was not clear which clinical area this related to. The results of the audits were reported quarterly through the IPC committee and clinical scorecards.
- Clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with hospital policy. Separate bins for clinical and domestic waste were evident throughout all areas visited.
- Staff followed the Spire Healthcare policy and local trust guidelines for screening of patients for MRSA. We saw the Spire Healthcare policy, which followed the Department of Health (DH) guidance for MRSA screening (2014). The wards had single rooms, which allowed isolation of patients if required.
- The hospital used equipment cleaning assurance labels to indicate re-usable patient equipment was clean and ready for use. We inspected commodes and found they were clean, labelled and ready for use. Clean equipment was stored in a separate clean utility room. All cleaning products and equipment were stored appropriately.
- The hospital carried out surgical site infection surveillance. Data supplied by the hospital showed there were 10 surgical site infections during the reporting period July 2015 to June 2016. Breast surgery reported three infections; two infections were reported in spinal surgery and two infections in upper gastrointestinal and colorectal. Gynaecology and urology both reported one infection. The rate of infections for spinal, upper gastrointestinal, colorectal, and urological procedures was worse than the rate of other independent acute hospitals we hold this type of data for.
- The infection control committee reviewed all infections; this included the input of a microbiologist. They had reviewed patient cases and found no themes had been identified to date.
- There were no surgical site infections resulting from primary hip arthroplasty, revision hip arthroplasty, primary knee arthroplasty, revision knee arthroplasty, cardiothoracic, cranial or vascular procedures. The rate of infections for other orthopaedic and trauma, breast and gynaecology procedures was better than the rate of other independent acute hospitals we hold data about.
- The pharmacy team carried out an audit of antimicrobial prescribing from September 2016 to November 2016, found practice was in line with local guidelines, and compliance was 100%.
- The hospital had a sterile services department (SSD). Theatre equipment decontamination was undertaken on-site. The SSD was ISO accredited. There were plans to replace one of the washers and this was on the hospital's risk register.
- We reviewed patient led assessment of the care environment (PLACE) results for the hospital from February 2016 to June 2016 and noted 100% for cleanliness. This was above the national average of 98%.
- Infection prevention and control training was included in the hospital's mandatory training programme. All staff had completed the training.
- The patient rooms did not contain clinical hand basins for hand washing which was not in line with latest guidelines. However, the space had been risk assessed and the room constraints were on the hospital risk register. Hand gel dispensers were available in all patients' rooms.

Environment and equipment

- The hospital had eight theatre suites. Four main theatres, two having laminar flow, a dedicated ambulatory care theatre, endoscopy suite, angiography suite and a minor procedures room situated within the outpatient's department.
- Resuscitation trolleys were easily located on the main corridors in each of the areas we visited. We checked the adult resuscitation trolleys in all clinical areas and found daily checks had been completed in line with best practice with the exception of the resuscitation trolley in theatre. Here we found checks were not completed on the 14 July 2016, 27 August 2016 and 28 November 2016.

- The Association of Anaesthetists of Great Britain and Ireland (2012) recommend a pre-use check of the anaesthetic equipment. We saw evidence of daily safety checks in line with best practice.
- We checked ten pieces of equipment including blood pressure machines, infusions pumps, cardiac monitors and suction machines. All equipment had visible evidence of safety testing and when servicing was next due.
- A sharps bin audit in February 2016 showed wards 1 and 2's compliance was 96% and 98% respectively. Areas of noncompliance were temporary closures were not in use when the bins were unattended which occurred in three out of nine cases on ward 1 and one out of eight cases on ward 2.
- In theatre four, we observed some pieces of equipment were rusty and extensive rust was visible on some storage trolleys. We also noted some defects to the walls for example, paint chipped to expose plaster and the theatre doors did not close properly. We raised this with the theatre manager who said there was a planned theatre refurbishment due to commence in April 2017.
- Theatre staff we spoke with said there were adequate stocks of equipment and we saw evidence of stock rotation to ensure equipment was used prior to expiry date. Staff said surgical instruments were available for use.
- During our unannounced inspection, we noted some theatres were overstocked and equipment not required for the list was stored on mobile trolleys. We discussed this with staff at the time who said there was insufficient storage. The hospitals theatre refurbishment plan aimed to improve the storage in theatre.
- We found flexible scopes used for difficult intubations did not have a record of when they were decontaminated. HTM 01-06 Decontamination of flexible endoscopes states flexible scopes should be used within three hours of processing unless stored appropriately. We raised this with the theatre manager and the hospital immediately purchased single use, disposable scopes the next day and the practice was changed immediately.
- A hoist was available for use if required on the ward. Bariatric equipment was also available on the wards and in theatres.
- The hospital obtained patient consent at pre-assessment to collect data and record breast implant prosthesis onto the hospital based implant register.
- On ward 1, some single rooms had fire escape doors, which were not alarmed. This meant an adult could exit the room without staff being aware. We discussed this with staff who said the rooms were used for day-case patients, and would not be used for patients with acute confusion or who were at risk of wandering.

Medicines

- Pharmacy staff provided a 24-hour, on-call service, seven days a week. The RMO was also able to access pharmacy and supply medications out of hours. The hospital had a policy to support this process.
- The hospital medicines management policy provided staff with information on obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medication.
- The hospital had a medicines management committee, which was chaired by representatives from the pharmacy department.
- We checked the storage of medications on the wards and in theatres. Medicines were stored in locked rooms, with access restricted to authorised staff. Emergency medicines were readily available and they were found to be in date. Intravenous infusions (IVs) were stored in a locked room.
- Medications requiring refrigeration were stored appropriately in fridges. The drugs' fridges were locked and there was a process in place to record daily fridge temperatures. We saw minimum and maximum fridge temperatures were recorded daily and were within the correct range. Staff could describe the process for reporting if the fridge temperature went out of range.
- Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register. We observed staff performing checks of control drugs in line with best practice. Records showed the administration of controlled drugs were subject to a second person check. After administration, the stock balance was confirmed to be correct and the balance recorded.
- We looked at the medicine administration records for 10 patients on the ward. We saw arrangements were in place for recording the administration of medicines and allergies were clearly documented. We found one

patient had been in hospital for six days and there was no evidence of a pharmacist review. On three charts, IV fluids were not signed for and on two charts; the batch number of the IV fluid was not recorded. On one chart, a new medication had been prescribed, but the time to administer had not been documented, therefore the medication had not been given. We raised this with the senior nurse on duty who asked the RMO to document the administration timing for the medication.

- Oxygen was prescribed for patients. However, on two charts, the target oxygen saturations for the patient were not recorded. Staff said the NEWS chart automatically set a target of less than 94%, therefore, if a patient's oxygen saturations were below 94%, this would trigger a score on the NEWS charts and appropriate action was taken.
- The pharmacy team carried out audits of the storage of medications and controlled drugs. No concerns were identified. Monthly audits of drug charts were completed to assess compliance with prescribing, completion and verification. In August 2016, the hospital was compliant with all areas and no concerns were identified.
- Staff in pre-assessment had guidance and had completed competencies for administering medication under patient group directions (PGDs). A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

Records

- All staff had access to IT and confidentiality policies relating to the safe transfer of data and images between services. The head of clinical services was the Caldicott Guardian for the hospital.
- All staff were required to complete information governance training every year. Training records showed 100% all of hospital wide staff had completed information governance training.
- Results from the nursing medical records audit from October 2016 to December 2016 were provided in the hospital's quarterly clinical governance report. Results showed seven areas were less than 75% compliant including, fluid fasting times, falls risk assessment on admission and reviewed post-operatively and manual handling assessed post-operatively. The audit results were to be discussed at the hospital's next clinical effectiveness meeting and an action plan developed.
- Appropriate risk assessments were completed for patients at pre-assessment. Staff completed fall assessments, Malnutrition Universal Screening Tool (MUST), VTE risk assessments and pressure ulcer risk assessments.
- We reviewed 13 sets of medical and nursing records on site and found they were legible and contemporaneous. Patient records were multidisciplinary and we saw the RMO, physiotherapist and nursing staff all documented in the same record.
- As set out in the consultants' handbook, consultants or their nominated deputy were expected to attend to every in-patient under their care at least once per day. We reviewed nine sets of records and found two did not contain daily entries from the patient's consultant either in the medical or nursing record. Results from the hospital's consultant medical record keeping audit showed from October 2016 to December 2016, 84% had an entry recorded by the consultant every day of the patient's stay.
- We reviewed 12 sets of nursing records and found all had the appropriate risk assessments completed for VTE, nutritional assessments, pressure areas and falls.

Safeguarding

- The hospital had systems and policies in place for the identification and management of adults and children at risk of abuse. A Spire Healthcare safeguarding vulnerable adults and children policy was available which set out responsibilities of staff. The lead nurse had updated the policy in December 2016. However, there was no evidence on the document to suggest it had been reviewed and ratified by the hospital's governance team.
- The paediatric lead and matron/head of clinical services were the safeguarding leads at the hospital. They were available for advice and support.
- The paediatric lead nurse had completed level three safeguarding training and represented the hospital at statutory health and social care safeguarding networks across the region.

- The paediatric lead nurse had completed a Masters module in safeguarding and was trained to level four in safeguarding. This allowed them to deliver face to face level three safeguarding training to staff locally.
- Consultants working at the hospital had to complete level three safeguarding children training and a record was kept of this on the practising privileges record. The hospital director monitored non-compliance of this and took appropriate action.
- All staff completed safeguarding adults level one and level two training and safeguarding children and young people level one and two training as part of their mandatory training programme. In addition, all qualified clinical staff had undertaken level three safeguarding children training. Training data provided by the hospital showed 100% compliance.
- We spoke with staff in theatres and on the ward; all staff could describe their role in relation to identifying and reporting a safeguarding concern. If unsure, staff said they would escalate this to the senior nurse on the ward or contact the safeguarding lead for advice.
- Female genital mutilation (FGM) was included in the hospitals safeguarding training. Staff were aware of FGM and understood their responsibilities to report any cases.

Mandatory training

- Mandatory training included; compassion in practice, controlled drugs, display screen equipment, equality and diversity, fire safety, food safety, health and safety, infection control, managing violence and aggression, mental capacity act, safe blood transfusion, safeguarding adults combined levels one and two and safeguarding children combined level one and two. In addition, all clinical staff completed safeguarding children level three training.
- Mandatory training was reported on the clinical scorecard and the senior management team tracked progress monthly. The training year ran from January to December. Data provided by the hospital reported 100% compliance with all mandatory training topics for 2016. Bank staff undertook the same mandatory training as permanent staff.
- All staff we spoke with confirmed they were up to date with mandatory training. Staff said training was accessible and they were given the time to complete training. The majority of training was completed via e-learning. Practical training sessions such as moving and handling and basic life support were face to face.
- Ward managers received quarterly emails of staffs' compliance with mandatory training.
- All RMOs were employed through a national agency and completed mandatory training with the agency. The hospital received confirmation of the training and kept a record of attendance. Consultant staff attended mandatory training at the local NHS trust, which was their main employer and this was evidenced and monitored through the appraisal process.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- The hospital had a corporate admission policy in place and patients were assessed at pre-assessment prior to surgery. We visited pre-assessment and saw appropriate risk assessments were completed, for example, VTE assessment and falls assessment.
- At pre-assessment, nursing staff used the American Society of Anaesthesiologists (ASA) risk grade to assess patients. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels, with level one being the lowest risk and level six being the highest. Any patient assessed as level three or higher was discussed with the anaesthetist. This process was clearly set out in the hospital's policy.
- The hospital had a service level agreement with a local NHS trust to transfer patients in the event of an emergency or if a deteriorating patient required an increased level of care.
- A RMO was on duty 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient's clinical condition.
- The hospital had sepsis guidance available for staff and a sepsis screening tool, which included a sepsis pathway.
- The hospital operated a 24-hour, on call service for unplanned returns to theatre. A team was available and would attend within 30 minutes.
- The hospital used the five steps for safer surgery safety checklist based on the World Health Organisation (WHO) checklist. This is an internationally recognised system of checks before, during, and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures.

- Results from the hospital's WHO surgical safety checklist audit from October 2016 to December 2016 demonstrated 94% average compliance with documentation and 87% average compliance via observational checks for procedures carried out in main theatres. An action plan was developed to address non-compliance and discussed at the medical advisory committee (MAC) meetings.
- During the inspection, we observed eight surgical procedures operations and reviewed 16 sets of patient records. In theatre, we found the WHO checklist was not consistently performed or embedded in practice. For example, we observed that the 'sign out' section was not verbalised or ticked as completed on the checklist. During another procedure we observed the anaesthetist had their back to the team and was looking at paperwork during the 'time out' section. When we reviewed the patient records, out of 16 sets the checklist was not fully completed in eight sets (50%). Compliance with the WHO checklist was highlighted on the hospital's risk register.
- The hospital used the National Early Warning Score (NEWS) to recognise deteriorating patients. NEWS scores were reported as part of the nurse handover process. Staff were able to describe the process for managing a deteriorating patient and the escalation process. Staff escalated deteriorating patients to the senior nurse and the RMO.
- NEWS scores were audited as part of the hospital's clinical score card. In quarter three of 2016, the hospital reported 100% compliance with NEWS. However, the process to audit NEWS was not robust. The audit did not include a check to ensure the patients' NEWS score had been calculated correctly. We raised this with the provider and the audit tool was updated to include this check and was due to be rolled out across the Spire Healthcare network from January 2017.
- We reviewed four sets of records for patients who had been transferred out of the hospital as they had become unwell. In each case, we saw the patient's NEWS score was correctly recorded, the patient had been escalated appropriately and all the correct actions had been taken. We reviewed a further seven NEWS charts for inpatients and found NEWS scores had been calculated correctly and escalated when appropriate.
- We reviewed 12 sets of nursing records and found all had the appropriate risk assessments completed. However, in three of these records, when the patient was identified as high risk, actions taken to reduce the risks were not documented and appropriate care plans were not in place. For example, in three sets of records patients were identified as having a high Waterlow score (used to assess a patient risk of developing a pressure ulcer). Preventative action taken to reduce the risk to the patient was not documented in the patients' care plan.
- Swab boards were not used in theatre to record swab counts. Staff used a paper record, which was attached to the patient's record. The Association for Perioperative Practice (AfPP) 2012 recommend provision of a dry wipe count board permanently fixed to the theatre wall. We reviewed the hospital's policy for swab, instrument and needle checking and found the hospital process was in line with their policy.
- There was a hospital policy in place for the emergency management of cardiopulmonary resuscitation. The hospital undertook regular simulated scenarios with clinical staff including cardiac arrest call, major haemorrhage and stabilisation in theatres.
- Staff had completed acute illness management training (AIM), immediate life support training (ILS) and advanced life support training (ALS). Of the staff working in theatre, six staff members had completed AIM training, 16 had completed ILS training and five staff members had completed ALS training. Of the staff working on the ward, 20 had completed AIM training, 31 had completed ILS training and seven had completed ALS training. The RMO had completed ALS training.
- The hospital was in the process of introducing mandatory acute illness management training for clinical support workers.
- At discharge, patients were given contact details for both wards and advised to contact if they had concerns. Results from the hospital's survey showed 98% of patients reported they were told who to contact if they felt they were worried about their condition after leaving hospital.
- Patients were risk assessed for VTE at pre assessment clinic, on admission to the ward and re- assessed within 24 hours of admission. Patients were discharged with information on deep vein thrombosis (DVT) signs and symptoms and given appropriate prevention.
- There was a security guard on duty at the hospital through the night.

Nursing and support staffing

- The hospital used a combination of the Shelford staffing tool and The National Institute for Health and Care Excellence (NICE) safer staffing guidance to plan staffing levels. This was to be evaluated.
- We saw from staffing rotas the wards used ratios of one registered nurse (RN) to five patients on an early shift, 1:6 on a late shift and 1:7 on a night shift.
- A weekly capacity meeting was held to review the following week's activity and plan staffing levels accordingly. Staff were flexed according to patient need and bank staff were utilised when required to ensure the appropriate number of staff were on duty.
- Staff held bed meetings every morning, Monday to Friday. The meeting included ward managers, theatre manager, the RMO, matron, pharmacist and clinical services manager. The meeting reviewed the number of inpatients, expected admissions and discharges, patient dependency and staff to patient ratios. Any staffing concerns were raised and addressed. Staffing levels were also reviewed later in the day and shifts were adjusted according to clinical need and theatre activity.
- The inpatient department had 44.7 whole time equivalent (WTE) registered nurses and 7.4 WTE health care assistants. The use of bank staff in the inpatient departments was lower than the average of other independent acute hospitals from July 2015 to June 2016.
- The theatre department had 16.57 WTE registered nursing posts and 17.5 WTE healthcare assistant and operating department practitioner posts (ODPs). The hospital had one ODP vacancy which was being recruited to.
- The use of bank and agency nurses in theatre departments had gradually reduced from 27% in July 2015 to 11% in June 2016. At the time of our inspection in January 2017, the use of agency staff in theatres was at 0% following successful recruitment.
- The use of bank and agency OPDs and healthcare assistants in theatre department was higher than the average of other independent acute hospitals. However, the percentage had reduced from 30% in July 2015 to 9% in June 2016.
- At the time of our inspection agency use in the hospital was at 0%.
- We observed the bed meeting and found it was well attended and any staffing concerns were discussed. However, the meeting did not include a safety brief. We raised this with the hospital director and on our unannounced inspection, the terms of reference for the meeting had been updated to include a safety checklist. This had also been added to the senior nurse daily sheet.
- Nursing handover took place twice a day, during the shift when staff changed. We observed a nursing handover, which took place by the patient's bedside. We saw the information shared was clear and concise. Staff discussed the patient's reason for admission, medical history, NEWS score, including urine output, medication and the plan for their hospital discharge.
- The hospital used volunteers in a variety of roles across wards and departments. Volunteers were DBS (disclosure and barring service) checked, undertook mandatory training and had specific policies for carrying out their roles. This ensured patients were kept safe.

Medical staffing

- All patients were admitted under the care of a named consultant. There were 331 consultants with practising privileges, who provided a range of specialities for patients at Spire Leeds Hospital. The term "practising privileges" refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there. Data showed all medical staff had their registration validated in the last 12 months.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care. They reviewed patients at weekends and were accessible out of hours. Consultants nominated a colleague to provide cover when they were not available. We saw a list of consultant cover on ward two.
- There was a RMO onsite 24 hours a day, seven days a week and a weekly rotation with a Monday handover. There was provision of an on-site residence for the RMO. The hospital audited night calls to the RMO. If the RMO was disturbed during the night, cover was made available the following day on request to the agency.
- The RMO felt well supported in their role and said consultants were accessible out of hours. Nursing staff described good working relationships with the RMO and consultants and felt they were accessible and patient's treatment plans were effectively communicated.

Good

Surgery

- There was an on-call rota for theatre staff and senior managers to support the out-of-hours service. Clinical staff had access to diagnostic and radiology services, which was available 24 hours, seven days a week to support clinical decision-making.
- All consultants and anaesthetists were required to be available at any point during their patient's admission. They had to nominate a covering consultant if they could not be contacted in an emergency or were not available to attend within 30 minutes.

Emergency awareness and training

- The hospital had a business continuity plan. This was available to staff on the hospital intranet. A hard copy was also kept on the main reception for use in the event of IT failure.
- The hospital had completed a desktop scenario for an infection outbreak and sudden loss of utility services.
- There was a hospital policy in place for the emergency management of cardiopulmonary resuscitation. The hospital undertook regular simulated scenarios with clinical staff including cardiac arrest call, major haemorrhage and stabilisation in theatres.
- The hospital ran fire evacuation tests and 100% of staff had completed fire safety training.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Policies and procedures had been developed and referenced to the National Institute for Health and Care Excellence (NICE) and national guidance. Staff said these were available on the intranet and easy to access. The service used standardised care pathways for specific procedures for example, hip and knee replacements.
- The hospital participated in national clinical audits including, patient reported outcome measures (PROMS), Commissioning for Quality and Innovation (CQUINS) and the National Joint Registry (NJR).
- Compliance with best practice guidelines was audited quarterly by the hospital. The hospital used clinical scorecards to monitor effectiveness. Examples of indicators audited included, VTE risk assessment compliance, unplanned return to theatre, theatre starves times, prosthesis best practice and surgical site infections in hip and knee arthroplasty. Any areas rated as red had an action plan in place and this was discussed at the weekly clinical effectiveness meeting.
- Clinical key performance indicators were reported every quarter. The results were used to benchmark and track performance against group performance targets. The results were discussed at governance meetings.
- The service recognised the need to develop a more substantial audit programme and focus on specific areas, for example, plastic surgery. Staff were meeting consultants to look at developing more local audits.
- The provider's sepsis guidance was written in 2015, based on national guidance. However, the guidance did not have a review date.
- The hospital had a Commissioning for Quality and Innovation (CQUIN) target for 2016/2017 for reducing the number of patients who smoked before surgery. This indicator reflected NICE guidance.
- The hospital collected data and recorded all breast implant prosthesis onto the hospital based implant register.
- The hospital's sterile services department was ISO accredited.

Pain relief

- Pain scores were recorded using the NEWS scoring system and were audited as part of the hospitals clinical score card. From July 2016 to September 2016, 100% of records had pain scores recorded.
- We observed staff reviewing patients' pain levels in the recovery area post-surgery and on the ward. Patients were offered pain relief in a timely manner and staff checked the pain relief administered had been effective.
- As part of the postoperative pain questionnaire, the hospital asked patients about their pain relief. From May to June 2016, 94% said they were offered pain relief regularly by nursing staff, 100% reported the pain relief was effective and 88.2% said their consultants had discussed their pain and how it should be managed.
- We observed staff discussing patients' pain relief and requesting reviews by the pharmacist and RMO if they felt patients' pain levels were not being managed effectively.

Nutrition and hydration

- Staff said they used the Malnutrition Universal Screening Tool (MUST) nutritional risk assessment to identify patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. We found MUST scores were completed in the records we reviewed.
- A variety of hot and cold food was available for patients. The hospital had access to food for patients out of hours and there was good choice for patients including vegetarian, gluten-free, lighter options and multi-cultural foods. All patients spoke positively about the food. We heard an example of staff going to collect a meal from a patient's favourite takeaway.
- Senior managers said that if a patient required a nutritional assessment, this service was available as a same-day referral.
- Patient-led assessments of the care environment (PLACE) scoring for the hospital from February 2016 to June 2016 showed ward food assessments scored 93%. This was above the England average of 91%.
- Results from the hospital's patient survey in November 2016, showed 71% of patients felt the quality of the food was excellent.
- The hospital had a dietitian who worked closely with the nursing team and the catering team to ensure patient's dietary needs were met.
- An audit of theatre fasting times was included in the hospital's clinical score card. From October to December 2016, only 32% of patients were fasted within best practice guidelines. This was below the hospitals target of 50%. Actions taken by the hospital included, adding information about fasting times to patient letters, reminding patients at pre-assessment about fasting times and improving communication between theatres and the ward.
- In order to improve compliance with pre-operative fasting, a local policy had been developed to standardise practice. We spoke with four members of staff about fasting times in line with best practice, one of these was not aware of the policy.
- We saw two patients in theatre who had been fasted for longer than the hospital policy of two hours for fluids. One patient had not had fluids for seven hours and 30 minutes and another had not had fluids for six hours.
- The hospital had implemented a working group to develop strategies to improve fasting times and was working with the MAC chair to educate staff and anaesthetists.
- We reviewed pre-admission letters and saw patients received clear instructions on fasting times for food and drink prior to surgery. This was individualised for each individual patient. Patients also received a leaflet entitled 'pre-operative fasting guidelines' to educate patients about hydration and nutrition prior to surgery. We saw checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- We reviewed six fluid balance charts and found they were accurately completed to show patient's fluid input and output.

Patient outcomes

- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS. Data was submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- From July 2015 to June 2016, there were 9,266 visits to theatre and 25 unplanned returns to theatre. In the same reporting period, the hospital reported 17 unplanned transfers of inpatients to other hospitals. The assessed rates of unplanned transfers and unplanned return to theatre (per 100 inpatient attendances) were not high when compared to a group of independent acute hospitals, which submitted performance data to CQC.
- In the reporting period from July 2015 to June 2016, there were eight unplanned readmissions within 28 days of discharge. This was not high when compared to a group of independent acute hospitals, which submitted performance data to CQC.
- The hospital audited the number of unplanned returns to theatre using their clinical scorecards. The results were reviewed at the hospital's clinical governance committee.
- The hospital participated in national audits for orthopaedic surgery, breast surgery, patient reported outcome measures (PROMS), and Public Health England surgical site surveillance.
- We reviewed PROMs data, which showed the hospital's performance was similar to the England average for primary knee and hip replacements (NHS patients) during the reporting period April 2015 to March 2016.
- In 2016, 99.4% of patients consented to the NJR database. This was better than the England average of 95% for independent hospitals.

- The hospital had achieved its CQUINS target annually.

Competent staff

- Data provided by the hospital showed 100% of staff had received an appraisal in the last appraisal year (January 2015 to December 2016).
- Staff described the appraisal process as a valuable experience and felt their learning needs were addressed. They were also given opportunities to attend courses to further their development.
- Staff described being supported in undertaking further learning to develop their skills and knowledge. We heard examples of different staff groups being supported by the hospital to complete courses. For example, nurse prescribing course, master's degree and day-case management courses. One member of staff said they had been supported "every step of the way" by the hospital.
- Housekeeping staff received British Institute of Cleaning Science training in September 2016. Two housekeeping supervisors were being supported in studying to diploma level.
- We reviewed nine sets of staff files and found there was an effective process in place for granting practicing privileges to consultants. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practice there.
- There were systems in place to review and withdraw the practising privileges of consultants. Any concerns about a consultant's practice would be discussed with the hospital director and MAC chair. Practising privileges were withdrawn in line with the hospital's policy in circumstances where standards of practice or professional behaviour were in breach of contract.
- No consultants had their practising privileges removed in the reporting period July 2015 to June 2016. However, we saw in the MAC minutes from September 2016, two consultants had their practising privileges suspended or withdrawn due to out of date appraisal and not being compliant with documentation. Consultants also had their practising privileges removed if they had not practiced at the hospital for 12 months.
- The hospital director and MAC chair liaised appropriately with the General Medical Council and local NHS trusts about any concerns and restrictions on the practice for individual consultants. Any concerns about a consultant would be shared with their responsible officer within their NHS employment.
- The RMOs were employed through a national agency. The agency was responsible for their ongoing training and provided continuing professional education sessions throughout the year. The chair of the MAC when required provided clinical supervision.
- New staff had an induction relevant to their role. Staff we spoke with said they had found induction comprehensive and it contained relevant information to help them carry out their role. Senior staff described spending time at other hospitals in the Spire Healthcare group for peer support.
- All new starters had a period where they were supernumerary in order to complete their induction programme with the support of a mentor.
- Agency staff completed an induction checklist.
- Nursing staff said they had received information and support from the hospital about professional revalidation.
- Data provided by the hospital showed 100% compliance rate of verification of registration for all staff groups working in inpatient departments and theatres.
- Some healthcare assistants escorted patients from recovery to the ward. Staff had spent time in theatre and we saw evidence of staff competencies. Staff said they only escorted patients who had a local anaesthetic and sedation or, patients following a general anaesthetic who had not received controlled drugs.
- Clinical staff had individual competency files. We reviewed the files of staff in recovery and saw evidence of completed competencies with managerial review in airway management, extubation, pain management, patient control analgesia (PCA), epidural and injectable medicines.

Multidisciplinary working

- We saw evidence of a multi-disciplinary team (MDT) approach to patient care and treatment. Staff described effective working relationships across all the areas we visited.
- We observed effective multidisciplinary working from different professionals during the morning bed meeting.
- Joint pre-assessment clinics with nursing staff and physiotherapists were held for patients undergoing hip and knee replacements.

- Staff working in pre-assessment liaised closely with patients' GPs. Staff completed memory screening and would refer patients to their GP if they identified a concern.
- We observed physiotherapy staff working closely with nursing staff to prepare surgical and orthopaedic patients for discharge and provide follow-up therapy. Physiotherapy staff worked closely with external community services and would contact the service if patients had ongoing therapy needs.
- Staff described good working relationships with consultants and said they were always available for advice if required.

Seven-day services

- There was a RMO in the hospital 24 hours a day with immediate telephone access to on-call consultants.
- Access to physiotherapy services were available on a Saturday and Sunday and provided an on call service 24 hours, seven days a week.
- Theatre services were available from 7.30am to 9pm, Monday to Friday and Saturdays from 7.30am to 4pm.
- There was an on-call rota for theatre staff and senior managers to support the out-of-hours service. Clinical staff had access to diagnostic and radiology services, which was available 24 hours, seven days a week to support clinical decision-making.
- The pharmacy was open Monday to Friday 8.30am to 5pm. On Saturdays, it was open 9am to 12pm. Out of hours a 24-hour on-call, seven days a week service was available.

Access to information

- Staff said they had access to the information they needed to deliver effective care and treatment to patients in a timely manner. Staff could access test results and diagnostic imaging.
- All staff had access to policies, procedures and guidance through the hospital intranet.
- On discharge, staff completed an electronic discharge summary for patients. This was printed and a copy was sent to the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Spire Healthcare consent to investigation or treatment policy was available for staff to refer to.
- The hospital had a corporate policy on the deprivation of liberty safeguards. This provided staff with guidance on how to support patients who lack capacity to consent to arrangements about their care and treatment.
- Ward areas had posters displaying information about the mental capacity act and deprivation of liberty safeguards.
- Mental capacity act training was included in the hospital's mandatory training programme. Staff were 100% compliant in this.
- Consent was audited as part of the hospital's documentation audit. Results from October to December 2016 showed consent forms were compliant with six out of the eight indicators. Areas of non-compliance included, patient name printed (approximately 45%) and patient dated (approximately 70%). The hospital had an action plan in place to improve performance.
- We reviewed five consent forms and found they were correctly completed in line with national guidance.
- Staff were able to describe the process they would follow if they felt a patient was unable to consent. Staff said they would escalate any concerns to the senior nurse.
- The hospital had a resuscitation policy, which provided information about 'Do Not Attempt Resuscitation' for patients with or without capacity.
- We reviewed five sets of records for patients undergoing cosmetic surgery and saw evidence of patients having a two-week cooling off period before surgery in line with professional guidance.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- In October 2016, the hospital had a 35% response rate to the friends and family survey for NHS funded patients. Of those patients, 100% were extremely likely or likely to recommend the hospital.
- All patients spoke positively about the care and treatment they had received. During the inspection, we received ten comment cards from patients relating to

surgery. All the comments were very complimentary of the care received from staff. Comments included, "Staff are unbelievably caring and compassionate ", "the care received was second to none" and "I cannot praise the staff at Spire Leeds enough, professional, caring and friendly".

- The hospital's patient satisfaction survey in November 2016, showed 93% of patients were extremely likely to recommend the hospital and 6% were likely to recommend the hospital.
- In the same survey, 94% of patients felt the care and attention they received from nursing staff was excellent, 99% felt they were given enough privacy when discussing their care and treatment, 100% felt they were treated with respect and dignity while in hospital and 95% felt involved in decisions about their care and treatment.
- Staff ensured patient's privacy and dignity was respected at all times. We observed staff knocking on doors before entering and closing patients' doors during care and conversations. In the anaesthetic room, theatre and recovery we observed patients' dignity been maintained.
- Patient-led assessments of the care environment (PLACE) for privacy, dignity, and wellbeing within the hospital scored on average 86% from February 2016 to June 2016. This was higher than the England average of 83%.
- We observed staff interacting with patients in a kind, respectful and considerate manner. Theatre escorts and nurses had a warm manner with patients who were recovering and were supportive, sensitive and encouraging towards patients' needs.

Understanding and involvement of patients and those close to them

- Results from the hospital's patient satisfaction survey in November 2016, showed 95% of patients felt involved in decisions about their care and treatment.
- The nursing handover took place by the patient's bedside, which allowed the nurse to introduce themselves to the patients and involve them in discussions about their care and treatment.
- Patients told us all staff introduced themselves and treated them as individuals and with respect. Patients felt involved in their care and decision-making and staff gave them information about their treatment plans.
- Staff spoke passionately about involving patients in their care. Visitors were able to stay on the ward as long as they needed. One patient said their visitor was offered something to eat. The hospital promoted John's Campaign, which allowed relatives to stay overnight with patients who were living with dementia. During our inspection, we saw a patient's carer had been able to stay with the patient overnight.
- We saw a physiotherapist involving a patient's family in their treatment and showing them how to use a sling.

Emotional support

- Staff we spoke with had an understanding of the emotional impact care and treatment could have on patients. They were able to describe how they would provide emotional support to patients.
- Staff provided emotional support to patients in a professional manner. We observed staff giving reassurance to patients who were anxious whilst awaiting surgery. Patients said they were put at ease by staff prior to their operations.
- Results from the hospital's 2015 patient engagement survey found 99.5% of patients reported they could find a member of hospital staff to talk to about their worries and fears whilst being treated at the hospital.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital had effective arrangements in place for planning and booking of surgical activities, ensuring patients were offered choice and flexibility.
- The hospital worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.
- Staff held a daily bed meeting to discuss staffing levels and clinical needs. Staff reviewed the number of admissions, discharges and patient dependency throughout the shift to assess on-going capacity.

Access and flow

Good

Surgery

- There were 2,656 inpatient admissions, 8,325 day case admissions and 9,266 visits to theatre in the reporting period July 2015 to June 2016. Of the inpatient and day case admissions, 40% were NHS funded and 60% were other funded.
- Patients were pre-assessed prior to surgery using the American Society of Anaesthesiologists (ASA) physical status scoring system. Discharge plans were discussed with patients and any potential support on discharge was identified. Results from the hospital survey showed 100% of patients felt the discharge process was well organised.
- Patient admissions for theatre were staggered throughout the day. Therefore, patients did not experience extended waiting times.
- From July 2015 to June 2016, the hospital cancelled 35 procedures for non-clinical reasons. All cancelled patients received another appointment within the following 28 days. Information provided by the hospital showed no harm had come to patients and the reason for cancellation included, consultant sickness, surgeon failed to attend sessions, anaesthetist unavailable and the rescheduling of patients.
- In the reporting period from July 2015 to June 2015, there were 17 unplanned transfers of inpatients to other hospitals, eight unplanned readmissions within 28 days of discharge and 25 unplanned returns to theatre. The assessed rates of unplanned transfers, unplanned readmissions and unplanned return to theatre (per 100 inpatient attendances) were not high when compared to a group of independent acute hospitals that submitted performance data to CQC.
- The hospital met the indicator of 92% of incomplete patients beginning treatment within 18 weeks of referral for each month in the reporting period (July 2015 to November 2015). However, from December 2015 to June 2016 the hospital did not achieve the 92% indicator. Updated information from the hospital showed the indicator was met from July 2016 to December 2016.

Meeting people's individual needs

- Staff assessed patients' needs during pre-assessment and on admission to ensure appropriate support was in place. The inpatient unit and theatre suite were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available.
- Patients living with dementia and patients with learning disabilities were assessed at pre-assessment and on admission were issued with a "this is me" patient passport booklet. Staff said patients living with dementia and learning disabilities were not routinely treated at the hospital.
- Dementia "champions" were available on the inpatient ward. Patient-led assessments of the care environment (PLACE) scoring for the hospital from February 2016 to June 2016, showed dementia assessment as scoring 78%, which was below than the England average of 80%.
- All staff had completed dementia training and were 'dementia friends'. The hospital supported John's Campaign which allowed carers to stay overnight with patients living with dementia. During staff handover, we heard a carer of a patient had stayed overnight with the patient.
- Staff were aware of how to access translation services for people whose first language was not English. Staff said these were booked for the ward in advance, following pre-assessment. Staff said family members would not be used to interpret and the hospital used the same interpreters and had built up a good rapport.
- The hospital provided translation services for languages other than English, hearing loops, British Sign language interpreters and patient information in braille.
- Information leaflets were available in ward areas. These included information about different surgical procedures, commonly asked questions and information about dementia from the Alzheimer's Society. On discharge, patients were provided with information about their after-care and the ward contact number in case they had any concerns post-operatively.
- Patients told us they received information and leaflets prior to their admission to hospital.

Learning from complaints and concerns

- The hospital had a complaints policy. The hospital director took overall responsibility for the management of complaints and signed all response letters. The hospital director chose a head of department to investigate a complaint. Hospital staff told us they tried to resolve complaints and concerns as soon as they were raised.
- If the complaint was not resolved at local level, patients could have their complaint escalated to an internal review. If the patient remained unsatisfied, they could take their complaint to the Independent Sector

Complaints Adjudication Service (ISCAS), for fee-paying patients, or the Parliamentary and Health Service Ombudsman for NHS patients for an independent review.

- An acknowledgment letter was sent within two working days of a complaint being received. Where a response to a complaint was not possible within 20 days, a letter was sent to the complainant. The hospital achieved 88% compliance with responding to complaints within 20 days against a corporate target of 75%.
- Response letters to complainants included an apology when things had not gone as planned. This was in accordance with the expectations of the service under duty of candour requirements.
- 'Please talk to us' leaflets were available throughout the hospital to give patients and their relatives the opportunity to raise any concerns about their care or treatment. We also saw posters displayed in inpatient areas informing patients how to make a complaint. The information was displayed in a number of different languages.
- From July 2016 to September 2016, the hospital received 22 complaints, two of these complaints related to the wards and 11 to consultants. Complaints and the associated learning were a standing agenda item for the monthly clinical governance meetings and cascaded through heads of departments and team meetings.
- Staff could describe their roles in relation to complaints management said they tried to resolve issues at ward level first. Staff described changes in practice following a complaint. For examples, the hospital had introduced a system to prioritise discharge medications for day-case patients to reduce delays in discharges.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- We saw strong leadership of the service from the hospital director who was supported by the hospital matron and heads of departments.
- All staff spoke positively about the hospital director. We heard examples of the hospital director getting to know new staff by taking their pictures for their hospital identity card, taking the time to ask staff about their well-being, and supporting staff during family bereavements.
- Both inpatient wards had a ward sister who was supported by the nursing services manager and matron.
- All staff spoke extremely positively about the leadership at the hospital. Staff felt supported by their managers from ward manager and service managers to the matron and hospital director.
- All managers at the hospital had attended formal training through Spire's Management Fundamentals programme and staff were being supported to complete qualifications to further develop their management skills.
- The senior leadership team were highly visible within the hospital. Staff said the matron and hospital director knew staff by their names and were very supportive and approachable.
- Staff described the senior leadership team as having an 'open door policy'. All staff felt able to confidently raise concerns and felt they would be listened to and appropriate action taken.
- All staff described good team working and told us it was a pleasure coming to work. Three members of staff described the hospital as feeling like "a family". Staff said they enjoyed working at the hospital, they reported fantastic teamwork, training opportunities, the environment and supportive management as the main reasons.
- Staff were proud of the service and care they delivered and felt this was reflected in positive feedback from patients.
- Staff told us they felt the management team and clinicians responded appropriately and proportionately to concerns and took appropriate action, including capability and disciplinary action when necessary. We saw examples of where the appropriate actions had been taken by senior managers in relation to poor practice and behaviours.

Vision and strategy for this core service

- The hospital produced a local vision which was, "Spire Leeds will support the Spire Healthcare vision and work towards 2020, when our aim is to make Spire Leeds a flagship hospital within the Spire Healthcare group of hospitals".

- The hospital used monthly staff forums to share the hospital strategy, vision and culture.
- All staff had a 'succeeding together' folder which set out the hospital's vision and strategy.
- The hospital had six strategic objectives that focused on delivering high quality care in terms of clinical effectiveness, patient safety and patient experience and to be recognised as a centre for regional, specialist private services not available elsewhere.
- All staff knew the corporate and hospital vision and values and were able to relate these to their role at the hospital. Staff said the hospital values formed part of their appraisals.
- Staff spoke enthusiastically about the hospital providing high quality care to patients and felt committed to offering high standards of care and treatment.

Governance, risk management and quality measurement

- The hospital had governance processes in place. These were described in the hospital's clinical governance and quality assurance policy dated October 2014, which incorporated the governance structure and reporting channels.
- The hospital had a local committee structure with regular meetings. There was a heads of department meeting every month, health and safety/risk committee every quarter, a clinical effectiveness meeting every week and a process review meeting every week. These all fed into the weekly senior management team (SMT) meetings and quarterly risk meetings, which in turn fed into the MAC and the quarterly clinical governance meeting.
- The MAC meeting discussed clinical governance issues and risk and the clinical governance meeting discussed clinical and non-clinical risks. Complaints and clinical incidents were discussed at the clinical effectiveness meeting and non-clinical incidents and complaints were discussed at the process review meeting.
- The hospital had a clinical governance lead responsible for risk management, audit, incident investigations, RCA reports and local policies.
- The clinical governance lead produced a quarterly clinical governance report. This was shared with the clinical effectiveness, clinical governance and medical advisory committees. The report included the results of hospital audits, clinical scorecard audits, clinical incidents, complaints and the risk register. Lessons learnt from incidents were also recorded.
- The quarterly clinical governance meeting discussed both clinical and non-clinical risks. Any clinical incidents or complaints were discussed at the weekly clinical effectiveness meeting and process review meeting.
- The hospital audited a range of indicators on their clinical scorecard and presented the results quarterly. Examples of the indicators included VTE risk assessment compliance, theatre starve times, effective discharge, NEWS, pain scores, surgical site infections in hip and knee arthroplasties, unplanned returns to theatre and critical care transfers. These were reviewed at the hospital's clinical governance committee.
- Following the serious incident in February 2016, 15 senior staff members had been trained in root cause analysis investigation. This had taken place during the summer of 2016 and had been delivered by the clinical governance lead. One member of the senior management team had received external root cause analysis training following the serious incident. Senior staff told us further root cause analysis training was planned for 2017. However, we were told staff without the training might be asked to undertake a root cause analysis investigation with supervision from a more senior member of staff with the appropriate training.
- The medical advisory committee was held quarterly and chaired by a lead consultant. We reviewed minutes from the 23 November 2016 and saw the meeting was well attended. Clinical incidents, practising privileges, quality assurance and new clinical services were discussed. The conditions of practising privileges were closely monitored for compliance and records maintained of appraisal, indemnity insurance and registration. No consultants had their practising privileges removed in the reporting period July 2015 to June 2016.
- We reviewed minutes from ward and department meetings, senior management team meetings and clinical effectiveness team meetings. We saw issues related to incidents, risks, complaints and audits were discussed.
- The hospital wide risk register had 198 risks identified. Each risk was rated based on the consequence and likelihood of occurring. Existing controls were recorded for each risk and these were also given a rating of adequate or inadequate. Each head of department

worked with the clinical governance lead to review the risks and controls relevant to their area and keep the register up to date. Staff were clear on how they wanted to develop the use of the risk register to drive improvement.
- The risk register was reviewed quarterly at senior management team meetings, heads of department team meetings and governance meetings. The top five risks were shared with the MAC and all staff were communicated with about risk management.
- We saw the hospital's 'top 5 risks' displayed in clinical areas. The top risks identified for December 2016 included, compliance with the WHO checklist, unrecognised deteriorating patient, single patient records, data protection breach and loss of contract.
- The hospital risk register had 10 risks relevant to the ward and 15 risks relevant to theatres. The risk register showed controls were identified to mitigate the level of risk and regular review progress notes were recorded.
- We reviewed the department communication newsletter and saw health and safety updates, clinical policies, training updates, complaints with a summary of the learning and incidents were shared with staff.
- We saw some policies and guidance for staff did not have appropriate document control. For example, patient information, audit forms and action plans did not consistently have review dates, version numbers or document the author.

Public and staff engagement

- All staff were invited to take part in an annual engagement survey. The hospital scored 97% for overall engagement. Staff forums were held to discuss any areas of concern. Staff in theatre scored the lowest in the survey and the hospital had produced an action plan to improve engagement.
- The hospital's '15 Step challenge' included former patients inspecting the hospital and providing an independent review and recommendations.
- Staff told us the hospital senior management team held regular staff forums to share information, discuss strategy and any other issues the hospital faced.
- The hospital shared health promotion information on social media.
- The NHS Friends and Family (FFT) scores were 98% to 100% from January 2016 to June 2016. This was similar to the England average. However, the response rate for the same reporting period was below the England average (between 16% and 22%).
- A patient satisfaction questionnaire was given to all patients to enable them to share their experiences. Results from the 2015 survey showed 99% of patients rated the overall quality of care as 'excellent' or 'very good'. The hospital used various means to collect patient feedback including comment cards and social media.
- The hospital used social media to share information regarding new services at the hospital, staff vacancies and relevant healthcare/ health promotion topics.
- The hospital had a volunteer service. Staff felt they enhanced the patient experience.
- The hospital performed well in staff, GP and consultant satisfaction surveys. Results from 2015, showed the hospital was ranked in first position in the Spire Healthcare group across all three surveys. In 2016, the hospital was ranked in first position in the Spire Healthcare group in GP and consultant satisfaction surveys and second for patient satisfaction.
- The hospital offered educational events to GPs, patients and members of the public.
- We saw posters in ward areas advising staff how to raise concerns and who to contact if they had any concerns. The hospital had a whistleblowing policy in place.
- We saw examples of 'you said', 'we did' displayed on ward one. A patient said they were unhappy with the wound care information given on discharge. The hospital had responded by updating the discharge information on wound care. In another example, the hospital had refurbished rooms on ward two following patient feedback.
- The hospital had an email network of previous patients who were happy to be contacted for feedback on improvements to services and facilities.
- The hospital management awarded 'inspiring people' rewards. Staff could nominate other staff members for good ideas or going that extra mile above and beyond their duty.
- Staff told us after 10 years working at the hospital they were given a bottle of champagne and after 21 years they were given a gold watch and a trip to London.

Good

Surgery

- In the summer, there were staff parties with a marquee on the lawn and at Christmas, there were departmental parties and corporate parties for staff, including a party for staffs' children.

Innovation, improvement and sustainability

- In 2015, the hospital won the Consultant Satisfaction Award for Spire Healthcare at the annual conference. The hospital had retained the number one position for consultant satisfaction for the past six years.
- The hospital had opened an ambulatory care unit in 2015, which included a purpose built unit for minor surgery under local anaesthetic.
- The hospital was investing in staff training and developing nursing staff to work within stoma care in order to meet the needs of the colorectal service and improve patient experience.

Good

Critical care

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

Are critical care services safe?

Good

We rated safe as good.

Incidents

- 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. There were no never events reported in critical care between July 2015 and June 2016.
- Eight incidents in critical care were reported between November 2015 and November 2016. All incidents were unexpected clinical events, for example, a cardiac arrest or unexpected transfer of a patient. Senior staff completed investigations following incidents. We reviewed one investigation, which identified contributory factors, a root cause, application of the duty of candour and an action plan.
- All staff we spoke with understood what to report as an incident and how to report it using the electronic system. They gave us examples of incidents that had been reported on the unit; these matched the themes we saw on the incident report.
- Staff received feedback about incidents from the critical care unit (CCU) manager and local hospital and national lessons learnt were circulated and kept in a communication file.
- Staff we spoke with demonstrated an understanding of the duty of candour and were able to give an example of how they would meet the duty if an incident occurred.

Clinical Quality Dashboard or equivalent

- See information under this sub-heading in the surgery section.
- The unit displayed the results from the hospital clinical score card. Examples of some of the indicators included, venous thromboembolism (VTE) risk assessment compliance, falls, pressure ulcers, national early warning score, pain score, unplanned return to theatre and critical care transfers.

Cleanliness, infection control and hygiene

- See information under this sub-heading in the surgery section.
- All areas on the unit were visibly clean and tidy.
- Staff cleaned the bed spaces regularly and kept a record on the observation chart.
- All the equipment we observed was visibly clean and all the disposable curtains around bed spaces were within date for replacement.
- We observed all staff were compliant with key hospital infection control policies, for example, hand hygiene, 'arms bare below the elbows' personal protective equipment (PPE), and isolation.
- There had been no incidences of methicillin resistant staphylococcus aureus infection (MRSA) or Clostridium difficile in critical care between July 2015 and June 2016.
- The unit's records for flushing taps to prevent legionella were up to date and complete.

Environment and equipment

Good

Critical care

- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients' privacy curtains separated the bed spaces.
- There was an adjoining corridor from the unit to the operating theatres.
- Staff checked the emergency trolley daily. The records for this, and other emergency equipment were up to date and complete.
- Six of the eight beds had facilities to ventilate patients. Emergency equipment was available at every bed space.
- Disposable items of equipment were in date and stored appropriately.
- All electrical equipment we observed was clean and had been safety tested within the specified time frame.
- The unit kept up to date equipment maintenance records.

Medicines

- The unit had appropriate systems to ensure medicines were handled safely and stored securely.
- Controlled drugs were stored in locked cupboards with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the hospital policy.
- Staff monitored medication fridge temperatures in line with the hospital policy and national guidance. This meant medications were stored at the appropriate temperature.
- We reviewed four medication charts. They had all been completed in line with national and hospital guidance.
- A pharmacist visited the unit daily.

Records

- Records were stored securely and all components of the record were in one place.
- In the four records we reviewed, the nursing documentation included care bundles and risk assessments. Nursing records were accurate, complete and in line with the hospital and professional standards.
- In three of the four records we reviewed, there was evidence of daily review by a consultant. In one record the consultant had not documented in the record for two consecutive days. However, nursing staff had documented telephone conversations they had with the consultant and the advice and treatment plan they were given. In two of the four records we reviewed, medical staff did not consistently sign and date their entries. This was not in line with hospital or professional standards.

Safeguarding

- Staff we spoke with were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the hospital's safeguarding policy and the safeguarding lead.
- The paediatric lead nurse had completed a Masters module in safeguarding and was educated to level four in safeguarding. This allowed them to deliver face to face level three safeguarding training to staff locally.
- All staff completed safeguarding adults at risk combined level one and level two training.
- Paediatric admissions were not accepted on the unit. The hospital had a service level agreement with the regional specialist transport service for critically ill children. All staff completed safeguarding children and young people combined level one and two as part of their mandatory training programme.

Mandatory training

- Mandatory training topics included areas such as fire safety, manual handling, infection control, compassion in practice and equality and diversity.
- Information provided by the hospital reported 100% compliance with all mandatory training topics.
- All nursing staff on CCU had completed advanced life support and paediatric immediate life support training.

Assessing and responding to patient risk

- The hospital was staffed 24 hours a day, seven days a week in line with the critical care and resuscitation structure in the hospital's resuscitation policy. Critical care staff provided outreach services to the rest of the hospital.
- The hospital used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care. In the four records we reviewed, staff had calculated, recorded and actioned the NEWS score in line with hospital policy.
- The hospital used a sepsis screening tool and pathway.

Good

Critical care

- The patient records we reviewed all included completed risk assessments for venous thromboembolism, pressure areas and nutrition.
- The hospital's operational policy for the critical care unit and the emergency transfers' policy provided clear guidance to staff about the stabilisation and transfer of a level three patient. The patient's consultant or anaesthetist would discuss the patient with the critical care consultant at the local NHS hospital and staff would follow the policy for arranging the transfer. All staff we spoke with were aware of the policy and process.

Nursing staffing

- Nurse staffing met the Guidelines for the Provision of Intensive Care Services 2015 (GPICS) minimum requirements of one nurse to two patients' ratio for level two patients' and one to one nurse to patient ratio for level three patients, if admitted for stabilisation and during transfer to another hospital. We reviewed the nursing rota for November 2016 which confirmed this.
- The unit's establishment was eight registered nurses. Staff worked flexibly on an annualised hours contract to meet the demands of the unit. If staff were not needed to work on CCU, they worked elsewhere in the hospital if they had the skills for the clinical area, for example, the wards or in angiography.
- The unit did not use agency staff. The CCU manager was developing a bank of critical care trained staff to work on the unit. The use of bank staff was not more than GPICS recommendations. We saw evidence of induction and training of bank staff.

Medical staffing

- The hospital had a lead consultant for critical care.
- The patients' admitting consultant and anaesthetist reviewed their patients daily. We saw evidence of this in three of the four patient records we reviewed. In one record, the consultant had not documented in the record for two consecutive days. However, nursing staff had documented telephone conversations they had with the consultant about the patient.
- The RMO visited CCU daily and reviewed patients at the nurses' request over a 24-hour period.
- Consultants were available to attend the unit within 30 minutes. Nursing staff told us they regularly telephoned the consultants at home if they needed advice.

Emergency awareness and training

- There was only one exit from the unit that a bed would fit through and there was equipment to move patients through another route if required. Staff we spoke with told us on hearing the fire alarm they would await further instructions from estates. The hospital had a 'stay put' policy when the fire alarm sounded to ensure patients were only moved if necessary and staff awaited advice.
- At our unannounced inspection, senior managers provided us with evidence of the CCU annual fire risk assessment completed in January 2016 and a fire risk assessment completed by an external company in November 2016. Staff on CCU had completed a fire evacuation drill following our inspection and had developed an action plan following this.

Are critical care services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- The unit's policies, protocols and care bundles were based on guidance from the national institute for health and care excellence (NICE), the intensive care society (ICS) and the faculty of intensive care medicine (FICM). Staff we spoke with demonstrated awareness of the policies and how to access them on the electronic critical care hub.
- The Spire Leeds hospital operational policy for the critical care unit and the policy for emergency transfers were up to date and in line with national guidance.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- The sepsis screening tool was written in 2015, based on national guidance. However, the guidance did not have a review date that incorporated the new 2016 NICE guidance (NG51).
- The critical care unit (CCU) participated in the hospital's clinical audit programme. This included a quarterly audit for the Spire clinical scorecard, regular audits of completion of NEWS scores and pain scores, infection control and medication audits.

- The unit manager had completed Spire Healthcare critical care core standards gap analysis in August 2016 and created an action plan.

Pain relief

- We observed staff assessing pain using the hospital scoring system and giving support to patients who required pain relief. Staff reviewed the effectiveness of the pain relief and spoke with consultants to make changes when needed.
- Staff we spoke with told us they worked closely with the anaesthetists to manage patients' pain.
- All patients we spoke with said their pain was well managed and staff acted quickly when they told them they were in pain.

Nutrition and hydration

- Nursing staff on CCU assessed patients' nutritional and hydration needs using the malnutrition universal screening tool (MUST). They completed a referral to the dietitian if it was required.
- Staff we spoke with told us they could access and commence nasogastric (NG) feeding, specialist diets and supplement drinks for patients. All patients we spoke with, who were able to eat, told us the food quality and choice was excellent.
- Senior managers said that if a patient required a nutritional assessment, this service was available as a same-day service.
- During our inspection, we observed water was available and within reach for patients on CCU who were able to drink.
- We reviewed four fluid balance charts on CCU, which were all completed appropriately.

Patient outcomes

- The Spire clinical scorecard included the number of critical care transfers for unplanned level two and three care. The hospital's score for the year to date at the end of September 2016 was 0.05; this was better than the target of less than 0.1.
- The unit was piloting a critical care clinical scorecard, which would enable the unit to benchmark the results with similar hospitals in Spire Healthcare. The patient outcomes measured were mortality, cardiac arrests, readmission to critical care within 24 hours of discharge and the number of patients transferred out of the hospital who required ongoing level two or three care. The 2016 average scores for the unit were all better than the target; mortality 0%, cardiac arrests 0%, readmission within 24 hours 0% and transfers out 0.03%.
- At the time of our inspection, CCU did not submit data to the Intensive Care National Audit and Research Centre (ICNARC). Senior staff told us this was under discussion at a national level in Spire Healthcare.

Competent staff

- See information under this sub-heading in the surgery section.
- During our inspection, we reviewed two CCU nursing staff files and saw evidence of up to date appraisals, mandatory and additional training, training on specialist equipment delivered by company representatives and critical care competencies.
- Spire healthcare had a critical care education lead. The manager of CCU worked closely with the education lead to plan and support staff training.
- All nurses on the unit completed the national competency framework for adult critical care nurses.
- The management team supported CCU staff to develop additional skills. For example, some nurses were completing competencies to work in the angiography department. All nurses had completed or were due to complete transferring the critically ill patient training and some nurses were completing master's degrees.
- Information provided by the hospital showed, at the time of our inspection, 38% of nurses had a post registration qualification in critical care. A fourth member of staff was due to complete this qualification in 2017. This would then meet the GPICS minimum recommendation of 50% of staff have completed the post registration in critical care.
- The hospital was trying to access a critical care course for the pharmacist to attend to meet the recommendations from GPICS.
- Staff on the unit had link nurse roles, for example, equipment, tissue viability, safeguarding. They attended relevant meetings and shared information with staff on CCU.
- New members of nursing staff received an induction onto the unit, were allocated a mentor and had a supernumerary period.

Multidisciplinary working

Good

Critical care

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit during our inspection.
- There was evidence in the patient record of input from the multidisciplinary team.
- A physiotherapist, dietitian and pharmacist visited CCU. Nursing staff told us they could access occupational therapy and speech and language therapy if required.
- All services, including consultants, therapies and diagnostics were available seven days a week.

Access to information

- Staff had access to guidelines, policies and protocols on paper and electronically on the unit.
- Staff were able to access blood results and x-rays via electronic results services.
- Nurses completed a discharge document for patients who were transferred to the ward. This was in line with NICE CG50 acutely ill patients in hospital standard and was due to be reviewed in 2019.
- A standard critical care network out of hospital transfer form was completed for patients who were transferred to another hospital or local NHS trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained verbal consent from patients before carrying out an intervention.
- Staff we spoke with demonstrated an understanding of consent, the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). They told us they would speak to the CCU manager, matron or consultant if they had concerns regarding a patient's capacity.
- All staff had completed eLearning on MCA.
- Staff we spoke with demonstrated an understanding of restraint, for example, chemical restraint or the use of mittens for patients' safety. However, they told us they had not had to use any form of restraint on the unit.

Are critical care services caring?

Good

We rated caring as good.

Compassionate care

- The unit kept thank you cards from patients and relatives. All the cards contained excellent feedback regarding the compassionate care received on the unit.
- Staff told us they received good feedback from patients about the care they received on the unit.
- We spoke with five patients and two relatives. All patients and relatives were positive regarding the care staff provided to them. Our own observations supported this.
- One patient we spoke with described all the staff in CCU as 'exceptional', they felt staff went the extra mile when delivering care and looking after patients and their relatives. All patients we spoke with could not tell us how staff could have delivered care that was any more compassionate than the care they received on CCU.
- We observed staff treated patients with dignity and respect for their privacy. During all interventions, staff drew curtains around patients. Patients were kept covered with sheets and blankets.
- All staff communicated in a kind and compassionate way with patients, relatives and other staff.
- Staff ensured call bells were placed within patients' reach and staff responded in a timely and respectful manner to the patient's requests.

Understanding and involvement of patients and those close to them

- All patients and relatives we spoke with told us they had been kept fully informed of their treatment and progress and they were involved in the decisions made by the multidisciplinary team. They said communication on the unit was better than at other hospitals.
- All the relatives we spoke with told us staff were welcoming, open and honest and gave them regular updates on the telephone and face to face.
- One relative was telephoned by a consultant at 10:30pm to inform them of the outcome of the patient's operation, the nursing staff also telephoned to inform the relative when the patient was settled on CCU.
- Relatives told us, to suit their personal circumstances, staff made exceptions to visiting times.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.

Emotional support

- During our inspection, we observed staff interacting and communicating with patients in a compassionate and

individual way. They offered emotional support to patients who attended other departments in the hospital for investigations by accompanying them for the duration of the appointment.
- We observed staff supporting patients, enquiring about their families and hobbies and using this information to motivate and progress patients with their recovery.
- Two patients we spoke with told us specifically about staff on CCU who gave them emotional support on the first evening following their operations.
- Both relatives we spoke with were extremely grateful to the CCU staff for the emotional support they were given.

Are critical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Critical care provision was for level two patients and to stabilise and transfer level three patients only. The hospital had a service level agreement in place for the transfer of patients treated in the critical care unit (CCU) at Spire Leeds hospital to the local NHS trust if level three care was needed.
- The service was trying to make links with the regional critical care network.
- A visitors' waiting room was available on the unit which contained seating and refreshments. There was no overnight accommodation on the unit for relatives. However, staff told us relatives may be able to stay in the patient's room on the ward if needed.

Access and flow

- The decision to admit to CCU was made by the patient's consultant together with their anaesthetist. Most decisions were made pre-operatively.
- Information provided by the hospital showed between July 2015 and June 2016, the bed occupancy for CCU was 10%. Bed occupancy for November 2016 was 11%, which equated to 13 level two patients and seven level one patients.
- The critical care clinical scorecard measured the number of patients transferred out from the unit who did not require level two or three care, patients with an extended length of stay in CCU and unplanned admissions to CCU. The 2016 average scores for the unit were all better than the target; transfers out not requiring level two or three care 0.03%, extended length of stay 0.1% and unplanned admissions 0.1%.
- Patients kept a room on the ward during their stay on CCU and were discharged back to this room when deemed ready by their consultant. This meant the unit did not have any delayed discharges.
- The unit did not have any mixed sex accommodation breaches.

Meeting people's individual needs

- Staff we spoke with knew how to access translation services for patients whose first language was not English. The unit had cards available to assist with communication.
- Staff we spoke with felt able to support patients living with dementia on the unit; they received training on dementia as part of the mandatory training programme. The unit had a link nurse for patients with dementia.
- The unit had a link nurse for patients with a learning disability. Staff we spoke with felt confident to care for patients with a learning disability and told us carers may stay with patients to assist staff to meet their needs.
- Staff had access equipment to care for bariatric patients on the unit.

Learning from complaints and concerns

- The unit had received no formal complaints in the six months prior to our inspection.
- Staff we spoke with were aware of lessons learnt from complaints in other areas through communication at staff meetings and newsletters.
- Staff we spoke with understood the process for managing concerns and how patients or relatives could make a formal complaint. Senior nurses were available to talk to patients and relatives about concerns they had at any time.

Are critical care services well-led?

Good

We rated well-led as good.

Leadership and culture of service

Good

Critical care

- Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. There was a lead consultant for critical care and the unit had a lead nurse.
- The unit manager attended heads of department and other relevant hospital meetings. They also met with the other critical care leads in Spire Healthcare regularly.
- Senior staff were very proud of the staff and the quality of patient care they provided.
- It was clear staff had confidence in the unit's leadership. All staff we spoke with reported feeling supported by their team and manager.
- Staff we spoke with told us the senior management team had an open door policy and were visible on CCU.
- Staff were proud to work at the hospital, they told us they had time to spend with and care for their patients.
- Staff felt the culture on the unit and in the hospital was open and honest and they felt supported to raise any concerns they had with any member of staff.

Vision and strategy for this core service

- Staff were aware the vision for CCU was to improve patient pathways between critical care and angiography and to increase capacity with the angiography suite. This involved training nursing staff to work in both departments so staff were able to care for patients throughout their pathway.
- We observed staff delivering care and demonstrating behaviours in line with the hospital and Spire Healthcare's values.

Governance, risk management and quality measurement

- There were five critical care risks recorded on the hospital risk register. Examples of the risks identified and recorded included non-compliance with GPICS and a medical emergency that may require an emergency intubation. The risk register showed controls were identified to mitigate the level of risk and regular review progress notes were recorded. For example, a gap analysis and action plan had been completed for non-compliance with GPICS and there was 24 hour seven day a week anaesthetist cover with staff trained in advanced and immediate life support at all times in case of a medical emergency requiring an emergency intubation. Staff we spoke with agreed the risks were representative of the risks in the service.
- The unit held a local risk assessment file. Staff completed a risk assessment if they identified a risk. The unit manager and staff we spoke with were aware of the process they would follow to escalate the local risk assessments.
- The unit collected data and completed the critical care clinical scorecard. This measured the number of patients transferred out from the unit (including those who did not require level two or three care), cardiac arrests, surgical site infections, patients with an extended length of stay in CCU, readmissions to CCU, mortality in CCU and unplanned admissions to CCU.
- The unit manager had completed Spire Healthcare critical care core standards gap analysis in August 2016 and created an action plan. We saw evidence during our inspection of progress made against some of the required actions.

Public and staff engagement

- The unit held monthly staff meetings. Prior to our inspection, we reviewed copies of the agenda and minutes. Items discussed were finance, risk management, complaints, incidents, audits and professional development.
- Staff we spoke with told us they thought communication on the unit and in the hospital was good.

Innovation, improvement and sustainability

- The unit was trying to make links with the regional critical care network to benchmark the service and share best practice.
- The unit manager was developing staff's skills in both CCU and the angiography suite to improve the patient experience.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

We rated safe as good.

Incidents

- Incidents were reported through an electronic reporting system. We reviewed all reported incidents between 1 November 2015 and 30 November 2016, and found 11 incidents involving children and young people. Eight incidents were recorded as no harm, two as minor and one as moderate harm. The most common incident reported was transfer of care to a NHS hospital.
- Staff we spoke with knew how to report incidents and were confident to do this. They were able to provide examples of learning from the incidents reported. They told us information about incidents across the hospital was shared during team meetings. We looked at team meeting minutes and saw incidents were discussed. Staff told us they had to sign to say they had read meeting minutes.
- We saw examples of learning from incidents in the paediatric steering group minutes. For example, the introduction of paediatric blood bottles following an incident where a sample was not available. Staff also told us about this incident and the changes in practice as a result.
- Staff were aware of the duty of candour and knew when this would be required.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. This included communal areas, bathrooms and toilets.
- Personal protective equipment was available for staff to use. Hand cleansing gel was available on entry to all areas and on the children's ward was placed outside and inside each room. We observed staff using hand gel between patient contacts.
- Staff adhered to 'arms bare below the elbow' infection prevention and control guidance.
- There were notices displayed for children and parents regarding hand washing.
- There were toys and books for the children to use on the children's ward. Staff told us these were cleaned after each use and had a monthly deep clean. We reviewed cleaning records and saw toys and books on the ward had a weekly condition check and clean. The toys also looked visibly clean.
- There were toys in the outpatient area for children to use. These were also cleaned weekly.
- Parents we spoke with told us they were happy with the cleanliness of the hospital.
- We observed good infection prevention and control measures in use in theatre.
- There had been no incidents of Meticillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile infection on the ward in the 12 months prior to our inspection.
- The hospital had changed its method of auditing hand hygiene. In June 2016 the hospital introduced observational hand hygiene audits, results from quarter three showed staff were 95% compliant however, it was not clear which clinical area this related to. The results of the audits were reported quarterly through the IPC committee and clinical scorecards.

- An environmental audit in November 2016 had identified a dusty environment in the office on the ward. There was an action plan for this and we did not see any dust on our inspection.

Environment and equipment

- On the children's ward, there were fire escape doors from each of the single rooms, which were not alarmed. This meant a child could exit their room without staff or their parents being aware. We raised this as a concern at the time of inspection. On our unannounced visit, we saw working door alarms were now in place with signage informing parents the doors were alarmed.
- Staff on the ward told us parents were informed not to leave their child unattended and to call for a nurse if they were leaving the room. We saw parents being advised to inform staff if they needed to leave the room at a pre-admission assessment clinic.
- There was no written information about supervising children for parents in the patient's rooms on our inspection. However, we reviewed the letters sent to parents when inviting them into the hospital for their child's procedure. This letter included the statement "children must be supervised at all times. Please make nursing staff aware if your child is to be unattended at any time".
- Staff in the outpatient's department told us parents were informed prior to attendance they must ensure their child was not left unattended. We reviewed the standard appointment letter sent to parents and found there was no explicit reference to parental responsibilities whilst in the department.
- There was paediatric emergency care equipment on the children's ward and in the outpatient's department. We saw daily checks were undertaken. However, the paediatric emergency care equipment was only suitable for children up to a certain weight. If there was an older or adolescent child requiring emergency care, the equipment had to come from an adjacent ward. If a child or an adult visitor collapsed in a corridor, there was no portable oxygen available to provide immediate treatment before the emergency trolley arrived. We highlighted this risk at the time of our inspection. When we returned to the ward on our unannounced inspection, a risk assessment had been carried out. Senior managers told us they had considered having portable oxygen on the ward but decided the risk of an unattended oxygen cylinder on the children's ward was too high as the emergency trolley was on the adjacent ward.
- The children's ward had eight rooms each with en suite bathroom facilities. Each room had piped oxygen and suction points, which were in working order.
- There was an equipment register with a record of safety checks. We checked four pieces of electrical equipment and found they were clearly marked and all in date.
- The hospital had three cots available for children less than two years of age. They were stored in the equipment store, were electrically operated and the base could be lowered to the floor.
- The entrance to the children's ward was locked. Staff accessed the ward by electronic fob. Patients and visitors accessed by buzzer, which initiated a camera so staff could see who was requesting access to the ward. Exit from the ward was also via the buzzer system activated by members of staff.
- There were security cameras monitoring activity in the hospital corridor and at main reception.
- The children's ward had been refurbished within the past 12 months. Staff told us ligature risk assessments had been carried out prior to refurbishment of the ward area. We saw a risk assessment had been completed in January 2016 but there were no dates for reassessment or an environmental audit.
- There were no separate waiting areas for children in the outpatients' department. However, waiting times for children were kept to a minimum with toys and books provided.
- The consulting rooms and physiotherapy department were not child orientated. However, there were portable toy/distraction boxes available when small children were attending.
- The physiotherapy department was not child orientated. Equipment such as crutches and boots for children was ordered by physiotherapy staff in advance and planned at assessment stage.

Medicines

- For our detailed findings on medicines, please see the safe section in the surgery report.
- The children's ward had a locked medicine's cupboard. Controlled drugs were stored in an appropriate cupboard on the adjacent ward and all stock checks were completed.

- The medicine's fridge was also on the adjacent ward. This was used to store one item for the children's ward. The fridge temperature was checked daily.
- Two registered nurses were required to check and administer controlled drugs. At all times if a child required controlled drugs in the night, there were two children's nurses on duty. From 01 October 2016 to 13 January 2017 only two children had needed to stay overnight. We reviewed staffing levels for these shifts and found on one shift there were two registered children's nurses and on the other shift there was a registered children's nurse and a registered nurse who had completed paediatric competencies and level three safeguarding training.
- We looked at three prescription charts and saw patient's weights and allergies had been recorded.
- A medication error had been reported. This was related to the transcription of a discharge medication resulting in the incorrect antibiotic being prescribed. Another member of staff noticed this and there was no harm to the patient. Some reflective work had taken place following this incident.

Records

- There was a singe patient record for children. Records were paper based and stored securely in the ward office.
- We looked at three sets of patient records. All patients had pre assessment documents and information was recorded on a care pathway. The pathway included risk assessments and observations. Records and handovers were signed by staff.
- An audit of the medical and nursing records was carried out each quarter. Twenty-five records were checked in the audit. Results from the audit carried out between June and September 2016 showed 97.4% compliance overall. The newly introduced check of recorded fluid fasting time scored 74% compliance. The WETFlAG score, which is a nationally recognised algorithm for resuscitation of a child based on their weight, had not been calculated and recorded on 8% of the records checked. We did not see results of audits discussed in minutes of team meetings we reviewed.

Safeguarding

- The hospital had not reported any safeguarding incidents in the 12 months prior to our inspection. The children's lead nurse was also the safeguarding lead for the hospital and was responsible for safeguarding training. There was a named consultant for safeguarding children.
- The paediatric lead nurse had completed a Masters module in safeguarding and was educated to level four in safeguarding. This allowed them to deliver face to face level three safeguarding training to staff locally.
- The lead nurse told us all staff nurses, bank nurses and doctors were expected to complete level three safeguarding children training. This was delivered in a face-to-face training session and via an electronic training programme. Data provided showed all staff working with children in the hospital were 100% compliant with this training.
- Consultants working at the hospital had to complete level three safeguarding children training and a record was kept of this on the hospital's practising privileges record. The hospital director monitored compliance of this.
- There was a safeguarding policy, which had been updated in December 2016, by the lead nurse. There was no evidence on the document to suggest it had been reviewed and ratified by the hospital's governance team.
- The hospital clinical services manager and the lead children's nurse had attended a conference on child sexual exploitation. However, there was no information in the policy about knowledge and response to child sexual exploitation. Managers told us staff received training about this in the mandatory Level three training delivered by the lead nurse.
- Female genital mutilation (FGM) and PREVENT training were recognised in the policy and we were told by staff this was included in the training provided by the lead nurse.
- The lead nurse participated in local health advisory groups for both adults and children's safeguarding. The lead nurse told us any concerns about children would be escalated to the local safeguarding children's team through the agreed reporting system.
- Staff we spoke with were aware of the policy and the process for reporting safeguarding concerns.
- Staff told us they did not receive safeguarding supervision. However, senior managers told us staff were aware of the open door policy and they were available to discuss any concerns staff may have.

- In outpatients, staff told us chaperones were provided during consultations and when children required examinations. This would be health care assistants and not a registered children's nurse. Staff told us that invasive examinations did not take place in outpatients.
- The hospital's paediatric policy stated "a chaperone is required for all examinations of children; parents should not act as a chaperone for their child." The policy did not clearly state the qualifications or training the chaperones required. However, all clinical staff had level 3 safeguarding training and competencies in chaperoning.
- The corporate procedures for the care of children and young people (clinical 11) stated, "if invasive procedures are to be carried out on a child 16 years and under the relevant sections of the risk assessment must be completed to assess the need for a registered children's nurse presence. If a registered children's nurse is not required to be present for the procedure, the procedure may go ahead as long as there is a registered children's nurse available for advice." However, in the corporate chaperone guidelines (clinical policy 42), there is no reference to children.
- In the corporate procedures for the care of children and young people (clinical 11), it stated, "a chaperone would normally be a parent or carer or someone known and trusted or chosen by the child". It also stated the parent may not be appropriate or acceptable and all departments should identify an appropriate member of staff. This contradicted the hospital's paediatric policy regarding chaperoning by a parent.
- The inconsistent provision of a suitable member of staff as a chaperone in the outpatient's department was identified as a risk on the hospital wide risk register as a low risk.
- We saw in the paediatric steering group minutes in October 2016 that chaperones were available for all consultants seeing children. However, the minutes indicated this had not been the case and where possible chaperones were being offered to consultants in clinics. It was also recorded that a senior paediatric support worker vacancy was advertised in October 2016 for the outpatients department to support the need for chaperones at paediatric clinics.
- There was a long-term plan to recruit a full time children's nurse to the outpatient's department but the timescale for this was not clear.

Mandatory training

• See surgery report for the content of the hospital's mandatory training content and schedule.

- All staff working with children and young people in the hospital were 100% compliant with mandatory training. This included infection prevention and control training.
- We saw in the paediatric steering group minutes that mandatory training compliance of consultants who saw children was being monitored.

Assessing and responding to patient risk

- The children's ward used the Paediatric Early Warning System (PEWS) to monitor and assess a patient's condition. These charts did not include a track and trigger pathway.
- The PEWS charts were being reviewed corporately to include this. The lead nurse was part of the steering group developing a new chart.
- There was a track and trigger process in place and staff were trained appropriately.
- Audit results from October to December 2016 showed 96% documented PEWS score on charts checked from the ward and 100% documented PEWS score in PACU. Audit results also showed 100% compliance with checking female patients' last menstrual period in the appropriate age group.
- One hundred and seventeen members of staff in the hospital were trained in paediatric immediate life support. The children's team (nine staff) were also trained in advanced paediatric life support.
- The hospital used a paediatric emergency care system (PECS). Children were weighed at pre-assessment clinic and assessed for any allergies. On admission, they were given a coloured band, depending on their weight, which correlated to the colour scheme of the paediatric emergency care system. For example, if a child had a green wristband on and required emergency care, the green packaged equipment and drugs in the emergency trolley would be used, as these drugs and equipment were pre-measured for the weight of the child.
- We observed an asthmatic patient wearing a red wristband to indicate a risk.
- If a patient became unstable or deteriorated, the hospital had a contract with a paediatric medical transfer service. In situations where a child required respiratory support an anaesthetist from the hospital would travel with the patient. For patients who required

NHS care, but did not require support with breathing, an emergency ambulance was used for transfer. A member of the nursing staff would escort the patient and handover to the NHS staff.
- There were guidelines for staff on the transfer of a patient in an emergency, which had been separated from the main policy for easy access when required.
- We saw correctly completed safer surgery checklists in all the records we reviewed. We observed the safer surgery checklist being undertaken on transfer to theatre.
- Parents were given a leaflet about sepsis on discharge from hospital along with details of who to contact if there was a concern after they left the ward.

Nursing staffing

- The children's ward had five permanent members of children's nursing staff and one health care assistant, who was also nursery nurse trained. The ward staff also provided the paediatric cover for the post-anaesthetic care unit (PACU). There was a vacancy for one whole time equivalent children's nurse.
- Nursing staff worked to an annualised hour's contract. This gave flexibility to cover shifts when children had been booked to attend the ward.
- The ward also had a small number of bank children's nurses who had completed the hospital induction and training programme. These staff tended to be used when the children's ward was open overnight. We looked at off duty rotas and staff told us the ward was not often open overnight. Between 15 August 2016 and 1 January 2017, the ward was open for seven nights.
- The children's ward was staffed during the day at a ratio of 1:3 nurses to patients, which met the Royal College of Nursing guidance. The ward was involved in the booking of elective patients so they could ensure staff requirements met the patient's needs.
- From the 01 October 2016 to 13 January 2017, only two children had needed to stay overnight. We reviewed staffing levels for these shifts and found on one shift there were two registered children's nurses and on the other shift there was a registered children's nurse and a registered nurse who had completed paediatric competencies and level three safeguarding training.
- The hospital had a busy outpatient's department. Between the period of July 2015 and June 2016, 3,068 children had attended the department. A registered children's nurse did not routinely support the children's outpatient clinics as no invasive procedures took place in the department. Health care assistants provided the care, which did not meet the standard minimum of one paediatric qualified member of staff in outpatient departments as recommended by the Royal College of Nursing (2013). A children's nurse from the children's unit could be contacted for advice by staff in the outpatient's department if required. The outpatient's department had registered nurses with paediatric competencies and level three safeguarding training. This was on the hospital wide risk register with a plan to recruit a registered children's nurse for outpatients. However, there was no clear date for this to be achieved.

Medical staffing

- Twenty paediatric consultants had practising privileges at the hospital. These were surgeons and physicians with a range of specialties.
- There was a resident medical officer (RMO) on the hospital site at all times. It was hospital policy to engage doctors with a minimum of four to six months paediatric experience and an advanced paediatric life support qualification. We spoke with the RMO on duty at the time of our inspection and checked the personnel files of the two current RMOs. We found they both had the relevant experience and qualifications.
- Staff told us they would contact the responsible consultant directly if they had any concerns about a child.
- It was hospital policy for all children to be admitted under a named consultant with paediatric practising privileges. We saw a robust process in place for checking consultants' suitability.
- Staff told us consultants came to see their patients routinely postoperatively and patients would be seen at least once a day.

Emergency awareness and training

- There had been two emergency training scenarios held involving children in June 2016. A number of learning points had arisen from these. This included staff being familiarised with the PECS bags and stabilising a child prior to transfer. This was included in training sessions.
- There was a paediatric emergency system in place. This involved children being colour coded on their records relating to their weight. This system of working was included in the paediatric life support training delivered to staff.

Good

Services for children and young people

- We were told members of theatre staff were to receive training in the European paediatric advanced life support (EPLS) training.
- There was a procedure for staff to follow if a child went missing. This had not been tested.

Are services for children and young people effective?

Good

We rated effective as good.

Evidence-based care and treatment

- The paediatric policy was dated December 2016; this covered the scope of the children's service in the hospital and reflected national guidelines, for example Royal College of Anaesthetists (2013), The Royal College of Surgeons, Standard for Children's Surgery (2013). However, there was no evidence on the document to suggest it had been reviewed and ratified by the senior management or governance team.
- We saw in team meeting minutes in December 2016 a copy of the updated paediatric policy had been sent to all members of the ward team to read.
- The policies and protocols we saw in radiography were up to date and reflected national institute for health care excellence guidance (NICE) .
- Clinical audits took place. Decisions regarding audit topics took place at the paediatric steering group and were based on incidents and cases discussed at the meeting.
- In radiology, all the protocols for children and young people had been taken from the local acute hospital trust. This included a paediatric exposure chart. These were all in date.
- There was NICE guidance in use in the allergy clinic.

Patient outcomes

- Staff we spoke with told us patient outcomes were good. However, measures of patient outcomes were limited to infection rates, readmission rates, unplanned returns to theatre and transfers to NHS care.
- Information regarding readmission rates to the hospital in the period June to September 2016 showed one readmission within 31 days of surgery and no unplanned returns to theatre. The provider had a set national target for these and benchmarked performance with other hospitals in the group through the use of a paediatric scorecard.
- There was no evidence of participation in national audits such as patient reported experience measures (PREMs) or benchmarking the hospital's performance externally from the group.
- Patient outcomes were recorded on a clinical scorecard. This showed audits, infection rates and unplanned readmissions and transfers to NHS care. The results of the scorecard were discussed at the paediatric steering group who met monthly. The clinical scorecard was also part of the quarterly governance report and was discussed at the medical advisory committee and clinical effectiveness meetings.
- We saw the revised paediatric medical records audit form. This was to be used for the period January to March 2017 and incorporated additional checks including PEWS score calculations being calculated correctly.

Pain relief

- Pain scores were recorded on the paediatric early warning record. We observed patients being asked if they had any pain. A visual pain chart was used for younger patients to assess their pain score.
- The children's lead nurse was an advanced practice nurse prescriber, which enabled them to respond to patient's pain if doctors had not prescribed pain relief.
- There were details of the paediatric clinical nurse specialist for pain at the local acute trust in the hospital's paediatric policy to contact for advice if required.
- Audit results for June to September 2016 showed documentation of pain scores was consistently at 100% on PEWS charts on the ward, in PACU and also on discharge.

Nutrition and hydration

- Fasting guidelines were in use. Patients and parents were given clear written instructions prior to admission about food and fluids. Patients were provided with small drinks in line with the guidance if theatre lists were changed or there had been delays.

Good

Services for children and young people

- Fluid fasting times less than 6 hours for children were audited quarterly. We saw compliance to be 74% between June and September 2016 and 60% between October and December 2016. The target set by the hospital was 50%.
- Patient's meals were prepared on site. There was a children's menu and children were encouraged to choose their food. The meals looked appetising and nutritious.
- We were told by managers the menu had been developed with input from a dietician and there was a healthy option available. Children had been involved in taste testing when the menu was updated.
- Senior managers said that if a patient required a nutritional assessment, this service was available as a same-day referral.
- One patient we spoke with was pleasantly surprised by the choice and quality of the food. However, one parent commented the choices were 'not very healthy'.
- There was access to food up to 6.30pm from the hospital kitchen. Snacks were available outside of meal times.
- Meals were provided to one parent during their child's stay, as there was no visitor's restaurant.

Competent staff

- Staff had regular appraisals with outcomes. Staff told us they had three appraisal meetings with their manager each year. Staff spoke positively about the appraisal system and the support towards additional training, for example paediatric epidural training.
- All staff on the children's ward had received an appraisal in the last 12 months.
- Staff on the children's ward had a mentorship qualification, which meant they could support student nurses. There were no student nurses working at the time of the inspection.
- The hospital was an accredited training centre for advanced life support training.
- Staff on the children's ward acknowledged the narrow scope of nursing practice, due to the limited types of procedures, treatments, care and complexities they admitted. Staff rotated between the ward and the PACU in order to maintain skills and knowledge in pre-assessment and immediate post-operative care.
- Staff said they would like to see the service develop towards a wider range of children's surgery, which would help them maintain their skills and knowledge.
- Senior managers were arranging for staff working in the children's service to gain more experience. This was to be achieved by rotating into the anaesthetic room and the adult ward to enhance knowledge and skills in airway management and phlebotomy.
- Staff told us there were opportunities to access additional training and qualification via external courses.
- Staff told us they did not undertake clinical supervision. However, support for professional revalidation was available.
- The hospital physiotherapists were not paediatric trained. Staff told us they were able to access advice from the local acute hospital trust if required.
- Registered nurses, physiotherapists and qualified radiology staff had a number of professional competencies related to the care of children and young people assessed annually. We saw six competency assessments, which showed assessment of children and communication with children and families was included. However, evidence to demonstrate these competencies had not been completed on two of the competency assessments.

Multidisciplinary working

- Some children were seen in the physiotherapy department.
- We observed good verbal handover of a patient between the PACU staff and the ward staff. Record keeping was good at the point of handover.
- We saw communication with community health services for children such as GPs, health visitors and school nurses.

Access to information

- Staff on the ward had access to NHS paper records for patients who were NHS funded.
- There had been no incidents of children attending outpatients without their paper records being available.
- Discharge letters were provided to GPs, school nurses and health visitors.
- Staff had access to information such as policies, procedures and guidelines on the hospital's intranet.
- Patient's test results and images were all easily available to the relevant staff through the electronic reporting systems.

Consent and the Mental Capacity Act

Good

Services for children and young people

- The records we looked at all demonstrated appropriate signed consent for children attending for elective surgery.
- Staff were aware of Gillick competency and an information leaflet to prompt staff to consider Gillick competency when assessing older children was available.
- The lead children's nurse was aware of the rights of young people aged 16 and 17 years regarding care and treatment on adult wards.
- Audit results for June to September 2016 showed documentation of consent for rectal medication in 96% of cases checked.

Are services for children and young people caring?

Good

We rated caring as good.

Compassionate care

- On the children's ward, we observed staff treating children and families with dignity and respect. We heard most staff using language appropriate to patient's age and level of understanding. However, in the outpatient's department we heard one member of staff using language more suitable for a much younger child.
- A patient told us the staff had all introduced themselves and were very attentive. Staff came into the room every 10 – 15 minutes.
- We spoke with three parents and two young people to gain an understanding of their experiences of care. All the feedback we received was positive. Parents felt they were given enough privacy but staff were also attentive to their needs.
- We saw staff use distraction techniques to reassure and calm children, and did their best to make it a positive experience for the child and parents. Staff were also supportive to parents, providing reassurance when they were upset.

Understanding and involvement of patients and those close to them

- We saw staff involve very young children in their care. They were given choices about how they would like to travel to the theatre. The young children we saw travelled in a play car and their parents went with them. Parents also went with the nurse to return their child back to the ward from PACU.
- The young person we spoke with said they had everything explained to them about the care they were receiving. They were happy with the way the staff spoke with them and they felt they had enough information.
- The parents we spoke with felt involved and well informed about the care of their child. One parent with a young child said they were impressed at the way staff asked their child questions first, to include them in the care. They appreciated this and said it was 'refreshing'.
- Information about the service was available in child friendly formats, such as photographs and pictures allowing children and young people to understand their care and contribute to decisions.

Emotional support

- We observed staff being sensitive to the emotional needs of children and their parents in all the areas we visited.
- We saw staff being supportive and providing prompt care for a patient who was unwell after surgery.
- Parents were encouraged to attend the post anaesthetic care unit.
- Nursing staff rotated between the pre assessment clinic, the children's ward and PACU so children were likely to see a familiar nurse in different areas of the hospital.
- Visiting hours were unrestricted for parents and family. However, the number of visitors may be restricted at the discretion of the nursing staff.

Are services for children and young people responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- There were service level agreements in place with the local clinical commissioning groups for the treatment of NHS patients to meet local demand.

Good

Services for children and young people

- A consultant led children's allergy testing service and immunisation clinic had recently been commenced at the hospital. This was held on the children's ward.
- There were criteria for admission to the ward. We saw in the paediatric steering group minutes in October 2016, there had been discussion about reviewing these criteria for children who experienced sleep apnoea.

Access and flow

- The hospital was consistently meeting the 18 week national indicator standard for referral to treatment time.
- The pre-operative assessment clinic was held on the ward. The children's nurses assessed the patients using a checklist which included allergies, preferences, parent's contact details and emergency contacts. The patients were also weighed and the appropriate colour coding recorded for the purpose of drug administration and emergency resuscitation care.
- A minimum of five working days' notice was given to patients/parents for admission. This allowed staff time to plan staffing on the ward and in theatre.
- Staff told us they would not book elective surgery cases onto the ward unless there were the appropriate staff available. Information supplied to us showed between 1 August 2016 and 30 November 2016 there had been no cancelled operations due to staffing issues on the ward or in theatre.
- There had been six cancelled operations between 1 August 2016 and 30 November 2016. These were due to clinical reasons, patients/parents changing their mind and failure of the patient to arrive.
- It was hospital policy to schedule children at the start of theatre lists if the list was not solely paediatrics.
- There was an agreement and pathway in place for patients to be transferred to the local NHS trust's paediatric ward if they had not recovered sufficiently to be discharged and there were no nursing staff available to cover the night shift. There had been no recorded incidents of this occurring between 1 January 2016 and 30 November 2016.
- Parents we spoke with were happy with the time they had waited for their child's appointment and subsequent operation. This had happened in less than four weeks.

Meeting people's individual needs

- The hospital paediatric policy stated the planning and delivery of care would recognise the multi-cultural nature and needs of the population.
- Individual needs of children were assessed in the pre-assessment clinic which was held on the ward. This helped the child become familiar with the ward and the staff.
- Each child was risk assessed prior to admission and then accepted for admission on a case-by-case basis. The consultant and anaesthetist discussed children with complex medical needs prior to being accepted for admission.
- Children with physical or learning disabilities would only be admitted if their needs could be adequately met. This was assessed at pre admission assessment clinic on the ward.
- The bedrooms on the children's ward had been decorated and equipped with age appropriate equipment, toys and books. Two rooms had more adult decoration to suit adolescent needs. There was Wi-Fi available to meet the recreational needs of older children.
- There were facilities, such as a camp bed, for one parent to stay overnight on the ward, in the room with their child. Food and drink was also provided for one parent during their child's stay as there was nowhere on site for visitors to purchase food. Parents were made aware of this prior to admission in the information sent to them.
- We saw a leaflet for children explaining what an x-ray was. This was written using simple language and pictures.
- On discharge from the ward, parents were able to contact the hospital for advice if needed. The children's nurses had an on-call rota when the ward was closed. A nurse from the adult ward could contact the children's nurse on-call for advice if a children's nurse was not on site.
- The post anaesthetic care unit (PACU) was shared with adult patients. It was not a child friendly environment. The children's bay was separated from the adults' recovery bays by a curtain, but adult patients in the area could be seen and heard. The bay did not contain any child friendly décor. Child friendly bedding was used and children were encouraged to take their favourite toy

to theatre with them. The Standards for Recovery for Safer Perioperative Practice, 2016, states paediatric recovery should take place in a child-orientated environment.

- We saw in the paediatric steering group minutes the issue of child-friendly distraction in the anaesthetic room was discussed with some ideas and suggestions on how to improve this part of the child's journey to be explored. However, there were no timescales for this.
- The service did not have a play therapist to support the play needs of children. However, on the ward a children's support worker had been appointed with play qualifications to address this.
- The children's ward could access a hoist if needed and we were told staff had received moving and handling training. There were appropriately sized hoist slings on the ward. However, equipment to meet the needs of children with a physical or learning disability was not in place on the ward. Senior managers told us any additional equipment could be accessed prior to the patient's admission if required.
- The hospital had access to translation services and staff told us they were aware of this. However, there had been an incident in August 2016, of a very young child attending theatre where the parent accompanying the child could not understand or speak English. The correct checks had not happened prior to the procedure.
- Staff in radiology told us they prioritised any children who had been referred. The radiology waiting area was not child orientated.

Learning from complaints and concerns

- There was a hospital wide complaints procedure.
- The children's service had not received any complaints between 1 January and 30 November 2016. The nursing staff would discuss complaints at team meetings and we saw there was a standing item on the agenda for this.
- No information about how to make a complaint for patients and families were seen on the children's ward. However, there was information on the letter given to children/parents after their outpatient consultation prior to attending the pre-admission assessment clinic and on the letters sent after attending this clinic.
- 'Please talk to us' leaflets were available throughout the hospital for patients and relatives to use to raise any concerns about their care and treatment.

Are services for children and young people well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The service was led by a lead nurse and a named paediatric consultant. The lead nurse reported to the head of clinical services.
- Staff were positive about working at the hospital. They told us management were supportive and there was a culture of openness. They told us there was a good working relationship between the consultants and the nursing staff.
- Staff told us they liked working at the hospital. They believed it gave them an opportunity to provide a quality service to patients.
- Staff told us they saw the matron frequently and said they would be able to approach her with any concerns they might have. We were given some examples of this happening.
- The hospital was supportive of advanced learning and developing staff. For example, staff on the ward were given opportunities to attend external courses.

Vision and strategy for this core service

- The vision of the service was for children and their families to receive the highest possible standard of care. We saw this was underpinned by the behaviours demonstrated by staff and the way they spoke about the service they delivered.
- The hospital paediatric policy stated "Admission to the ward was child centred, based on a partnership between the family and the health care team". However, we did not see a written strategy document specifically for the children's ward. The staff hoped the service would expand offering more services to more children in the future.
- The hospital values were clearly displayed on the ward and staff knew what they were and what they meant.

Governance, risk management and quality measurement

Good

Services for children and young people

- The hospital had governance processes in place. These were described in the provider's clinical governance and quality assurance policy dated October 2014, which incorporated the governance structure and reporting channels. However, this did not include the remit of the paediatric steering group. Channels for reporting were indicated in the hospital's paediatric strategy.
- The hospital had a local committee structure with regular meetings. This included a heads of department meeting every month which was attended by the head of clinical services.
- There were also health and safety/risk committee meetings every quarter, a clinical effectiveness meeting every week and a process review meeting every week. These fed into the weekly senior management team (SMT) meetings and quarterly risk meetings, which in turn fed into the medical advisory committee (MAC) and the quarterly clinical governance meeting.
- The medical advisory committee was held quarterly and chaired by a lead consultant. Appropriate paediatric consultants including the chair of the paediatric steering group attended this meeting.
- The hospital had a clinical governance lead responsible for risk management, audit, incident investigations, RCA investigation reports and local policies. They also produced a quarterly clinical governance report. This was shared with the clinical effectiveness, clinical governance and medical advisory committees. The report included the results of hospital audits, clinical scorecard audits, clinical incidents, complaints and the risk register. Lessons learnt from incidents were also recorded.
- The paediatric steering group met monthly. We reviewed minutes from two meetings and saw issues such as morbidity and mortality, policy updates and incidents were discussed. However, minutes or matters arising from this meeting were not a standing agenda item on the weekly senior management team meeting or on the quarterly medical advisory committee.
- We reviewed minutes from ward meetings, senior management team meetings and clinical effectiveness team meetings. We saw issues related to incidents, risks, complaints and audits were discussed. A weekly clinical effectiveness group was held and minutes were available for staff to read. We saw in ward meeting minutes that staff were encouraged to read these to keep up to date with what was going on in the hospital. However, we saw no evidence of staff confirming they had read these.
- The hospital wide risk register was reviewed quarterly at the SMT meetings which reviewed risks in the children and young people's service. The paediatric lead nurse had worked with the clinical governance lead to review the risks and controls relevant to their area and keep the register up to date. Staff were clear on how they wanted to develop the use of the risk register to drive improvement.
- The risk register was reviewed quarterly at senior management team meetings, heads of department team meetings and governance meetings. The top five risks were shared with the MAC and all staff were communicated with about risk management.
- There were risks identified in outpatients for children relating to ability to react to a child with deteriorating health and the inability to provide a chaperone. These risks had been scored at four and three respectively. Both these risks were due for review at the end of January 2017. We saw some actions had been taken to mitigate these risks such as emergency simulations involving a child and a plan to recruit appropriately trained staff into outpatients.
- There was some disconnect between the Spire Healthcare policies and what was happening within the hospital. For example, the corporate admission and discharge policy stated "the minimum age at which a child will be admitted to a Spire hospital for all procedures is three years (with the exception of Manchester only)". Patients were being admitted to Spire Leeds hospital who were younger than three years, which was in line with the local paediatric policy.
- We saw some policies and guidance for staff did not have appropriate document control. For example, audit forms and action plans and letters/information for parents without review dates, version number or author.

Public and staff engagement

- The ward had engaged young people to contribute to the refurbishment of the children's ward.
- Children and young people contributed to the menu development.
- Response rates to friends and family tests were low at 26.2%. This was better than the national average of 24.1%. Managers at the hospital were aware of this and

had plans to improve the response rate. For example, we saw a simple feedback care system was in operation in the outpatients department and managers told us the hospital volunteers were promoting this.
- There was very positive feedback about the ward on their Facebook page.
- Feedback was used in the form of "you said, we did" information displays.

Innovation, improvement and sustainability

- There were plans to have more specialities for paediatrics at the hospital in the future.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Outstanding
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- The hospital had a good culture of incident reporting and we found good evidence of feedback and learning from incidents. Staff understood their responsibilities to raise concerns.
- Incidents were reported using an electronic reporting system, staff we spoke with knew how to report incidents using this system. Radiology staff told us their most recent incident had occurred on 9 November 2016. A patient had their lumbar spine x-rayed but there was no image on the digital radiology so the patient was x-rayed again in another room. The investigation showed the dose had not been greater than 10 times the safe level so the incident was not reported to the CQC. It was reported to the radiation protection advisor.
- In the reporting period (July 2015 to June 2016), there were 29 clinical incidents and four non-clinical incidents within outpatients and diagnostic imaging. The rate of clinical and non-clinical incidents was lower than the rate of other independent acute hospitals.
- We reviewed radiology incidents for the 12 months from January to December 2016 during the inspection. We noted the majority of these were near miss incidents, which had been picked up during the 'pause and check 'stage before the procedure was carried out. This was an example of good practice.
- Learning from incidents was shared at staff meetings in order to improve quality and learn lessons. In radiology, incidents were used in workshops for continual professional development. The radiology manager and deputy manager had received training in carrying out root cause analysis as part of their management training.
- However, we found there was a lack of knowledge about incident trends in radiology and outpatients. Senior managers were not aware of the most common incidents in their departments and trends were not monitored.
- Shared learning summaries were used at hospital meetings throughout the hospital to ensure staff received feedback following incidents.
- Staff we spoke with were aware of the requirements of the duty of candour. They told us they would be open and honest with patients if any harm had been caused. Duty of candour was included in staff mandatory training and there was a policy and leaflets, which explained duty of candour in simple terms. The nursing services manager, whose responsibilities included outpatients, explained the process and told us they had been involved with two incidents that had required the duty of candour to be implemented.

Cleanliness, infection control and hygiene

- There were effective systems in place to reduce the risk and spread of infection; people were cared for in a clean, hygienic environment.
- In the reporting period (July 2015 to June 2016), there were no incidences of hospital acquired MRSA (Meticillin resistant Staphylococcus aureus), MSSA (Meticillin sensitive Staphylococcus aureus), Clostridium difficile (C.diff) or E.coli.

- We saw 'five steps to hand hygiene' information on display in the outpatient treatment rooms.
- The hospital had changed its method of auditing hand hygiene. In June 2016, the hospital introduced observational hand hygiene audits, results from quarter three showed staff were 95% compliant however, it was not clear which clinical area this related to. The results of the audits were reported quarterly through the IPC committee and clinical scorecards.
- The infection prevention and control (IPC) lead was responsible for infection-control audits within the hospital. They told us staff were fully aware of hand washing and hand hygiene audits. A consultant microbiologist supported the IPC link meeting and IPC committee meetings.
- We observed staff using personal protective equipment (PPE), such as gloves and aprons, appropriately and complying with the arms bare below the elbow requirement. We observed hand gel in wall-mounted dispensers and on reception desks with signage encouraging people to use it. Hand wash, sanitisers and creams were available in all areas.
- Appropriate containers for the disposal of clinical waste, including sharps bins, were available and in use in all the departments visited. Outpatients had carried out a waste audit in November 2016; we reviewed this audit and found all the actions required had been completed.
- All outpatients consulting rooms had carpets in the consultation area. Some consulting rooms had a separate examination area and we saw these had laminated flooring. A senior member of staff told us if the patient was coming for a dressing change, then this would be carried out in the treatment room. Curtains were disposable and were changed every four months in outpatients and every three months in radiology, or when required if contaminated.
- The outpatient nursing staff and healthcare assistants were responsible for cleaning two consulting rooms each day. They restocked the trolleys and checked equipment was in date. The equipment checked in all departments visited was visibly clean and had green 'I am clean' stickers attached.
- Domestic staff cleaned the outpatients department at 6am before the clinics started; they completed cleaning checklists. We reviewed the last 12 months of cleaning checklists; these were all completed as required.
- We saw the mammography room in radiology did not have a hand washbasin. However, hand sanitiser was available for staff to use. The radiology manager told us there were plans to extend this room within the next two years and a hand washbasin would be included in the new room layout.
- We reviewed radiology cleaning rotas, which were completed by domestic staff and radiographers; we found good compliance. However, records suggested some radiology equipment (in CT) was cleaned weekly; staff confirmed cleaning was carried out daily. The cleaning records were changed to daily as a result of our feedback during the inspection.
- Radiology had policies for the management of patients with infectious diseases, in order to protect people from healthcare associated infections. We reviewed these policies, which included a policy for the management of patients with suspected or confirmed tuberculosis.

Environment and equipment

- The outpatients, radiology and physiotherapy departments were located on the ground floor of the hospital. Outpatients and radiology were co-located and shared a main waiting room. Signage throughout the internal and external areas was clear.
- All waiting areas appeared to have sufficient seating, which was made from washable material. High seat chairs with arms were available for patients with mobility problems.
- The outpatients department had 18 consulting rooms, two treatment rooms, a plaster room and a recovery room. Equipment for use in the rooms was kept on trolleys. For example, in treatment room one, there were two separate trolleys; one with blood taking equipment and one with wound care equipment. This meant equipment for different procedures was stored separately.
- Resuscitation trolleys were easily accessible in all of the departments visited. They had paediatric emergency grab bags on top. We checked the contents of the resuscitation trolleys and records of daily and monthly checks; the contents were all in date and records completed as required.
- All equipment in the outpatients, radiology and physiotherapy departments we looked at had been electrically checked and was in date. We reviewed equipment maintenance records for these departments; these were comprehensive and well maintained.

Good

Outpatients and diagnostic imaging

- We found one temperature monitoring machine which had been due for maintenance in November 2016. We informed the nurse about this and they escalated the issue immediately.
- Physiotherapy was located in Roundhay Hall, which was the older part of the hospital. There were two gymnasiums and a private treatment room. Staff told us the private treatment room was generally used for women's health appointments or for patients with hearing impairments.
- There was also a trim trail in the grounds. Senior managers told us this was installed at the request of patients.
- The hospital had recently had an external health and safety audit, which had scored 98%. All of the departments carried out environmental audits. For example, in outpatients, the September 2016 audit had shown that a new washbasin was required. We saw the actions from this audit had been completed and the new washbasin had been installed.
- The hospital experienced some Wi-Fi connectivity problems due to external factors. The Wi-Fi affected radiology's mobile x-ray machine and meant staff had to connect to the network directly to download radiology images.
- The hospital's patient led assessment of the care environment (PLACE) scores for the period February 2016 to June 2016, were the same or higher than the England average for cleanliness, food, privacy and dignity, and the condition appearance and maintenance of the environment.
- The radiology department had three reporting rooms, two general x-ray rooms, a magnetic resonance imaging (MRI) scan room, a computerised tomography (CT) scan room, and dedicated rooms for ultrasound, fluoroscopy and mammography. The mammography room also contained a panoramic ortho-pan-tomography machine; staff told us this machine was rarely used.
- Radiology was also responsible for two image intensifiers in theatre and a mobile x-ray machine. Radiographers went into theatres to use the image intensifiers.
- The mobile x-ray machine was kept on the critical/ intensive care unit. We went with the radiology manager to look at this machine. We found local rules were displayed, there was an exposure chart and a numbered protective lead coat attached to the machine.
- All radiology equipment was digital radiology (DR) which is the newest technology available. The hospital had an equipment replacement programme and staff told us hospital managers were responsive when new radiology equipment was required.
- The deputy radiology manager told us one ultrasound machine was, "due to be replaced next year." There were also plans for a new angiography suite for cardiac and vascular cases.
- Radiology had a small separate patient waiting area within the department, with two adjacent changing cubicles. Patients could lock these rooms and take the key with them.
- Access to the radiology department was protected by the use of digital locks on the doors. There was appropriate signage saying 'staff only' and warning of the danger of exposure to radiation.
- The MRI department had its own waiting room and changing area. Access to the MRI department was restricted. All rooms in the MRI department were locked to prevent other staff from coming in and the MRI scanner door was locked when unattended.
- Staff told us warning signs were put outside the theatres when imaging was in progress. However, we did not visit the theatres as part of this inspection.
- Radiology had local use rules in place to manage the use of personal equipment. This included lead coats, which were used to protect the radiographers during examinations. These were numbered and regularly maintained and checked to ensure there were no tears or damage. This provided assurance that staff wearing the protective lead coats were not exposed to ionising radiation.
- We observed the lead coats in use were all in good condition and saw evidence of safety checks. Lead coats were also available in theatres and interventional radiology staff were responsible for regularly checking the safety of these.
- The radiology department had digital imaging facilities with an integrated picture archiving and communication system (PACS). This meant medical staff and healthcare professionals could access x-ray and scan images in outpatient areas and on the wards. Images could also be transferred to other healthcare providers via the image exchange portal (IEP) and PACSMail.

- Radiology administrative staff told us they had recently requested bigger computer screens, new chairs and a light and these were all installed very quickly. They said these had improved their working conditions in the radiology administrative office.
- At the time of the inspection, the pathology laboratory was verifying a new haematology machine, which would be used to check blood for transfusion to patients. The hospital had plans for the refurbishment of the pathology laboratory. However, the pathology manager was unsure of the completion timescales.

Medicines

- See information under this sub-heading in the surgery section.
- Appropriate arrangements were in place obtaining, recording, and handling medicines. We found medicines were stored securely in appropriately locked rooms and fridges in all of the areas we visited. No controlled drugs were stored in the departments.
- Staff recorded fridge and room temperatures where medicines were stored every day. We checked current records and historic evidence and found these were all completed and correct.
- Prescription pads (Spire Healthcare prescription sheets) were securely stored and managed in outpatients. There were no nurse prescribers working in outpatients.
- Medical staff were given one prescription sheet at a time, as and when needed. Patients could go to their own GP for an NHS prescription if they preferred to do this.
- The outpatients department had a small stock of medicines for patients to take home. We saw these included a selection of antibiotics and medicines for pain relief. There was a form to record when these had been dispensed out of hours. Patients were sent to pharmacy in hours. Only medical staff could prescribe medicines for patients.
- Patient group directions (PGDs) were used in outpatients and radiology; we saw these were all signed and up-to-date.
- The hospital had recently started electronic prescribing.
- The hospital had fridges for storing blood for transfusion in the pathology laboratory and in theatres.

Records

- Patient records were managed in a way that kept people safe. We saw records were accurate, completed correctly, legible, up-to-date and stored securely. The hospital was working towards introducing a single patient record.
- The outpatients and physiotherapy departments used paper records. Radiology used a mixture of electronic and paper records. The radiology information system (RIS) was electronic. Staff scanned documents onto the RIS; these included referral forms, WHO checklists and consent forms. This was an example of good practice.
- Patient records were stored securely within the departments we visited. We saw all outpatient consultation rooms and secretaries offices were digitally locked. There was a large safe within the outpatients department, which was used to store medical records securely until they were required. Three months of paper records were kept on-site, after which time they were archived off-site.
- There was a dedicated medical records team on site. We spoke with the team manager and a team member about the processes for obtaining medical records for outpatients' clinics.
- We reviewed 10 sets of patient records in outpatients and five patient records in physiotherapy. We found these were legible and were well maintained with care pathways and other documentation fully and correctly completed.
- The provider reported that over the previous three months the hospital had not seen any patients in outpatients without all their relevant medical records being available.
- The provider said if a patient attended outpatients as an emergency and their records were not available then a temporary set of medical record would be provided. Staff used the most recent copies of clinic notes and letters so notes were available for the consultant. These were tracked, traced and merged on return.
- If a patient attending the dressing clinic did not have their notes available, the nurses used their discharge letter or accessed the online system to look up to the date and type of surgery. Outpatient notes relating to the visit were recorded by the nursing staff and filed in the patient medical record as soon as possible.
- Hospital staff were not allowed to take medical notes off site. If a patient required transfer to another hospital, their medical records were photocopied to accompany them.

Good

Outpatients and diagnostic imaging

Safeguarding

- See information under this sub-heading in the surgery section.
- People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.
- Safeguarding policies were in place and provided staff with information about identifying, responding to and reporting any safeguarding concerns; this was supported by staff training.
- The paediatric lead nurse had completed a Masters module in safeguarding and was educated to level four in safeguarding. This allowed them to deliver face to face level three safeguarding training to staff locally.
- All staff completed safeguarding adults level one and level two training and safeguarding children and young people level one and two training as part of their mandatory training programme. Training data provided by the hospital showed 100% compliance.
- Clinical staff and consultants completed safeguarding level three training; training records showed 100% compliance with this training.
- Staff we spoke with were knowledgeable about what actions they should take in the event of a safeguarding concern.
- We saw safeguarding leaflets and posters on display in the departments we visited. All staff were aware of their requirements to recognise and report female genital mutilation (FGM). FGM is illegal in the UK and since October 2015, health professionals have a statutory duty to identify and report cases. Gynaecology procedures were carried out in the colposcopy room (treatment room one) within outpatients.
- Feedback from patients we spoke with showed they felt safe at all times. Comment cards completed by patients also mentioned feeling safe and well cared for.

Mandatory training

- Data provided showed staff received appropriate mandatory training; compliance rates for mandatory training were consistently high and above the Spire target for end of year compliance, which was 95%.
- Mandatory training included fire safety, health and safety, infection control, life support, manual handling and equality and diversity.

Assessing and responding to patient risk

- The hospital had systems and processes in place for assessing and responding to patient risk. We saw there were nurse call buttons in all areas, including the outpatient consulting rooms and the recovery room.
- There were clear processes in place for staff to follow in the event of a patient's health deteriorating. We reviewed the unwell patient policy online in radiology. Radiology staff could access these policies easily.
- The hospital had a ward transfer policy; we reviewed this policy and saw it included instructions about the transfer of visitors who became unwell while on the hospital site.
- We saw equipment for the protection of patients was available in all the rooms where treatments or procedures took place. For example, in the ophthalmology laser room there were eye protection goggles.
- We observed practice in the outpatient's ophthalmology laser room; the door to the room had restricted access on the outer lock. This ensured the door was locked when in use and other staff or patients were unable to enter the room while laser treatment was in progress.
- We were assured when a patient was expected; laser treatment appropriate signage was put on the door while it was in use. We also saw there were appropriate risk assessments in outpatients for the use of lasers and local rules were on display, dated 29 April 2016.
- We reviewed the laser safety reports from 2014 and 2015; the next report was due in February 2017.
- Sentinel node imaging was carried out at the hospital. There was a policy for the disposal of radioactive waste in radiology; we reviewed this policy. This was an example of good practice.
- The most recent Radiology Protection Advisor's audit report, issued on 15 November 2016, showed work with ionising radiation was carried out in compliance with the relevant legislation. We found the recommendations made in report had already been actioned and there were no outstanding actions to be completed. For example, the audit recommended monitoring of eyes and fingers of relevant staff working in theatres and angiography and the appointment of suitable Radiation Protection Supervisors in angiography and in theatres, for work with radioactive materials (sentinel lymph node biopsies).
- The five steps to safer surgery including the World Health Organisation (WHO) safety checklists were used in radiology and outpatients. We reviewed the WHO

safety checklist folder in outpatients and six completed WHO safety checklists in radiology; these were all correctly completed. In radiology, the WHO safety checklist was used for drainages, biopsies and interventional procedures. WHO safety checklists were also used in cardiac angiography and ultrasound.

- Radiology audited the use of the WHO safety checklist and carried out observational audits. We reviewed the most recent audit results and action plan from December 2016, these showed good compliance with the use of the checklist.
- Outpatients used a theatre register for procedures carried out in the minor procedures and treatment rooms. We reviewed this and saw swab counts (if swabs were used) and specimens taken were recorded alongside staff comments related to the procedure.
- Outpatients also used a team brief checklist, which was completed for each consultant. We reviewed sheets from April 2016 to the date of the inspection. The nurse allocated to the consultant completed these. The checklist included questions such as 'what went well,' 'is anything to make the list safer,' 'is there anything to make the list more productive' and a second check showed whether the WHO checklist was completed. Use of this checklist was an example of good practice.
- In radiology, we observed appropriate signage, which identified areas where radiological exposure was a place, in line with IR(M)ER regulations. This ensured visitors and staff did not accidentally enter a controlled zone.
- We reviewed the radiology positive patient identification policy. Radiology used a three-point identification check to ensure the procedure was being carried out on the correct patient.
- The MRI Department used a three-point check and justification, which had to be signed. This was to make sure the correct patient had the correct scan. Request for MRI scans were vetted by the radiologists prior to the appointment being booked.
- Radiation staff wore dosimeter badges to monitor their exposure to radiation. These were sent away for analysis on a regular basis.
- The radiology manager and radiology deputy manager were both radiation protection supervisors (RPSs) for the hospital. There was also an RPS in theatres and in angiography.
- The medical physics department in a nearby NHS trust provided radiation protection advice; they provided the hospital's nominated radiation protection advisor (RPA).
- Radiology staff explained the hospital's lone working policy; if they were in the hospital out of hours they were required to sign in at reception and carry a pager.

Staffing

- There were sufficient qualified, skilled and experienced staff to meet people's needs. Senior staff in all departments told us staff worked flexibly to accommodate the needs of the service.
- Staff and patients we spoke with told us there were always enough staff to meet people's needs. Outpatients' staff told us they were, "always plenty of staff on duty" and they were very experienced.
- On 1 July 2016, the hospital employed 7.1 full-time equivalent (FTE) outpatient nurses and 4.3 FTE healthcare assistant in the outpatients department. The ratio of nurses to healthcare assistants in outpatients was 1.7 to 1.
- At the time of the inspection, the outpatient department was fully staffed. The staffing establishment for outpatients was seven FTE qualified staff (nurses), three FTE non-qualified staff (healthcare assistants) and three FTE bank qualified staff.
- There was one new position vacancy in outpatients; this was to support the hospital's single patient records project and was for 33 hours a week.
- The sister in outpatients told us staffing had increased over the previous 12 months; this was due to the increased requirement for chaperones to be present during consultations.
- Staff from some specialties worked across inpatient and outpatient areas and were not included in the outpatient staffing establishment. For example oncology, paediatrics, pre assessment, cardiology and urodynamics.
- The rate of use of bank and agency nurses in outpatients between July 2015 and June 2016 was between 0% and 7%, apart from in January 2016 when it was 10%. This is lower than the average for other independent acute hospitals.
- The rate of use of bank and agency healthcare assistants in the outpatients' department between July 2015 and June 2016 was between 0% and 14%. This is lower than the average of other independent acute

hospitals, apart from in November 2015. There were no agency nurses or healthcare assistants working in the outpatient department between April 2016 and June 2016.
- Sickness rates for outpatient nurses were lower than the average of other independent acute hospitals for the reporting period July 2015 June 2016, except for in October and November 2015, April 2016 and June 2016.
- Sickness rates for outpatient healthcare assistants were lower than the average of other independent acute hospitals between November 2015 and June 2016.
- There were no unfilled shifts in outpatients between April 2016 and June 2016.
- Staff turnover for outpatient nurses in the reporting period July 2015 to June 2016, was below the average of other independent acute hospitals.
- Staff turnover for outpatient healthcare assistants was above the average for the independent acute hospitals in the same reporting period.
- The radiology department was fully staffed and had one fixed term contract in post to cover maternity leave. There was a team of four or five bank staff in radiology available to cover as required.
- The hospital employed 9.6 FTE radiographers (including those working in MRI and CT), 2.6 FTE radiology assistants and 3.43 radiology admin staff. There were no nurses in radiology.
- The radiology managers told us there was low staff turnover in radiology and many of the staff had worked at the hospital for several years.

Medical staffing

- Patients attending outpatient clinics for appointments related to procedures carried out at the hospital saw their own consultant.
- Two resident medical officers (RMOs) were employed by the provider and provided medical cover 24 hours a day, seven days a week. Staff told us the RMO was always readily available.
- There was a radiologist on site seven days a week. There was no formal on-call radiologist rota. Radiologists were available to be contacted out of hours and were aware they were required to cover clinical emergencies as and when required. Staff in radiology told us they never had any problem contacting the radiologists if they were needed urgently.
- The hospital used a biochemistry consultant and haematology consultant to interpret pathology results. Pathology staff told us these consultants always arranged cover if they were on annual leave.
- Staff we spoke with in all departments confirmed all consultants and radiologists were always contactable, or would have cover arranged.

Emergency awareness and training

- See Surgery section for main findings
- The hospital undertook scenario testing to check services were safe; these included fire drill and resuscitation scenarios.
- The hospital had completed a desktop scenario for an outbreak of infection or sudden loss of utility services.

Are outpatients and diagnostic imaging services effective?

Effective was inspected but not rated.

Evidence-based care and treatment

- Spire policies and procedures were developed corporately (nationally or locally) and took account of current, relevant, evidence-based best practice such as National Institute for Health and Care Excellence (NICE) guidance. The hospital audited policy compliance.
- We found physiotherapy staff were following The Chartered Physiotherapy Society and NICE guidelines and oncology breast care specialist nurses were following the national cancer strategy and NICE breast cancer guidance. Radiology complied with the ionising radiation regulations.
- The radiology and physiotherapy departments carried out local audits.
- Radiology carried out a thermoluminescence dosimetry audit of dosimeter badges. They also carried out a hand and eye radiation dose audit for cardiologists and radiologists. These audits were examples of good quality control practice in radiology.
- We reviewed the quality assurance records for the two ultrasound machines; these were carried out weekly. Results were all up to date and very good.
- Mammography images were all double read as recommended by the NHS breast-screening programme (NHSBSP).

- We reviewed the mammography quality assurance folder and saw daily and weekly checks were completed. The hospital worked with another hospital, exchanging quality assurance results every three months. This peer review of images met with the current 'standards for the reporting and interpretation of imaging investigations (2015).' The results from the most recent mammography peer review audit in August 2016, showed the five mammographers produced at least 80% of their images in the G (good) category or above, as recommended by the NHSBSP guidelines.
- The pathology department was accredited with the United Kingdom Accreditation Service (UKAS); their last inspection was in May 2015. The pathology manager told us all non-conformities from this inspection had been cleared and they had received their accreditation certificate on 1 December 2016.
- Pathology used the Q-pulse electronic document management and control system. However, the hospital and radiology department did not have a system for local document control.

Pain relief

- People's pain was assessed and managed. The hospital had a patient information leaflet about 'managing your pain at home'.
- When we asked staff in outpatients what they would do if patients reported experiencing pain, they said they would assess the level of pain and contact the consultant or RMO for advice. Only medical staff were allowed to prescribe medication.
- When we reviewed patient care records, we saw that pain relief administered was recorded along with whether this was effective in relieving patient's pain. Staff monitored the efficacy of the pain relief administered, to ensure patients' pain was minimised and well controlled.
- Four physiotherapists were qualified to carry out acupuncture. They were accredited with the appropriate professional body and the hospital supported their annual updates with study leave and attendance at relevant courses.
- The transcutaneous electrical nerve stimulation (TENS) method of pain relief was available within the physiotherapy department. Staff we spoke with told us this was used infrequently.
- One of the physiotherapists attended the hospital's pain steering group, which met quarterly.
- Patients seeing consultants in the pain clinic were referred to physiotherapy if the consultant felt it would be beneficial. Patients with chronic pain were managed by their consultant and physiotherapy staff would be involved if a musculoskeletal problem contributing to the pain. The physiotherapy department did not have a pain specialist physiotherapist.

Patient outcomes

- During the inspection, we reviewed five sets of physiotherapy care records. We saw the physiotherapy department used the 'patient specific functional scale' to measure functional outcome for patients. This was used at the initial assessment, follow-up assessments and on discharge to monitor outcomes. Physiotherapists also agreed treatment goal and objectives with patients. For example, we saw one patient had achieved an excellent clinical outcome and achieved their treatment goal of returning to playing football.
- We reviewed the average length of stay data for 2014 and 2015, which had been collated in February 2016. This audit showed an improvement in average length of stay (AVLOS) for patients. For example, in 2015 the hospital performed 200 total hip replacements (THR) and 215 total knee replacements (TKR). Comparing 2015 with 2014, the percentage of THR patients home by day 5 had increased from 87.2% to 93.6% and for TKR patients it had increased from 87.8% to 94.1%.
- The physiotherapy manager was planning to start preoperative classes for knee replacement patients. This was known to impact on post-operative outcomes.
- Physiotherapy were also working collaboratively with dietetics to develop a 'physio led exercise' service. This new method was to be piloted and audited prior to roll out using patients.
- Radiology had a comprehensive audit programme and audit results showed no areas of concern. For example, radiology staff carried out:
  - regular six-monthly audits of image quality in general radiology and MRI,
  - the quality of completion of surgical checklists, consent forms and request forms,
  - quality assurance files in general radiology, mammography, CT and MRI,
  - annual quality audits in x-ray and MRI, carried out by another provider
  - monthly MRI recall audits,

  - annual identification check / justification of exposure and pregnancy check audits in general, fluoroscopy, mammography, CT and MRI,
  - audits of warning lights.
- Radiology undertook annual audits on radiation exposure limits the local diagnostic reference levels (DRLs). Local patient dose surveys are carried out to ensure doses are lower than the national reference levels and within 20% of the local reference levels.
- We reviewed the most recent DRL audits, which had been carried out in September 2016, these included fluoroscopy procedures, mammography and the orthopantomagram. Patient doses recorded did not identify any concerns about over-exposure of patients to doses of radiation. Diagnostic reference levels were on display in all of the rooms in radiology.
- There was a lack of evidence of department-specific audits in outpatients. However, the nursing services manager told us they wanted to do more service-specific audits in outpatients.

Competent staff

- Staff were qualified and had the skills they needed carry out their role effectively and in line with best practice. Appropriate training was available for all staff including healthcare assistants. Staff told us improving their skills and knowledge was encouraged.
- Staff competencies were checked annually and consultant competence was regularly reviewed and practice embedded. Nursing staff in outpatients completed a competency booklet.
- We reviewed the training records and certificates for all of the staff who used the clinical lasers; these were all up to date and included consultants, registered nurses and healthcare assistants.
- Staff in all departments visited had all completed their annual appraisal at the time of the inspection. Data provided by the hospital showed appraisal rates were 100%, including consultants. The appraisal year ran from January to December. Staff told us they received a mid-year review.
- All staff undertook the Spire induction process and a local induction within the departments. We found evidence of this, staff told us the induction process and support offered was very good, and they had a named preceptor (mentor).
- All healthcare assistants and nursing staff in outpatients were competent in phlebotomy (taking blood). We saw records, which confirmed staff had to be trained and observed carrying out the procedure before they were signed off as competent.
- Radiographers who worked in mammography had the certificate of competence in mammography. Three permanent radiographers and two bank radiographers were qualified in mammography. All radiographers were competent to work in theatres and on call.
- There were four radiographers who worked in the MRI Department; they all had their postgraduate certificate of education. One of the four MRI radiographers had a Master's degree and another was undertaking a Master's degree.
- Radiology staff used the image exchange portal (IEP) to transfer patients' scans between services. All radiology staff were trained in this procedure.
- Radiology had recently upgraded the departmental induction programme for new staff. We reviewed this documentation and saw it was comprehensive and of a good standard. The radiology managers explained the induction process was the same for permanent staff as for bank and agency staff.
- Radiology held a list of non-medical referrers; these were required to undertake IR(M)ER training. We reviewed the list of practitioners; we saw there was one physiotherapist who could make referrals. There was also a radiographer in MRI who could make referrals for imaging the orbit of the eye. MRI is one of the best methods for evaluating orbits of the eye.
- Radiology had competencies for staff on each piece of equipment. Each staff member had their own file training on equipment; we reviewed staff competency records and saw the trainer and trainee were required to sign the radiographer off as being competent.
- The audit trail for initial specific equipment training on MRI equipment was not clearly evidenced for staff working in the MRI department. However, competencies were completed. IR(ME)R regulation 11 requires the employer to keep and have available for inspection an up-to-date training record for all staff showing the date on which training was completed and the nature of the training.

Multidisciplinary working

Good

Outpatients and diagnostic imaging

- Multidisciplinary working at the hospital was good and we saw numerous examples of good multidisciplinary working between teams for the benefit of patients.
- Staff from the hospital attended multidisciplinary team (MDT) meetings at the local trust. For example, the hospital employed two breast care consultant nurse specialists, who attended multidisciplinary meetings at the local trust.
- Staff working in radiology told us they had very good communication with the consultant radiologists who worked at the hospital.

Seven-day services

- The hospital provided seven-day services with on call cover in radiology and pathology.
- Outpatient clinics were open between 8am and 9.30pm Monday to Friday, on Saturday clinics were open from 8am to 2pm.
- There was an on-call system/rota in cardiology/ respiratory; three clinical physiologists provided cardiology respiratory testing out of hours if the consultant requested it urgently.
- General radiology was open from 8.30am to 7.30pm Monday to Friday; the department opened later on Tuesday and Friday evenings in order to support the breast clinics in outpatients.
- On Saturday mornings, radiology was open from either 8.30am to 12.30pm or 9am to 1pm, to fit in with the times of outpatients' clinics.
- Staff told us if there was a theatre list outside normal working hours, for example 8pm at night, then radiographers would be in the department to provide support.
- The MRI department did not work out of hours or at the weekend; the department was open until 7:30pm on Tuesdays, Wednesdays and Thursdays.
- There was an on-call rota for radiographers.
- There was a radiologist on site seven days a week. There was no formal on-call radiologist rota. Radiologists were available to be contacted out of hours and were aware they were required to cover clinical emergencies as and when required. Staff in radiology told us they never had any problem contacting the radiologists if they were needed urgently.
- The pathology department was open from 8am to 7pm Monday to Friday and 8am to 1pm on a Saturday. Four biomedical scientists worked on call on Sundays and overnight; an additional biomedical scientist was in training to join the pathology on-call rota.

Access to information

- Staff had access to all the information they needed to deliver effective care and treatment. Policies and procedures were available to staff on the hospital's intranet.
- Consultants could access the radiology picture archiving and communication system (PACS) and pathology results from every consulting room. This meant they could see patients' x-ray, scan and blood test results online during consultations. Staff we spoke with told us there were no problems accessing images or pathology results.
- All staff working in radiology service had direct access to electronic copies of images held by other healthcare providers via the image exchange portal (IEP). This meant hospital staff could access up-to-date patient x-rays and scans without any delays. Efficient and secure image exchange is essential for reviewing radiologists and consultants, as it provides access to relevant medical history when diagnosing and treating patients. It also significantly reduces the amount of unnecessary reimaging and supports healthcare to share more knowledge and information, ensuring information is available whenever and wherever needed.
- The pathology manager told us printers were set up across the hospital and at the two local Spire hospitals. This meant staff could print off patient pathology results at the point of request.
- Any pathology results that required urgent action would be flagged on the computer system and the biomedical scientists would also ring through any results which were outside normal limits.
- Staff told us it was frustrating having different IT systems that would not 'speak' to each other. For example, reception staff in outpatients had to use three different IT systems. Radiology staff told us the 'e-refer' radiology appointment request system would improve their service.
- Informative discharge letters were provided to patients, with a copy to their GP, in a timely way.

Good

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007). Training figures provided by the hospital showed high rates of compliance for staff undertaking this training, which were above the hospital target of 95%.
- When we asked staff about assessing patients' capacity to consent to a procedure they all demonstrated an understanding of their responsibilities and how to escalate any concerns.
- Staff in outpatients told us the consultant undertook capacity assessments, when indicated. Radiology did not keep any forms for assessing patient capacity. Radiology staff told us they would consult with the safeguarding team/lead if they were unsure about a patient's capacity to consent.
- Good consent documentation was seen in radiology and for minor procedures and laser treatments in outpatients. We reviewed six consent forms for interventional procedures in radiology; these were all completed as required. Written consent was not sought from patients for joint injections (in line with Spire policy).
- The hospital had a consent policy and mental capacity act policy.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- Patients and relatives we spoke with during the inspection were all very happy with the care and treatment they had received. We spoke with six patients and three relatives.
- Staff told us they felt patients received good care, they told us they were very proud of how caring everyone was with patients. Radiology staff told us they got to know many patients well, as they came back follow-up.
- Friends and family test results for NHS funded patients from the most recent month was 99%. This meant 99% of patients were likely or highly likely to recommend the hospital. In the reporting period (July 2015 to June 2016), the hospital had a response rate of 22% for NHS funded patients; this was lower than the England average. We saw friends and family feedback forms were available in patient waiting areas.
- Comment cards completed by patients before and during the inspection were all positive. They said they were treated with kindness and respect by staff. Comments about outpatients included:-
  - I have been completely satisfied with my treatment from start to finish.
  - Each time I have arrived the reception staff have been polite and efficient.
  - All the staff have been friendly, respectful and very professional.
  - The service throughout my patient journey has been fantastic.
  - On every occasion I have been completely satisfied with the staff consultants and facilities (time period - from July 2016).
  - The best medical care anyone could ask for, patients are seen as a priority and treated accordingly. My wife has been treated here for cancer for the past 11 years; without her consultant and the Spire team she would not be here now.
  - I have visited this Spire hospital over a period of 15 years. The care has always been of a high standard in all aspects. It is comfortable and safe but primarily it is totally professional.
- Comments about physiotherapy included:
  - The whole process has been great, the care and advice has always been available, nothing was too much trouble.
  - I have been very impressed with the Spire hospital. Each time I arrive the reception staff have been polite and efficient. I have not had to wait around without being told what's happening. All the staff have been friendly, respectful and very professional. I was given information and appropriate choices.
  - I have been completely satisfied with my treatment from start to finish.
  - I have enjoyed concern, care and guidance during my treatment.
- Our observations of interactions between staff and patients showed staff were caring and kind. We observed reception staff welcoming patients, showing

them to their waiting areas or consulting rooms and introducing them to the doctors, nurses or other staff caring for them. The majority of the staff we spoke with told us they had received customer care training.

- There was a strong, visible, person-centred culture. Staff gave an example of how they had identified that a patient attending appointments was nervous. They arranged to greet the patient at the entrance to the hospital and walk with them to their appointment area to help minimise anxiety.
- We found numerous examples of staff of all grades going the extra mile during inspection. For example, we observed the estates manager with a set of jump leads; they told us they had just helped a patient to start their car in the car park because the car battery was flat.
- One staff member, in a focus group, told us how a patient who needed end of life care was discharged to a hospice and the intravenous medicine they needed was not sent with them. The hospital's pharmacist drove a 75 mile round trip to deliver the medicine they needed.
- Staff in outpatients told us about a patient who had obsessive-compulsive disorder who had an appointment in the department. The patient was worried about hygiene and cleanliness. Staff had spoken with the patient before the appointment and explained what would happen and had supported them throughout their time in the department. It ended up being a positive experience for the patient; by working together they managed to carry out all the tests required.
- Staff told us they felt giving good patient care was fully enabled by their managers.
- We saw the reception desk in main outpatients had screens between three receptionists. This provided privacy for conversations between patients and reception staff. A notice was on display telling patients that if they wanted to speak in confidence, private rooms were available.
- In outpatients, two staff always stayed in the department until the last patient had left. Staff told us this could often be 10pm.
- Patients who were undergoing minor procedures in outpatients were admitted to the recovery room where there were lockers for their clothes and bags and comfortable seating. Family members or carers could stay in this room with the patient. Staff completed pre assessment paperwork with the patient in this room. This ensured the patient's privacy was respected.
- Staff in outpatients told us they used the recovery room as the private/confidential area to talk to patients before their procedures. The recovery room also had a telephone, which was used for any confidential calls.
- In the general physiotherapy room/gymnasium, we saw there were four bays where patients could undergo consultations. These were separated by curtains, which meant conversations could be overheard. When we asked the physiotherapy staff about this, they told us they were unable to use partitions in this area because it was a grade two listed building.
- The hospital had a chaperone policy; compliance was good and was recorded in the patient record and monitored. We saw notices in all areas visited advising patients to request a chaperone if they needed one. There was a button on the nurse call bell in the outpatient consulting rooms, which consultants used if they needed to call for a chaperone.
- All nursing staff and healthcare assistants who acted as chaperones had been trained.
- In radiology, chaperones were used in the ultrasound room; radiology assistants and radiographers acted as chaperones for patients during their mammograms.

Understanding and involvement of patients and those close to them

- Patients were kept fully informed about their care and worked in partnership with staff to ensure their individual preferences and needs were incorporated into their care and treatment plans. Patients were asked about their preferences for sharing information with their partner, family members and/or carers; these were respected and reviewed throughout their care.
- In radiology, staff told us patients were always offered a choice of appointments.
- We reviewed 10 sets of patient records in the outpatient department. We saw they all had clear pathways and evidence of discussions with patients about the risks and benefits of the different treatment options.
- Patient feedback showed staff took the time to ensure they understood their care treatment and condition. Patients were provided with any information they needed, both by staff and in written leaflets.
- Radiology sent out appropriate information leaflets or booklets with patient appointment letters.
- Feedback from the comment cards about understanding and involvement included:-

Good

Outpatients and diagnostic imaging

- Care and advice has been always available, nothing was too much trouble.
- The consultant explained things clearly, I was given information and appropriate choices.
- All of my questions were answered.

Emotional support

- Emotional support for patients was embedded in their care and treatment. We found good examples of emotional support being given to patients during the inspection. For example, the breast care nurse stayed with a patient until 10pm after they had been given some unexpected bad news about their diagnosis. They also phoned the patient's friend and asked them to come and collect the patient from the hospital, rather than letting them drive themselves home. Then they rang the patient the following morning to see how they were feeling and to discuss their treatment options.
- One radiology assistant told us about a patient who was very nervous about having their MRI scan. In order to support the patient, they went into the MRI scanning room with them, held the patient's hand during the procedure and sang songs to the patient to distract them from the unpleasant experience.
- The hospital used volunteers to sit with patients while they were waiting for their appointments if they were anxious about their appointments, care and treatment.
- Staff provided information about support groups to people using services and those close to them. Family members, friends or relatives were encouraged to stay with patients during their visits to the hospital.
- One patient commented that, "The physiotherapist gave me reassurance and confidence after my operation".

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned to meet the needs of the patient population.
- The physical co-location of radiology, outpatients and appointment bookings facilitated patient flow through the services. Services were all flexible in the use of resources and staff.
- Staff in outpatients told us the resources in the department were managed by the use of the master planner and daily room planner. This ensured the use of the available rooms was maximised and staffing was appropriate.
- We saw all waiting room areas had hot and cold beverages for patients to use: newspapers, magazines and information leaflets were also available.
- The reception desk in main outpatients had three receptionist positions. Patients booked in at this desk for general outpatients, x-ray, MRI and CT scans.
- The outpatient's sister told us clinics were always busy and it was rare to have consulting rooms unused. There were several regular clinics, which ran every week.
- In cardiology, a new service was being developed to screen young footballers for cardiac problems. Physiotherapists at local football clubs could refer patients directly.
- The consulting rooms where the breast clinics were held in outpatients were located near to the ultrasound room. This meant patients seeing a breast surgeon were near to the scan room.
- Late clinics and weekend clinics all provided good access to services for patients that worked full-time, meaning they did not have to take time off work to attend appointments. Patients could obtain appointments with very little waiting times. For example, physiotherapy appointments were available within 48 hours.
- The radiology department reserved appointment slots for acute or urgent patient referrals, including MRI scans. This meant patients could have these procedures carried out straight away when they were needed. If an oncology patient was referred in the morning, they had a radiology appointment the same afternoon.
- Waiting times in radiology at the time of the inspection were short. For example, there was a five-day wait for a routine MRI scan or ultrasound scan. Radiology monitored waiting lists.
- Patients were always offered the first available appointment, but could easily rearrange if this was not convenient.

Good

Outpatients and diagnostic imaging

- The radiology department provided a full range of diagnostic imaging tests and x-rays, including MRI and CT scans. This meant patients could get the majority of tests they needed done on site.
- In addition to routine x-rays of patients' pelvis, knees and lumbar spine, the hospital also carried out hysterosalpingograms in fluoroscopy. Radiology also offered barium video fluoroscopy with a speech and language therapist.
- Radiology staff told us patients could be referred for investigations straight from their GP and the reports would go back to the GP within two days.
- The pathology laboratory on site provided quick results for patients' blood tests. Other types of samples were sent away to other laboratories to be tested. Couriers transferred samples twice a day and emergency couriers could be booked if required.

Access and flow

- Between July 2015 and June 2016 there were 76,053 outpatient attendances at the hospital; this figure included 3,617 appointments for children under the age of 18. Of these, 29% were NHS funded and 71% were other funded.
- The provider's performance was consistently good, for example they regularly exceeded the national indicators for referral to treatment (RTT) waiting times.
- The provider met the referral to treatment (RTT) indicator of 92% of patients on incomplete pathways waiting 18 weeks or less from the time of referral in the reporting period July 2015 to June 2016. The percentage of patients seen within 18 weeks was between 95% and 100% during the reporting period.
- Indicators for non-admitted patient treatment beginning within 18 weeks were abolished in June 2015. However, more than 95% of NHS- funded patients at the hospital started non-admitted treatment within 18 weeks of referral in the reporting period July 2015 to June 2016. In five of the 12 months in the reporting period, 100% of patients were seen within 18 weeks and in three of the 12 months, 99% of patients were seen within 18 weeks.
- Patients that did not attend (DNA) their appointments were recorded on the electronic patient administration system. Consultants' secretaries followed up DNAs for non-NHS patients.
- The NHS followed up DNAs for orthopaedic patients attending the hospital. The outpatients' department did not receive feedback about this monitoring.
- We looked at a report of DNAs, which was run on 16 January 2017 for the date range 9 January 2017 to 15 January 2017. This showed there had been 86 DNAs at the hospital out of 1267 cases and 1353 total appointments. This meant the DNA rate during this period was 6%. No actions were taken locally with these DNA monitoring reports and there was no analysis of the reasons why these patients had not attended their appointments. There were plans to introduce a text reminder system for patients during 2017.
- Physiotherapy staff told us there were between 50 and 75 DNAs per month in physiotherapy. They told us all DNA patients were contacted to ask whether they wanted another appointment. However, there was no evidence to show any actions were being taken to reduce the numbers of patients that did not attend their initial appointment.
- Several outpatient clinics ran 'one stop' clinics. These included cardiology, respiratory and ophthalmology. The patient saw the consultant, the relevant tests were undertaken, and the patient returned to the consultant for their results.
- Patients attending the department for a breast care appointment were allocated a double/triple appointment. When we spoke to the breast care specialist nurse, they told us they checked the patient's results and images before each clinic. This meant patients received their results straightaway.
- Other staff told us patients using the breast care service could request a particular consultant. They confirmed patients got same day results following mammograms; they said this was important to the patients using the service.
- In radiology, the radiologists vetted requests for procedures and decided which protocol could be used. Staff told us this was currently done on paper but would be easier online, as an online system would remind consultants to request the relevant additional tests needed. They said this had been brought up corporately and they hoped it would be a future service development.
- Radiology staff felt the mammography service was outstanding. Some mammography patients were

screened as part of a wellness programme. However, the majority of mammography patients were symptomatic and the radiologists gave the patients their results straightaway.
- Consultant radiologists dictated their results using a voice recognition system. This ensured patients got their results as quickly as possible. All radiology results were reported on site.
- Radiology staff checked the breast clinic lists every day to ensure the images were available in advance.
- The hospital had no patients waiting six weeks or longer from referral for MRI, CT and non-obstetric ultrasound.
- Patients we spoke with were universally happy about the availability of appointments, waiting times for appointments and being kept informed if there were any delays.

Meeting people's individual needs

- The services provided at the hospital were designed to meet the needs of people with additional needs, such as those living with dementia, learning disabilities and physical disabilities. The templates used in outpatients had prompts to remind staff to consider whether a patient had additional care needs.
- Staff working in the MRI department were dementia champions; they regularly carried out procedures on patients with, or suspected of having, dementia as part of a research trial.
- Radiology staff told us they would check when the appointment was made whether the patient had any additional needs and would allocate extra time if required. Radiology had access to a hoist, if this was required for patients with disabilities or mobility problems.
- Outpatients, radiology and physiotherapy were all located on the ground floor. Some corridors were narrow but were wheelchair accessible and disabled toilets were available in all areas. However, the main outpatient reception desk did not have a lower area for wheelchair users and the radiology changing rooms were not wheelchair accessible. Staff told us patients would change in the x-ray room if they were unable to use the changing rooms.
- The hospital's patient led assessment of the care environment (PLACE) scores for the period February 2016 to June 2016 were lower than the England average for disability and dementia.
- The hospital subscribed to dementia friends training and 'John's campaign'. This is a campaign supporting the rights of people with dementia to be supported by their own carers in hospital. Staff told us they rarely saw patients who were living with dementia.
- Interpreters were available for patients for whom English was not their first language; these were organised by the administrative/bookings staff. Staff in radiology told us they saw quite a lot of patients who did not speak English. Staff in all the departments visited told us there were no problems accessing interpreting services if required.
- A hearing loop was available for deaf people and there were leaflets designed for use by people who were visually impaired.
- Bariatric patients were accommodated. Radiology staff told us an electric wheelchair was used to transfer bariatric patients from the ward and they would not be laid down for their x-ray or scan.
- When we asked staff in outpatients whether they were informed in advance if a patient had any special/ individual needs they said they were not usually informed in advance.

Learning from complaints and concerns

- See surgery section for main findings.
- The rate of complaints per 100 day case and inpatient attendances was similar to the rate of other independent acute hospitals.
- Data provided showed between 1 February 2016 and 31 August 2016, there were no complaints in outpatients, two complaints in radiology and one complaint in physiotherapy. These complaints had been investigated and actions taken to prevent reoccurrence.
- Learning from complaints about clinical issues was discussed at the clinical effectiveness meeting. Non-clinical complaints were discussed at a process review meeting.
- Senior staff told us learning from complaints was shared with staff at departmental meetings. Staff we spoke with confirmed this.
- The pathology department had not received any complaints in the reporting period; the pathology manager told us the department regularly received compliments.
- We saw information leaflets and posters were available telling patients how to make a complaint.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The hospital had a clearly defined management and organisational structure. The hospital was led by the hospital director and head of clinical services; supported by managers/heads of each department.
- Staff were very happy and effective teamwork was evident and positive. The culture throughout the hospital was honest, open and transparent. All staff we spoke with were proud of their services, the care they provided for patients and liked working at the hospital.
- A new member of staff told us the team working in the outpatients department was, "refreshing." They said this included the wider team within the hospital, such as the specialist nurses. Several staff told us relationships with the other staff in the hospital felt, "like a family."
- Staff told us their managers were supportive, approachable and visible. Staff in outpatients told us managers supported their professional decisions and they were, "never thrown in at the deep end".
- Staff told us managers were responsive to requests. They said they had good relationships with consultants and medical staff and they were also supportive.
- Staff were facilitated to improve services for the benefit of patients. For example in physiotherapy the manager told us they were proud of their state-of-the-art equipment and said they were enabled to drive the service forward with support from senior management.
- Staff told us the hospital was a nice place to work it was very friendly with a long-standing workforce undertaking diverse roles. They said all the staff were caring and flexible.
- Staff in radiology told us it was a good team and they all worked well together.

Vision and strategy for this core service

- See information under this sub-heading in the surgery section.
- The hospital's vision was, 'to be recognised as a world class healthcare business, bringing together the best people who are dedicated to developing an excellent clinical environment and delivering the highest quality care.
- Managers told us the organisation worked hard to ensure all staff understood the vision and strategy. We found staff were aware and engaged with the vision, strategy and values of the hospital. We saw noticeboards, which displayed information about the hospital's vision, mission and values.

Governance, risk management and quality measurement

- See information under this sub-heading in the surgery section.
- The radiology manager attended the weekly clinical effectiveness meetings, clinical governance meetings, process review meetings, health and safety and heads of department meetings.
- The pathology manager attended the weekly clinical effectiveness meetings, heads of department meeting, health and safety meeting, and infection prevention and control meeting. They also attended the quarterly transfusion committee and visited the two local Spire hospitals they provided pathology services to once a month.
- There was a hospital wide risk register and each department had its own section. There were no local risk registers.
- Senior staff in radiology told us the main risks for the department were equipment failure, PACS (picture archiving and communication system) failure and MRI scanner down time. Over exposure to radiation was on the hospital wide risk register. However, there had been no incidents of over exposure to radiation at the hospital.
- We reviewed physiotherapy documentation audits from May 2016 and December 2016; these were part of a Spire Healthcare national audit tool. The audits were carried out to evaluate whether the outpatient's team was maintaining the Chartered Society of Physiotherapy recommended standards for patient record keeping. Results of both audits achieved above the target compliance level of 80% (88% in May 2016 and 86% in December 2016).
- Radiology had a comprehensive audit programme and audit results showed no areas of concern.

Good

Outpatients and diagnostic imaging

Public and staff engagement

- Staff told us communication within the hospital was good. There was a lot of information on display for staff and the public. Staff also received information via email, the intranet and various bulletins. There was a social committee within the hospital.
- There were regular team meetings in all departments we visited. These were held every month. Records in outpatients showed there had been eight team meetings in the past 12 months.
- Staff told us the hospital had achievement rewards for good or outstanding work, which included the Inspiring People award scheme. A radiology department assistant told us they had been awarded one of these and had received some vouchers.
- The hospital had a whistleblowing policy and a fact sheet was given to all staff. Posters were on display in staff areas. When we asked staff about bullying, they all told us they had no concerns.
- The nursing services manager with responsibility for outpatients told us they had involved staff in doing a SWOT (strength, weaknesses, opportunities and threats) analysis.
- In physiotherapy, the manager told us the induction tool in use was devised by one of the physiotherapists. This was one of their annual appraisal objectives.
- Friends and family test (FFT) results for NHS funded patients were good. For example, in December 2016, 99% of patients said they were likely or highly likely to recommend the hospital. However, between July 2015 and June 2016, the hospital's FFT response rate for NHS funded patients was 22%, which was lower than the England average.

Innovation, improvement and sustainability

- The MRI department was part of a dementia trial where MRI scans were carried out on patients to provide a baseline scan.
- In cardiology, clinical physiologists were involved in investigations for sleep apnoea in train drivers. Staff at the hospital carried out overnight oximetry monitoring as part of this process.
- The hospital was working towards a single patient record; there was a steering group working on this which met monthly. Using a single patient record would be a major improvement.

Outstanding practice and areas for improvement

Outstanding practice

- All staff demonstrated a very caring approach to their patients. We saw all patients were treated with dignity and respect and feedback from patients was consistently positive. The approach to care was patient-centred and all staff demonstrated a high level of commitment to ensuring patients had a positive experience. We heard of numerous examples, where staff had gone the extra mile to ensure patients had a positive experience.
- All staff working in radiology service had direct access to electronic copies of images held by other healthcare providers via the image exchange portal (IEP). This meant hospital staff could access up-to-date patient x-rays and scans without any delays. Efficient and secure image exchange was essential for reviewing radiologists and consultants, as it provided access to relevant medical history when diagnosing and treating patients. It also significantly reduced the amount of unnecessary reimaging and supported healthcare to share more knowledge and information, ensuring information was available whenever and wherever needed.
- The breast care nurses had developed a 'survivorship booklet' for breast cancer patients, to help them come to terms with their condition and treatment and the emotional impact of having and surviving cancer, and wanted to roll this out through their professional networks to other independent providers.
- The breast care nurses were also developing the use of electronic tablets as a teaching aid to demonstrate reconstruction techniques and outcomes to women undergoing surgery as part of their treatment for breast cancer.
- New hospital volunteers were asked to complete the '15 step challenge', a national scheme to identify how the hospital felt from the moment a patient or visitor arrived.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the safer steps for surgery, which includes the WHO checklist, is consistently adhered to.
- The provider should continue to implement measures to improve fasting times for patients.
- The provider should ensure the senior management team and the medical advisory committee take note of actions and matters from other groups within the hospital, such as the paediatric steering group.
- The provider should ensure there is a robust process for document control for documents produced at the hospital.
- The provider should ensure that appropriately trained staff undertake incident investigations.
- The provider should review audit tools of the National Early Warning System (NEWS) include correctly calculated scores.
- The provider should review the process for recording and sharing learning from near miss incidents.
- The provider should risk assess situations where one registered children's nurse is caring for children on the ward.
- The provider should review the chaperone policy and the admission and discharge policy in relation to children to ensure the requirements are clear for chaperones and age of children admitted.
- The provider should monitor did not attend (DNA) rates in outpatients and have a robust system for recording and following up children who did not attend appointments.
- The provider should ensure that all records are completed in line with hospital and professional standards including the provision of care plans for patients identified at risk of falls or developing pressure ulcers.
- The provider should review their local audit programme in the outpatients' department.