Spire Thames Valley Hospital

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Thames Valley Hospital is operated by Spire Healthcare Limited. It opened in the 1960s initially as a nursing home, and its' ownership has changed a number of times over the years. Spire Healthcare Limited took ownership in 2007.

The hospital treats patients from Buckinghamshire, Berkshire and Middlesex. Spire Thames Valley is a two-storey hospital with one ward that has 37 private ensuite rooms providing inpatient and day case care and a 2 bed extended recovery unit.

Current facilities include: nine consulting rooms, two pre-assessment rooms, one minor procedure treatment room, physiotherapy treatment room, two laminar flow theatres and one endoscopy unit and an in-house theatre sterile services department. Diagnostic imaging facilities include a digital mammography, ultrasound, x-ray and magnetic resonance imaging (MRI). Two days per month, a mobile computerised tomography (CT) service is on site.

Specialities at the hospital include: Bariatric (Obesity) surgery, Oncology, Breast surgery, Oral surgery, Cardiology, Orthopaedic surgery, Colorectal (bowel) surgery, Cosmetic surgery, Dermatology, Physiotherapy, Dietetics, Plastic & reconstructive surgery, Ear, Nose & Throat, Psychology, Endocrinology, Renal medicine, Fertility, Respiratory medicine, Foot & ankle surgery, Gastroenterology, General surgery, Hand & wrist surgery, Urology, Immunology & allergy testing, Vascular surgery, X-ray/MRI/Mammography, Gynaecology, Cardiac Stress Echocardiograms.

Children and young people were only seen in outpatients and diagnostic imaging. We inspected services for children and young people using the outpatient framework and have reported findings for children and young people in a separate section.

[Note the hospital ceased surgical services for patients below the age of 18 with effect from August 2019.]

Services were provided to patients who were self-funding, those covered by private medical insurance and to NHS patients who had been referred by their GP or who had booked via the NHS "choose and book" service. Chemotherapy and children and young people services was not provided to NHS patients.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 6 and 7 November 2019.

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

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

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

Services we rate

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

We found good practice within the services:

Summary of findings

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

We found the following areas of outstanding practice

- The oncology service had been awarded a Macmillan Mark of Quality Environment (MQEM) for achievements in quality for cancer care environment.
- The oncology service was awarded an Exemplar award by the provider's group clinical director and had been recognised for excellent care and service for cancer patients in 2018.
- Staff were extremely motivated to deliver care that was kind and compassionate. They anticipated the needs of their patients and ensured their needs were acknowledged and met. We saw how staff took the time to interact with people who used the services and those close to them in a respectful and considerate way in theatres and on the wards.
- Staff did not merely react to patient needs or requests, they consistently assessed their needs and strived to build personal relationships, so they could understand their patients' needs and preferences. Staff demonstrated a genuine desire to enhance the patients' experience and to ensure their needs were met and exceeded.

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

- The provider should consider raising the awareness of risk and how to report it with all staff.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Good

Spire Thames Valley Hospital

Services we looked at

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

Summary of this inspection

Background to Spire Thames Valley Hospital

Spire Thames Valley Hospital is operated by Spire Healthcare Limited. The hospital opened in 2007. It is a private hospital in Wexham, Buckinghamshire. The hospital primarily serves the communities of Buckinghamshire, Berkshire and Middlesex. It also accepts patient referrals from outside this area.

At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in August 2019.

The hospital has been inspected previously, the last inspection was in November 2016 when we carried out a full comprehensive inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manager, three CQC inspectors and four specialist advisors with expertise in surgery, outpatients, diagnostic imaging and governance. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology.

Information about Spire Thames Valley Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited all departments. We spoke with 52 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 25 patients and 2 relatives. During our inspection, we reviewed 25 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected once before and this inspection took place in November 2016, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2018 to June 2019)

- In the reporting period July 2018 to June 2019, there were 4,777 inpatient and day case episodes of care recorded at the hospital; of these 8% were NHS-funded and 92% privately funded.
- 34% of all NHS-funded patients and 19% of all privately funded patients stayed overnight at the hospital during the same reporting period.
- Three young people aged between 16-17 years were admitted as overnight patients and 18 were admitted as day cases. One young person aged between three and 15 years was admitted as an overnight patient and 47 were admitted as day cases.**Note the hospital ceased surgical services for patients below the age of 18 with effect from August 2019.
- There were 20,754 outpatient total attendances in the reporting period; of these 92% were privately funded and 8% were NHS-funded.

Summary of this inspection

- 966 children attended as outpatients, of these 107 were aged two and under, 646 were aged between three and 15 years and 213 were aged between 16-17 years.

As of June 2019, 201 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Regular resident medical officers (RMO) worked on a weekly rota.

The hospital employed 26 full-time equivalent registered nurses, 11 full-time equivalent care assistants and operating department assistants. In addition, there were 98 full-time equivalent other hospital support staff. The hospital also had its own bank staff. The accountable officer for controlled drugs was the registered manager.

Track record on safety (April 2018 to March 2019)

- One Never Event
- 416 Clinical incidents: 364 no harm, 15 low harm, 37 moderate harm, zero severe harm, zero death
- One serious injury
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- 36 complaints, none of which were referred to the Parliamentary and Health Service Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service

Services accredited by a national body:

- BUPA Approved Breast Care accreditation
- BUPA Approved Bowel Cancer accreditation

Services provided at the hospital under service level agreement:

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

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. There were processes in place to monitor training compliance.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The hospital controlled infection risk well and used control measures to prevent the spread of infection. Staff kept themselves, equipment and the premises clean.
- The premises, facilities and equipment were suitable and kept people safe. Staff were trained to use equipment and they managed clinical waste well.
- Equipment was maintained and well looked after.
- Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Assessments were in place to alert staff when a patient's condition deteriorated.
- The service had enough staff with the right qualifications, skills and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave new and bank staff a full induction.
- The provider managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

However;

Summary of this inspection

- The hospital had identified a concern regarding the lack of dedicated clinical sinks in patient bedrooms meaning staff and visitors used the basin in the bedroom's en suite bathroom. A risk assessment had been carried out and a refurbishment plan was in place to include compliant sinks in patient rooms.

Are services effective?

Good

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

- The hospital provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- The hospital managed patients' pain effectively and provided or offered pain relief when required.
- The provider made sure staff were competent for their roles. Managers appraised staff's work performance.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- The hospital monitored the effectiveness of care and treatment and consistently used the findings to improve them.
- Staff supported patients to manage their own health, care and well-being and to maximise their independence during and following treatment and as appropriate for individuals.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Are services caring?

Good

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

- Staff cared for patients with compassion. Patients were treated with dignity, respect and kindness during all interactions with staff. Feedback from patients was positive about their care and treatment. We saw staff were friendly, kind and caring and responded quickly and compassionately when patients called for assistance.
- Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.

Summary of this inspection

- Patients were communicated with and received information in a way that they could understand.
- Children and young people's services ensured a family centred approach. Staff spoke with patients, including children and young people, and families in a way they could understand.

Are services responsive?

Good

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

- The hospital planned and provided services in a way that met the needs of local people. The hospital ensured flexibility, choice and continuity of care.
- The hospital took account of patients' individual needs and preferences, including patients with dementia and children and young people. Staff made reasonable adjustments to help patients access services and adapted them when needed.
- Patients could access the hospital when they needed and there was minimal waiting time for patients to receive the right care promptly.
- It was easy for people to give feedback and raise concerns about care received. Concerns and complaints were treated seriously, investigated and lessons learned were shared with all staff and used to improve services.

Are services well-led?

Good

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

- Leaders had the integrity, skills and abilities to run services. They understood and managed the priorities and issues faced. They were visible and approachable for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The vision was to be the go to private healthcare brand famous for clinical quality and customer service.
- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The hospital used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Summary of this inspection

- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of their service.
- The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The hospital engaged with patients, staff, the public and local organisations to plan and manage appropriate services.

However;

- There was a concern that staff who did not recognise a potential or actual risk would not necessarily escalate risks. Meaning senior leaders may not be aware or be able to review possible risks within the hospital.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Services for children & young people	Good	N/A	Not rated	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

Are medical care services (including older people's care) 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. This also includes the management of medicines and incidents. The information applies to all services unless we mention an exception.

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

Mandatory training

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

The service provided mandatory training in key skills to all staff and worked hard to ensure they achieved compliance. Staff told us they were given time to complete their mandatory training and were prompted by senior staff to make sure they were up to date.

Staff had access to a range of electronic and face to face training. Mandatory training included anti-bribery, compassion in practice, infection control, information governance, safeguarding and basic life support and immediate life support. Staff in both endoscopy and oncology were 100% compliant with online training.

Resuscitation training was carried out face to face. Staff working in endoscopy were 100% compliant with resuscitation training. Staff working in oncology were 80% compliant with this training. Out of the five staff working in oncology there was one member of staff who needed to undertake the face to face resuscitation, training and they had this training booked.

The hospital had recently introduced National Early Warning Score 2 mandatory training. Therefore, not all staff had completed this training at the time of our inspection.

Staff undertook sepsis training at the hospital, to help them identify and support treatment of sepsis at the hospital. The training was included during the resuscitation and acute illness management training. Staff told us to support staff knowledge of sepsis, on 18 November 2019, four talks were planned from a sepsis survivor for all staff/consultants to attend.

For detailed findings on mandatory training, please see the surgery section.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff working in endoscopy

were 97% compliant with safeguarding adults and children level 2 training and staff working in oncology were 100% compliant with this training. These compliance rates were better than the provider's target of 95%.

Staff understood their responsibilities and adhered to safeguarding policies, this included working in partnership with other agencies. Staff knew who to contact if they required safeguarding advice or support.

Staff working in oncology and endoscopy described how they would identify adults and children at risk of or suffering significant harm, and when they would make a safeguarding referral.

For detailed findings on safeguarding, please see the surgery section.

Cleanliness, infection control and hygiene

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

Staff followed current guidance from the National Institute for Health and Care Excellence (NICE) Quality Standard (QS 61) Infection Prevention and Control. Clinical staff were bare below the elbows and the service audited hand hygiene compliance quarterly. From 1 July 2018 to 30 June 2019, oncology and endoscopy staff consistently achieved hand hygiene compliance rates of greater than 95%. When compliance rates dropped prompt action was taken to address.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw the correct use of PPE such as disposable gloves and aprons. PPE was available in endoscopy and oncology.

The hospital had identified a concern with the availability of clinical sinks in patient bedrooms. Within oncology the hand basin was in the patients' ensuite area, with hand rub in the patients' bedrooms. A risk assessment was undertaken on 30 September 2019. The oncology lead told us there were plans to place clinical sinks in the oncology bedrooms at the next refurbishment. Staff were using the hand rub in the patients' bedroom, and if their hands visibly soiled the hand basins in the patients' bathrooms. The provider informed us in January 2020 that the installation of new sinks in all the oncology bedrooms had been completed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. At our inspection in November 2016, staff decontaminated endoscopes on site. Due to our concerns around infection control risks, this process stopped post inspection and staff sent endoscopes off site for decontamination. At this inspection we saw the endoscopy unit had recently been refurbished to provide a dirty to clean pathway for endoscopes to be decontaminated, which on the day of inspection was still to be recommenced on site.

We visited the theatre used for endoscopy procedures and found it visibly clean.

The oncology suite had suitable furnishings that were easy to clean. Staff kept cleaning records which were up to date and showed that all areas were cleaned daily. Records showed there was a deep cleaning programme for both areas. The infection control lead undertook quarterly environmental audits of the areas used by endoscopy patients. The audits undertaken in March and June 2019, showed a compliance rate of 97%.

For detailed findings on cleanliness, infection control and hygiene, please see the surgery section.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained how to use the equipment. Staff ensured clinical waste was handled in line with national guidance.

The hospital had five dedicated rooms for the oncology department, all with beds, chairs and ensuite facilities. There were call bells for patients to use if help was needed.

The endoscopy theatre, waiting area, recovery area and decontamination area were all located in theatre. Staff shared resuscitation equipment with theatres. The oncology department used resuscitation equipment obtained from the nearby outpatient department. We checked the resuscitation trolleys and their records and found them to be tamper proof, appropriately stocked, checked daily and ready for use.

The hospital had the necessary number and size of endoscopes which enabled the scheduled lists to proceed uninterrupted.

A new endoscope washer disinfector was purchased for the decontamination area. Staff had received training on the new washer disinfector, and there was a maintenance contract.

The hospital had existing maintenance and repair contracts for all equipment used in endoscopy. There were lockable cupboards for the storage of hazardous cleaning chemicals, which met the Control of Substances Hazardous to Health regulations 2002 (COSHH).

Consumable equipment was stored in unbroken packaging and were within their expiry date.

Staff managed sharps in line with the Department of Health, Management and disposal of healthcare waste (HTM 07-01). All sharps containers were stored correctly and safely and clearly labelled. Staff in oncology followed safe precautions for the handling of cytotoxic waste, which included the use of purple lidded sharps bins for the disposal of cytotoxic waste, in line with COSHH regulations.

For detailed findings on environment and equipment, please see the surgery section.

Assessing and responding to patient risk

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

There were systems and process to determine patients' suitability for surgery. The American Society of Anaesthesiologists score was used to assess the physical status of endoscopy patients before surgery. All patients had their individual health risks assessed upon admission.

Patients attending for an endoscopy completed an 'assessing you for admission' questionnaire. A registered nurse reviewed the questionnaire prior to the procedure. This ensured patient's suitability and fitness was assessed for the planned procedure.

Oncology patients were assessed against a specific risk assessment designed for oncology patients. This assessment included blood tests and sepsis screening to ensure patients were well enough to receive treatment. The assessment documentation also included information about the risks of chemotherapy, and how these risks were managed. Oncologists or haematologists started all chemotherapy treatments.

Patients received written information about when and who to contact for advice. Oncology patients were able to contact the hospital out of hours via telephone if they needed to discuss any concerns or report any adverse effects of chemotherapy. It was not always possible for patients to speak with a chemotherapy nurse specialist. The service used the United Kingdom Oncology Nursing Society triage tool, which senior staff working in oncology had supported senior staff on the ward to use. The resident medical officer would contact the treating oncologist if needed for advice. We reviewed call data which showed that in 2016 there were 32 calls and in 2018 six calls. The number of calls had reduced because patients receiving treatment were contacted before the weekend to see if any advice or support was needed. The six calls in 2018 included one patient who was told to attend the emergency department and five others who were supported with the management of side effects.

For relevant patients, a line could be inserted centrally (a long thin hollow tube that was inserted into a vein near the heart) in radiology for the administration of their chemotherapy. This provided access to large vein in the body, as the chemotherapy can cause irritation if delivered into the smaller veins of the arms or legs.

Staff used a nationally recognised tool to identify deteriorating patients and escalated their concerns in line with the provider's escalation policy. All people admitted to endoscopy and oncology were regularly assessed using the National Early Warning Score 2 (NEWS2). NEWS2 is based on a simple scoring system in which a score is allocated to physiological measurements undertaken when patients present to or are being monitored in hospital. We reviewed four NEWS2 charts following patients who had endoscopy procedures. For one patient action was required. Staff took the appropriate action, and the patient's NEWS2 score improved.

Staff in endoscopy completed a five steps 'surgical safety checklist for endoscopy' for each patient. This is a recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We saw staff worked through the checklist correctly during our visit. We requested copies of the audits that had been undertaken of the five steps to

safer surgery from 1 July 2018 to 30 June 2019. The theatre manager submitted two observational audits for endoscopy patients undertaken in September and November 2018, which showed 100% compliance.

For detailed findings assessing and responding to patient risk, please see the surgery section.

Nurse staffing

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

There were three registered nursing staff working in the endoscopy service which included the theatre manager. These staff supported gastrointestinal endoscopy procedures. There was an operating department assistant to support the anaesthetist. The theatre manager confirmed the staffing skill mix and competencies were enough to support endoscopy procedures. The theatre manager confirmed there had not been any cancellations due to staffing.

Each morning at the 9am ward safety huddle staffing requirements were discussed. If there were any concerns these would be escalated to the senior management team huddle at 10am, where measures would be taken to address any staffing shortfalls. On the day of our inspection, there were two registered nurses and a health care assistant to support the seven patients on the endoscopy list. One of the registered nurses explained they were a bank nurse, who said they felt like a regular member of the team.

There was also a member of nursing staff to support patients going to and from theatres. This member of staff also attended the endoscopy outpatients' clinics, which meant they had met patients before the day of their planned procedure.

The oncology team had three registered nurses. Two chemotherapy nurses were always on duty when a patient was booked in for chemotherapy treatment. The acting oncology lead confirmed the skill mix and competencies of staff enabled the needs of patients that attended the unit to be effectively met.

In addition, a healthcare assistant was due to start work in the oncology department providing three days a week additional support. More administrative support was also to be provided one day a week.

From 1 July 2018 to 30 June 2019, no agency staff were used in oncology or endoscopy.

Medical staffing

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

There were five oncologists who worked at the hospital. Staff told us that when an oncologist was on annual leave, they would always arrange cover from another oncologist with practising privileges to work at the hospital.

There were five endoscopists working at the hospital, with practising privileges. However, there was one with regular lists at the hospital, who undertook most endoscopies.

A resident medical officer (RMO) provided 24-hour, seven days a week cover at the hospital.

For detailed findings on medical staffing, please see the surgery section.

Records

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

Patient notes were comprehensive, kept confidential and stored securely. They were mostly paper records. We reviewed four endoscopy records and three oncology records. These were fully completed, accurate, legible and up to date.

Staff kept accurate endoscope tracking records in line with national guidance. This was to ensure all the items used during the procedure could be tracked in the event of a suspected disease transmission.

The endoscopists recorded the details of the procedures electronically.

For detailed findings on records, please see the surgery section.

Good

Medical care (including older people's care)

Medicines

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

There were systems and processes to ensure the safe administration of chemotherapy. Staff ensured they applied these in practice. The prescription, recording of the administration of chemotherapy and oncology medicines was completed electronically. Injectable chemotherapy, ready for administration was purchased from a licensed specialist supplier. A safe process was in place when chemotherapy medicines were received at the hospital. Two nurses trained in the administration of chemotherapy were always involved in the checking of chemotherapy medicines before they were administered. Pharmacy staff were based in the oncology unit treatment room, which enabled close working, effective communication and instant support to oncology staff.

Staff provided specific advice to patients and carers about their medicines. Patients were given a cancer treatment record, which included information about the possible side effects of chemotherapy. It also included a guide for patients to follow should they experience side effects.

Staff carried out a monthly audit of the electronic chemotherapy prescribing documentation. From January to March 2019, compliance was 69% against a target of 80% or greater. An action plan to address the audit findings was developed. It included ensuring there was evidence of consultant review of patients during treatment in the notes, better communication and empowering staff to challenge any gaps in the documentation. From April to September 2019, compliance had improved to 100%.

Medicines were stored securely in locked cupboards in line with the provider's policy. Medicines that required temperature-controlled storage were stored in a locked fridge. We saw minimum and maximum temperatures had been checked and recorded appropriately. Staff we met described the actions to take if temperatures were not within the acceptable range.

Staff stored controlled drugs safely and they were administered with records kept according to legislative requirements.

Patients in endoscopy may have a procedure under sedation. The hospital had a sedation policy, and staff ensured medicines were available in case a patient had an adverse reaction to sedation.

Staff in theatres and oncology ensured anaphylaxis kits were available for treating severe allergic reactions. In the oncology unit, an extravasation kit was available. An extravasation kit is equipment used to remove an intravenous drug or fluid that has leaked from a vein into the surrounding tissue. Extravasation kits were in date. Staff were aware of the procedure for managing extravasation.

Chemotherapy spillage kits were available in the oncology department. They were accessible and in date. A chemotherapy spillage happened on the day of our inspection. Staff managed the spillage as outlined in the hospital policy. The patient was booked in the following day to complete their chemotherapy treatment.

For our detailed findings on medicines please see the surgery report.

Incidents

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

Staff knew what incidents to report and how to report them. The hospital used an electronic reporting system, and staff were aware of their responsibility to report incidents. We saw staff actively report the incident relating to the chemotherapy spillage. The oncology team used reflective practice to consider incidents, to learn lessons and prevent the type of incident from reoccurrence. Reflective practice is the ability to reflect on actions and engage in a process of continuous learning.

From 1 July 2018 to 30 June 2019, there were four incidents linked to the endoscopy service. The incidents were described as communication, documentation/ patient information, engineering/ estate management and a medication incident. The theatre manager reviewed and investigated the incidents. The incidents did not result in any patient harm and were closed.

Good

Medical care (including older people's care)

From 1 July 2018 to 30 June 2019, there were 29 incidents linked to the oncology service. The three most common incidents were categorised as expected deaths, cancer services and medication incidents. Senior staff investigated the incidents and found no lapses in care which led to patient harm.

There was local and cross organisational learning following the incidents. For example, medication safety incidents relating to the incorrect or late delivery of chemotherapy were to be notified to head office for trend analysis.

There were eight expected deaths from 1 July 2018 to 30 June 2019. These were within 31 days of chemotherapy. The oncology lead investigated all expected deaths within 31 days of chemotherapy to see if there were any areas for development.

An example of learning for the multidisciplinary oncology team was the need for more detailed communication amongst oncology team members with regard to care and treatment decisions, when patients were reaching the end of their life. This was to ensure patients always received the most appropriate care and treatment as their condition changed. The learning was also shared more widely at the monthly rapid response meeting chaired by the director of clinical services. The meeting was held to share the learning from incidents and complaints with heads of departments.

For our detailed findings on incidents please see the surgery report

Clinical Quality Dashboard

For our findings on the clinical quality dashboard please see the surgery report.

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

Good

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

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

Evidence-based care and treatment

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

Staff provided care that took account of National Institute for Health and Care Excellence (NICE) guidelines and best practice. The policy for the management of suspected neutropenic sepsis with an oncology patient referenced the criteria for when patients should attend an NHS hospital. The provider used the National Early Warning Score 2 to assess and respond to any changes in all patients' condition. This was in line with NICE Clinical Guidance [CG50]: Acutely ill adults in hospital: recognising and responding to deterioration.

The endoscopy service was actively working towards the Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation. The service had self-assessed themselves against the JAG global rating scale (GRS), in October 2018, March and October 2019. The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. Their self-assessed GRS scores showed ongoing improvement against the 16 assessed areas.

Staff booked procedures in line with the British Society of Gastroenterology guidelines.

There was an agreed list of provider audits undertaken by staff working in oncology. This included an audit of the electronic prescribing of chemotherapy and the consent process. This provided assurance that the oncology department met the national systemic anti-cancer therapy prescribing guidance and the national cancer standards. From January to March 2019, there had been areas of non-compliance. Staff took actions, and from April to September 2019 compliance for both these audits was 97% or greater.

The oncology unit had been awarded the Macmillan Quality Environment Mark (MQEM). This was a detailed quality framework used for assessing whether cancer care environments met the standards required by people living with cancer. The MQEM recognised that the hospital

provided an accessible, welcoming and comfortable environment for people with cancer. It also acknowledged that the oncology unit respected privacy and dignity for patients and those close to them, and that the facilities helped improve well-being.

The service had provided a one stop breast clinic for the last 18 months, this minimised the number of times patients needed to attend the hospital. This clinic ensured patients had access to the required staff and tests on one occasion. This included a consultation with a breast consultant, physical examination, a mammogram and an ultrasound (with a biopsy if needed). The breast care nurse told us patients were usually able to access the clinic within 48 hours.

For our detailed findings on evidence based care and treatment please see the surgery report.

Nutrition and hydration

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

Patients due to attend for a colonoscopy, an examination of the rectum and colon using a flexible telescopic tube about the thickness of an index finger called an endoscope, were given detailed advice on how to prepare for the procedure. The preparation included administering a laxative and advice regarding dietary and fluid intake.

For patients having a gastroscopy, an examination of the food pipe, stomach and duodenum using a flexible tube called an endoscope, advice on diet and fluids was also given including when to stop eating and drinking. The preparation was to enable a clear view of the parts of the patients' gastro-intestinal tract being examined. Four patients we spoke with had found this information clear and easy to follow. Staff completed a swallowing assessment for gastroscopy patients one hour following the procedure, if they had received an anaesthetic throat spray in the endoscopy theatre. Staff then offered patients a drink and a light snack. There was a variety of menu options available for patients and the chef catered for the needs of patients with special diets.

All the oncology patients were day case patients. Staff offered patients drinks and light snacks during and after their treatment. One patient told us how they had ordered one thing and then not felt like it when it came at lunchtime. The patient told us how staff supported her with making a different choice, that the patient was able to enjoy.

A drinks trolley which included light snacks was available outside the oncology patient bedrooms. This was popular with patients, as staff were able to respond very promptly to any requests.

Staff also explained they were able to access support from a dietician if needed, to support patients' dietary needs.

For our detailed findings on nutrition and hydration please see the surgery report.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

We saw three endoscopy procedures. Staff monitored patients pain levels and comfort during and after their procedures.

Endoscopy patients were offered a throat spray to reduce discomfort and /or intravenous sedation, to minimise any discomfort or pain whilst undergoing a gastrointestinal endoscopy. Medical staff also performed gastrointestinal endoscopies under a general anaesthetic where this was clinically indicated. The list of seven patients who had an endoscopy procedure on the day of our inspection had a mixture of patients having intravenous sedation and a general anaesthetic.

For our detailed findings on pain relief please see the surgery.

Patient outcomes

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

Data from each endoscopy procedure was recorded in an electronical tool. This measured the clinical quality of the procedures undertaken in line with Joint Advisory Group (JAG) gastrointestinal endoscopy guidelines. This included but was not limited to the number of procedures undertaken by each consultant, perforations rates, specimen retrieval rates, sedation and pain.

The minutes of the first endoscopy user group meeting held in September 2019 showed that the group reviewed the consultant procedure outcome data. No causes of concern were noted. The endoscopy lead consultant said that if endoscopy consultants were not able to demonstrate minimal numbers of patients treated at the hospital, they would provide the necessary evidence that higher numbers of patients were treated elsewhere. The provider had a policy which detailed the process for the management of performance concerns.

The hospital had three accreditations. The hospital had BUPA breast accreditation, BUPA bowel accreditation and BUPA MRI accreditation for cancer services.

For our detailed findings on patient outcomes please see the surgery report

Competent staff

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

Managers supported staff to develop through appraisals of their work. Staff we spoke with told us they had a yearly appraisal and found it a helpful tool in supporting their ongoing development. All staff working in oncology and endoscopy had an appraisal during 2019.

The breast care specialist nurse had undertaken courses that included 'principles of metastatic breast cancer care' in 2017 and a MacMillan university course in 2018. The course was entitled 'enhancing cancer care through work related practice'

Managers made sure staff were competent for their specific role. Medical staff performed endoscopy procedures and were supported by nurses with specific endoscopy skills. Staff working in endoscopy had training and were competent in clinical aspects of endoscopy which included the support of patients through a procedure, management of specimens and the decontamination of endoscopes.

Nurses and pharmacy staff that worked in oncology were assessed against specific competencies for their role. For example, nurses received training on how to administer chemotherapy medicines safely. A pharmacist we spoke with had completed the British Oncology Pharmacy Association competency in 2016. We saw that the pharmacy manager had validated this pharmacist oncology specific competency yearly.

Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in independent hospitals following approval from the medical advisory committee. This included the hospital making such checks as disclosure and barring service checks, qualifications and experience to practice.

Managers made sure staff received specialist training to support their clinical practice. Staff working in oncology were encouraged to attend a specialist oncology conference in Leicester every two years.

An endoscopy nurse told us about a conference where they had been able to see inside an endoscope. This had helped them to understand fully how to care for and manage the endoscopes.

A bank nurse we spoke with told us they had completed mandatory training and received an appraisal during the current year. Senior staff at the hospital explained there was an induction checklist to use with bank and agency staff if needed.

The resident medical officer cover was supplied through an agency who also checked their competency. This included ensuring the resident medical officer was trained in advanced life support.

Multidisciplinary working

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

Staff held regular multidisciplinary (MDT) meetings to discuss patients and improve their care. The acting oncology lead confirmed MDT meetings took place at the local NHS trust in conjunction with Spire Thames Valley staff, for all oncology patients. Records of these discussions were recorded within patient records.

We were told chemotherapy could not be administered without these notes. MDT data was regularly audited. From

Good

Medical care (including older people's care)

January 2019 until September 2019, compliance with MDT notes being in the patients' records was reported as 100%. Breast cancer MDT team meetings, to plan patients care and treatment, were held regionally weekly using video link. Attendees at the meeting included oncologists, radiologists, surgeons and specialist nurses.

Oncology patients were discussed in a multidisciplinary team meeting at a local NHS trust, and this provided opportunity for peer review and benchmarking. Oncology nursing and medical staff monitored and recorded individual patient outcomes at review and at further chemotherapy treatment cycles.

For our detailed findings on multidisciplinary working please see the surgery report.

Seven-day services

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

Oncology patients could seek advice from a senior nurse at the hospital, 24 hours, seven days a week. Senior staff used the United Kingdom Oncology Nursing Society triage tool to record the call. Patients could contact the hospital if they wanted to discuss or report any concerns or adverse side effects.

Endoscopy patients could also ring the hospital to seek advice from a senior nurse at the hospital 24 hours, seven days a week, if they had any concerns following a procedure.

Pharmacy services were available Monday to Friday 8.30am to 4.30pm and 9am to 1pm on Saturday. Pharmacy staff provided on-call cover, out of hours, on a rota basis.

For our detailed findings on seven day services please see the surgery report.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. This included advice on keeping hydrated for patients having procedures in theatres. For oncology patients, information included leaflets on 'coping with fatigue' and 'coping with hair loss'.

For our detailed findings on health promotion please see the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Consultants gave patients information about their planned endoscopy as part of the assessment process in the outpatient department. They explained the risks and benefits, and asked patients to sign a form consenting to the procedure. Staff checked verbally with patients on the day of the procedure if they were still happy to go ahead. However, this did not follow the provider's consent policy that written confirmation of consent should be obtained if the patient had signed the consent form in advance.

We alerted the service to what we found and senior managers immediately took action to improve practice, including sharing our concern at the hospital safety huddle attended by heads of department and put in place measures to include an audit of second consent in the audit programme. We were also shown evidence that this issue was placed on the governance meeting agenda for further discussion.

Staff we spoke with understood the principles of consent and the Mental Capacity Act (2005). Staff we spoke with had not assessed any patients who lacked capacity. Staff told us as it was a consultant led service, if a patient lacked capacity they would escalate to the responsible consultant. The consultant would then carry out a capacity assessment.

Staff obtained consent from patients before care and treatment. In oncology, the consultant assessed patient understanding prior to obtaining consent with specifically designed consent forms for systemic anti-cancer therapy. Staff told us this included a documented discussion of risks and benefits. Chemotherapy nursing staff undertook a quarterly consent audit. From January to March 2019, compliance with consent was 74% against a target of 95%. Following this audit, staff undertook actions which

included adding in a check of the consent form to the pre-treatment checklist for chemotherapy nurses and oncology pharmacists. From April to September 2019, compliance with consent was 100%.

For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards please see the surgery report.

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

Good

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

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considered way. Staff introduced themselves and explained their roles to patients, who were all cared and treated for in individual rooms. Staff offered patients having a colonoscopy procedure shorts, a gown and dressing gown to maintain their dignity. We spoke with eight patients who all commented on how they felt well looked after and cared for by all members of staff.

Patients said staff treated them well and with kindness. Comments included “lovely, kind” “incredible so positive”; “everybody was fabulous; very understanding”; “great hospital” and “always treat with respect. All lovely”. One patient commented, “following a day having treatment they telephone you when you are home in the evening to check you are okay, then the following morning, and said you know they care”. A member of staff in oncology had written a poem about one patient’s care. The patient also told us how they felt really cared for and that they mattered.

Caring and compassion was reflected in the way services were delivered. This included access to Wi-Fi and telephones in patient bedrooms, 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 in things to distract them whilst undergoing treatments.

For our detailed findings on compassionate care please see the surgery report.

Emotional support

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

Staff gave patients and those close to them help**,** emotional support and advice when they needed it. We saw how patients had time to ask staff questions and how staff took time to listen and respond to all their questions and alleviate concerns. We spoke with eight patients and they all spoke highly of the staff and how they had helped them during their visit.

Patients particularly in oncology, described how they felt emotionally supported. Patients commented on how they felt care to be patient focussed. For example, patients felt supported to take holidays when they felt well. Patients told us staff worked with patients to schedule their treatments.

A patient in endoscopy relaxed when staff explained in detail how long their stay was likely to be, so as the patient could plan their childcare that afternoon with confidence. Patients also told us how staff noticed when they wanted to be quiet. Patients told us how the person-centred approach made them feel more comfortable about their situation, and minimised distress.

Patients also involved their relatives as they wanted to. We saw that relatives were cared for by staff, and able to support their loved ones. Staff could be seen going the extra mile for patients. This included, the hospital providing a taxi to bring the patient and the relative to the hospital, to

ensure the patient's care and treatment continued as planned. For this patient, blood tests normally undertaken 48 hours in advance were being undertaken on the same day, and the results were requested urgently. This was to minimise distress for the patient and their relative, who also had health needs to be met, of the need to come to the unit twice in quick succession.

There were signs promoting patients to request a chaperone if they would like one present, when having care and treatment.

Staff understood the emotional and social impact that a person's care and treatment or condition had on their well-being and those close to them. The acting oncology lead nurse explained that if needed, advice and support could be obtained from physiotherapy, and the breast and colorectal specialist nurses. They also explained that to support people with their religious needs, pastoral care was available from the local NHS trust.

For our detailed findings on emotional care please see the surgery report.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us, particularly in oncology, they had a named nurse which they found helpful and provided them with consistency. Patients told us staff were always willing to spend time to explain their care, treatment and condition. Patients explained what treatments they were receiving and were happy that the doctors and nurses kept them up to date with their treatment plan. For example, a patient told us how the way their treatment was administered had been discussed with them, to make the treatment as comfortable as possible.

Staff talked with patients and families in a way they could understand. Patients were provided with relevant information about their care and treatment. Patients in the oncology unit stated staff kept them informed about their care, involved in any decision making and listened to them. For instance, patients receiving chemotherapy treatments were advised of the risk of neutropenic sepsis (due to a temporary reduction of white blood cell count during treatment) and given information to allow them to recognise signs or symptoms of sepsis after treatment. A patient we spoke with explained how the pharmacist had given them advice about managing brittle finger nails and constipation.

Patients undergoing an endoscopy procedure were provided with relevant information by staff, both verbal and written, to make an informed decision about their care and treatment.

For our detailed findings on understanding and involvement of patients and those close to them please see the surgery report.

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

Good

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

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of people accessing the service. The hospital provided planned endoscopy procedures and an oncology service for insured and self-pay patients. The hospital pre-planned all admissions to allow staff time to address any issues that may be identified for further investigation.

Facilities and premises were suitable for the services being delivered. All patients had private rooms with ensuite facilities. There was a lift for patients being admitted for an

endoscopy procedure to access the ward. The oncology suite of five rooms were on the ground floor. This meant there was step free access for people with reduced mobility. Free car parking was available on site.

The service had systems to ensure patients' needs were met. The oncology service told us there were good links with the pathology service with an NHS trust. This meant blood tests results for oncology patients were always available at the point when patients were assessed for their fitness for a chemotherapy cycle.

For our detailed findings on service delivery to meet the needs of local people please see the surgery report.

Meeting people's individual needs

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

Patients received information relevant to their procedure prior to their attendance. For patients having an endoscopy procedure, the information included guidance on preparation, arrival time, the procedure and aftercare.

Patients day procedure pre-admission questionnaire included an assessment of people's individual needs, which included a question to check if any additional support was needed, to support effective communication and understanding. Staff told us they would explore with patients further if a need was identified. Staff in oncology showed us the chemotherapy pathway, which also included a prompt for staff to ask a patient if they had any special needs or disabilities.

Staff in the medical service understood the needs of people living with dementia, and there were dementia champions on the wards to support staff and patients as needed.

The oncology specialist nurse explained to us that if patients became palliative, they would refer them to a local hospice.

Patients in the oncology unit had access to scalp coolers, and staff were trained to use the equipment. Scalp cooling can sometimes reduce or prevent hair loss caused by chemotherapy.

The hospital was 'MacMillan adopted'. The benefits included being able to refer oncology patients to courses run by MacMillan. The breast care specialist nurse told us about courses which included 'Looking good feeling better services', 'Stepping stones' and 'Moving forward'. These courses were held locally but not at the hospital.

The breast care specialist nurse knew about a local charity that was dedicated to supporting breast care patients. The breast care specialist sign posted staff to the charity, for the support these patients were able to access to promote their wellbeing.

Managers made sure staff, and patients, relatives and carers could get help from translators when needed.

For our detailed findings on meeting people's individual needs please see the surgery report.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed time frames and national targets. Following a GP referral for an endoscopy procedure, consultants assessed patients in the outpatient department. They reviewed patients to see if they met the admission criteria, carried out assessments and discussed a plan of treatment. This meant staff could plan the flow of patients. A member of nursing staff attended the appointments, to support the co-ordination of patients' endoscopy procedures and provide patients with a familiar face. Consultants carried out endoscopy procedures, at a date and time to suit patients, usually within one to four weeks of referral to the hospital. Senior staff told us there had been one patient in the age bracket 16 to 17 who had an endoscopy from 1 July 2018 to 30 June 2019. The theatre manager explained that if a 16 or 17 year old young person had an endoscopy, they would need to have been assessed as fit to go on the adult patient pathway.

NHS consultants referred oncology patients to the hospital following diagnosis at an NHS hospital. A patient could have a chemotherapy treatment from Tuesday to Thursday. There was no waiting list for this treatment. The oncology

nurses explained they joined consultant clinics across all oncology pathways over a five-day week, ensuring patient support and advocacy through their hospital journey. These staff also recorded information in the patients records as needed to ensure continuity of patients' care.

Patients told us that cancer treatment appointments were available at times that suited their needs. Patients we spoke with told us they had specifically chosen the hospital because of the service it provided.

Patients had access to a single room for their cancer treatment. Rooms were used for one patient a day, this meant patients could stay after their treatment had been completed, if they felt unwell or wanted to rest.

For our detailed findings on access and flow please see the surgery report.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise a concern. Staff had placed information about how to raise a concern or complaint within oncology and within the ward where endoscopy patients were admitted and discharged. Staff working in endoscopy and oncology, told us they had not received any formal complaints from 1 July 2018 to 30 June 2019.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff in oncology told us about an informal complaint they received from a patient about noise in the corridor. A sign had now been put up at the entrance to the oncology suite that advised people to be aware that they were entering a corridor with patient bedrooms and to be mindful of any noise. The five oncology patients we spoke with did not raise any concerns about noise.

For our detailed findings on learning from complaints and concerns please see the surgery report.

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

Good

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

Our rating of well-led improved. We rated it as good

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The senior management team at the hospital included a hospital director and director of clinical services. They were responsible for the day to day management of the hospital and development of the hospital. The director of clinical services was interim and had been in post since August 2019.

The endoscopy service was led by the theatre manager, supported by two nursing staff competent working in endoscopy.

In the oncology service there was an acting lead, due to the previous oncology lead recently leaving their post. The oncology lead position was out to advert.

Staff told us department leads were visible and approachable. They said they were supportive and would try to address any problems highlighted by staff and escalated them to the senior leadership team when needed.

Staff were supported by the local hospital leadership team to develop their skills. Staff had attended training and conferences relevant to their area of work. The oncology team in December 2018 received the Spire Healthcare Limited national award for an exemplary cancer care service.

The theatre manager/ endoscopy lead had attended leadership training, that had helped them to understand themselves and their staff strengths and weaknesses better. The theatre manager talked about how the training had helped them to work out the most suitable lead roles to put staff in, for example, auditing to check quality of care.

For our detailed findings on leadership please see the surgery report

Vision and strategy

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

The hospital followed the Spire Healthcare Limited vision which was to be recognised as a world class healthcare business. This vision was underpinned by a strategy which aimed to deliver the highest quality patient care.

Staff working in the medical services demonstrated their commitment to the hospital vision, by working to improve the performance of their departments. The endoscopy service was working towards achieving the Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation. By participating in accreditation, the service had enrolled on an ongoing programme of service and quality improvement.

The vision for the oncology service was to be recognised as a quality provider of oncology services locally and within the organisation. Staff values in oncology included 'putting patients at the centre of all we do and making the complicated simple'.

Staff appraisals considered objectives linked to the hospital strategy, hospital targets and departmental improvements. Staff were also measured against how well they demonstrated the hospital values and behaviours.

For our detailed findings on vision and strategy please see the surgery report.

Culture

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

The culture within the endoscopy and oncology service was centred on the needs and experience of people who used the services. Staff of all levels showed patient care and treatment was a priority and told us they wanted to provide the best possible service.

Staff we spoke with felt valued and told us about the opportunities they had had to develop their knowledge and skills, and how valuable this had been.

There was a culture of openness and honesty amongst the staff we spoke with in endoscopy and oncology. Staff we met with told us they liked working at the hospital and felt they all had a good team of colleagues who were supported by their line managers. Staff felt able to raise concerns, and that senior staff were approachable.

For our detailed findings on culture please see the surgery report.

Governance

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

The oncology service held quarterly clinical governance meetings, which linked into the hospital governance meetings. We reviewed the minutes of the meeting held on 9 July 2019. The meeting was chaired by the oncology lead in post at that time. Attendees included oncology consultants, chemotherapy specialist nurses and a chemotherapy specialist pharmacist. Agenda items included; mortality and morbidity reviews, review of incidents, clinical governance which included a check to see if there was anything to report from the medical advisory committee or anything to take to the medical advisory committee, pharmacy and audit.

The theatre manager/ endoscopy lead led the first endoscopy user group meeting on 25 September 2019.

Attendees at the meeting included the lead consultant and gastroenterology nursing staff that worked in endoscopy. Attendees reviewed the terms of reference which were agreed. These included holding the meetings quarterly, inviting all the consultant gastroenterologists and to ensure there was patient representation. Agenda items included review of consultant outcome data, incidents, staff development, patient experience and an action log to ensure any actions were completed.

Both oncology and endoscopy had a consultant who attended the quarterly medical advisory committee meeting. Their attendance ensured the consultants had a knowledge and understanding of the clinical governance at the hospital.

The theatre manager/ endoscopy lead and acting oncology lead attended meetings at the hospital, such as heads of department meetings, to ensure they had an understanding of activity and governance across the hospital.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety, consent and patient pathways. Audits were completed monthly, quarterly or yearly by each department depending on the audit schedule. Results were shared at relevant meetings such as governance meetings. Following our inspection, an audit of confirmation of consent on the day of admission was added to the audit programme. We were also shown evidence that this issue was placed on the governance meeting agenda for further discussion.

For our detailed findings on governance please see the surgery report.

Managing risks, issues and performance

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

There were two risks that related to the medical service. The first risk was in relation to the endoscopy service and the risk to volumes of work because the service did not have Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation. Senior staff had put actions in place to reduce the risk, this included the refurbishment of the decontamination area for endoscopes which had recently been completed.

The second risk was a lack of dedicated clinical hand wash sinks in patient rooms. Staff had put actions in place to manage the risk and completed a risk assessment.

Senior staff ensured expected death notifications were consistently notified to the CQC as required.

For our detailed findings on managing risks, issues and performance please see the surgery report.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service collected, analysed, managed and used information well to support all their activities, using secure electronic systems with security safeguards. The service had access to the information they needed to manage their staffing to ensure they could meet the needs of the services. The service regularly reviewed quality performance which the endoscopy lead and acting oncology lead discussed at hospital wide meetings they attended with other department managers.

The oncology service used electronic prescribing. This enabled all health professionals in contact with patients to access the same chemotherapy treatment protocols. The system also enabled them to see the same up to date patient information to better inform prescribing decisions and minimise risk.

There was sufficient information technology equipment for staff that worked in oncology and endoscopy. Clinical staff accessed information about patients using a computer securely with individual log in details and passwords. Information included referral letters, blood test results, x rays and other investigation results. Staff in oncology and

endoscopy sent a discharge letter electronically to patients' GPs detailing their care and treatment. Staff could access information on the hospital intranet, which included clinical policies and standard operating procedures.

For our detailed findings on managing information please see the surgery report.

Engagement

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

Patients could give feedback on the service and their treatment and staff supported them to do this. The oncology service had sent a feedback questionnaire to patients in March 2019. Staff told us 16 questionnaires were returned and they had all been positive. The acting oncology lead told us that further patient surveys were planned.

The theatre manager told us that feedback questionnaires had been given to endoscopy patients, and these had all had positive feedback. The theatre manager explained that patient feedback was a standard agenda item to be reviewed and discussed at the endoscopy quarterly user group.

For our detailed findings on engagement please see the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The acting oncology lead commented on how patients can be anxious about the need to have a line inserted centrally (a long thin hollow tube that was inserted into a vein near the heart) in radiology for the administration of their chemotherapy. The acting oncology lead told us they now always go with patients who are anxious. Staff had noticed how patients now appeared more relaxed during the procedure.

Complementary therapy was to be provided at the hospital. Senior staff at the hospital told us there was a plan to explore local service providers by the end of January 2020, to prepare a business case by the end of February 2020 and have the service in place by the end of June 2020.

For our detailed findings on learning, continuous improvement and innovation please see the surgery report.

Good

Surgery

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

Are surgery services safe?

Good

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

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. This also includes the management of medicines and incidents. The information applies to all services unless we mention an exception.

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

Mandatory training

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

The provider's training compliance target was set at 95% and data showed 97% of staff working in surgery had competed their mandatory training.

Mandatory training was provided through a combination of e-learning and face to face training. Modules included, but were not limited to, manual handling, infection control, health and safety, sepsis and information governance.

Managers continuously monitored compliance and ensured staff were reminded when their training needed to be updated. Managers supported staff to keep up to date with mandatory training by giving them protected time to do so. Staff confirmed that this was the case.

The hospital had recently introduced National Early Warning Score 2 mandatory training. Therefore, not all staff had completed this training at the time of our inspection.

Medical staff received their mandatory training from their employing NHS trust. Training compliance was checked routinely by the provider. Resident medical officers (RMOs) completed mandatory and yearly update training with their agency. The hospital received training certificates that verified RMOs training status. This included advanced life support, European paediatric advanced life support, blood transfusion, infection prevention and control, safeguarding children level three. Additional training, such as use of the hospital's electronic incident reporting system, was provided to RMOs and consultants as required.

There were additional role specific training modules available to clinical staff. This included training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Staff told us they received the right training to be able to do their jobs and meet the individual needs of those they cared for.

Safeguarding

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

The hospital had clear systems, processes and practices to safeguard adults, children and young people from avoidable harm and abuse. Safeguarding policies were in-date and accessible to all staff and reviewed regularly.

Safeguarding policies included contact details for the local authority safeguarding teams and information on female genital mutilation and PREVENT (anti-terrorism). This was in line with the recommendations from the Intercollegiate Document Adult Safeguarding: Roles and Competencies for Healthcare Staff and the Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff.

Data we reviewed showed 97% of staff had received level two safeguarding adults and children training. 96 staff had received level 3 safeguarding children training and five staff had received level 3 safeguarding adults training. The hospital had a safeguarding lead who was training to level 4 in both adults and children's safeguarding. This was in line with national guidance.

Staff were able to recognise the signs of abuse and knew how to raise a concern. They also knew who to contact if they required safeguarding support or advice.

The level 4 safeguarding lead was a member of the local safeguarding board and ensured all staff received a recent update on PREVENT. Prevent is one of the four elements of CONTEST, the Government's counter-terrorism strategy. It aims to stop people being drawn into terrorism.

The provider had not reported any safeguarding concerns to the CQC between July 2018 to June 2019.

Cleanliness, infection control and hygiene

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

The hospital had up-to-date policies for infection, prevention and control (IPC) and related topics such as decontamination and isolation precautions. Staff could access these through the hospital's electronic system.

There were effective systems to prevent and protect people from a health-care associated infection. All areas we visited appeared clean and well maintained. This was in line with current guidance from the National Institute for Health and Care Excellence (NICE) Quality Standard [QS61]: Infection Prevention and Control.

There was an IPC team who met quarterly and maintained oversight of the management of IPC. This included the director of clinical services as the director of infection prevention and control, an IPC lead supported by department link staff and a microbiologist.

There was an annual IPC audit programme, which included hand hygiene audits, environmental cleaning audits and surgical site infections. However, it was acknowledged the IPC audits were not completed in the expected time frames due to staff absence and changeover. An IPC audit tracker and schedule were introduced and there was a focus on completing the audits and getting them back on track. Audit results were fed into the clinical audit, safety and effectiveness group.

The hospital had identified a concern regarding the lack of dedicated clinical sinks in patient bedrooms meaning staff and visitors used the basin in the bedroom's en suite bathroom. A risk assessment had been carried out and a refurbishment plan was in place to include compliant sinks in patient rooms. To mitigate the concerns, we saw staff were using the alcohol-based sanitising gel in the patients' bedroom, and if their hands were visibly soiled washing them using the hand basins in the patients' bathrooms. Additionally, staff had access to portable hand washing facilities that could be deployed on the wards if there was an infectious patient. This approach had been approved by the hospital IPC team until new clinical sinks had been installed.

Hand hygiene audit results in all clinical areas were above 95%. This showed that staff followed hand hygiene policies to reduce the risk of spreading infection.

All areas across the wards, pre-operative assessment unit and the theatre department were visibly clean and free from dust. All soft furnishings were wipeable and in a good state of repair with no rips or damage. This was compliant with The Department of Health's Health Building Note 00/09.

The hospital had two theatres and both had laminar air flow ventilation systems. This was compliant with the Department of Health's Health Technical Memorandum

03-01. This meant there was an adequate number of air changes in theatres per hour, which reduced the risk to patients of infection. This was serviced on a six-monthly basis and the filters were changed.

We noted a good clean to dirty flow of equipment and personnel through the theatre suite. This help to reduce the risk of spreading infection.

In one theatre, we noted a hard to reach window that did not look clean or able to be easily cleaned. We highlighted this to the director of clinical services who immediately undertook a risk assessment. This led to mitigating actions being put in place to enable effective cleaning and monitoring of this hard to reach area.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw the correct use of PPE such as disposable gloves and aprons. PPE was available in all clinical areas. Staff in theatres wore appropriate theatre clothing (scrubs) and designated theatre shoes.

The hospital had its own central sterilisation service to clean and sterilise theatre instruments and equipment. The service had International Organisation for Standardisation accreditation which is a global quality management standard.

The hospital reported surgical site infection (SSI) performance directly to Public Health England (PHE). All patients were followed up at two and 30-days post-discharge, during which staff asked questions in line with PHE SSI monitoring. If a patient raised any wound infection concerns this was reported through the incident reporting system and investigated.

There were 20 surgical site infections reported for July 2018 to June 2019. This equates to a rate of 0.52% of all surgical patients (3858 surgical admissions in the period). We saw they were investigated, and no root causes were identified, for example no trends had been identified with particular surgeons, operations, theatres, or scrub teams. However, learning from the incidents were shared.

From July 2018 to June 2019, zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA) (a skin infection that may cause pneumonia), E-Coli (a bacterium that can cause severe abdominal cramps, bloody diarrhoea and vomiting) and Clostridium difficile (c.diff) (a bacterium which infects the gut and causes acute diarrhoea) were reported.

The hospital had up-to-date policies to support staff with the correct disposal of waste. There were separate colour coded arrangements for general waste, clinical waste and sharps. Theatres had an effective clean and dirty flow for the disposal of clinical waste and used instruments. Sharps containers were labelled with the hospital's details for traceability purposes.

Environment and equipment

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

The ward was spacious, and patient centred. Inpatient rooms were well equipped, with ensuite wet rooms and air conditioning. There was free Wi-Fi and a television in each room. The rooms had a large shower area with hand rails which provided space for patients with mobility issues. The wards and theatre were well signposted from the main entrance.

The servicing of equipment was tracked and logged electronically. Records showed servicing of large items of equipment in the hospital was under service level agreements with the company who provided the equipment.

Staff had enough suitable equipment to help them to safely care for patients. This included anaesthetic equipment, theatre instruments, vital sign monitors and commodes. We saw that all anaesthetic equipment was checked daily prior to use.

There was appropriate resuscitation equipment available in case of an emergency. Resuscitation trolleys were situated in the theatre, ward and day care unit. They were all well organised and had tamper evident seals in place. We reviewed records which showed the resuscitation trolleys and their contents were checked daily in line with hospital policy. Theatres also had a difficult airway trolley, transfer bag and malignant hyperthermia kit. Malignant hyperthermia is a type of severe reaction to certain medications used during general anaesthesia.

Patients who needed implants, such as hip prosthesis, had this clearly recorded in their notes. This included the device number and size. This meant all implanted devices could be tracked in case of any faults developing. Implants were also stored in a designated store room, which was well organised and reduced the risk of the wrong implant being used. The hospital also recorded implants used on national registers, such as the breast implant register and the national joint register. This showed which patient received which type of implant and when, to allow tracking if needed.

Consumable equipment, for example, syringes, needles and dressings, were managed effectively across all areas we visited. The consumable items we checked were stored in unbroken packaging and were within their expiry date.

Patients could reach call bells and staff responded quickly when called. Each patient room and bathroom had call bells to alert staff when assistance was required.

Assessing and responding to patient risk

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

There was a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response.

There was a care pathway for elective surgical procedures. The pre-assessment process was clearly described in each care pathway. Patients for elective (planned) surgery underwent a thorough nurse led pre-operative assessment before their operation. Questions included the patient's past medical history, allergies, current medication, and previous anaesthetic and/or infection risk.

We reviewed the care pathway for hip replacement surgery. Clinical risk assessments we reviewed were complete and included anaesthetic score, vital signs, urinalysis, Waterlow score (to assess the risk of pressure sores), thrombosis risk assessment, bleeding risk assessment and falls risk assessment.

Female patients were informed that a pregnancy test may be required on admission to reduce any risk to an unborn foetus in the case of patients who were not aware they were pregnant.

All patients over the age of 75 years completed an abbreviated mental test score for dementia screening. All patients screening positive for dementia then went on to be fully risk assessed to make sure they understood and had mental capacity to make an informed consent decision about their treatment.

Anaesthetists held pre-assessment clinics where they reviewed patients who were classed as high risk for anaesthesia or had medical conditions that deemed them at risk of developing complications after surgery. The American Society of Anaesthesiologists score was used to assess the physical status of endoscopy patients before surgery.

Any patients who were identified as high risk by the pre-operative nursing team were referred to an anaesthetist prior to their admission. Patients identified as high risk or had potential complications diagnosed following test results, for example uncontrolled diabetes, were referred to the consultant for further review before surgery was undertaken.

Patients classed as higher risk were monitored post-operatively in the hospitals two-bedded extended recovery unit if required. This was equipped for patients who needed higher levels of care and observation, such as continuous monitoring. The theatre recovery staff would not return a patient to the ward until they were completely stable.

Staff used recognised tools to complete risk assessments for each patient on admission / arrival. We reviewed five patient records, all risk assessments were completed post-operatively. The completion of post-operative risk assessments was regularly checked as part of the medical records audit.

Patients had a physiotherapy assessment following their surgery to make sure they were not developing a post-operative chest infection and to check they were able to mobilise.

Staff used a nationally recognised tool called the National Early Warning Score 2 (NEWS2) to identify deteriorating patients and escalated them appropriately. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored

according to pre-determined parameters. There were clear directions for actions to take when a patient's score increased. There were appropriate triggers in place to escalate care, which members of staff were aware of.

We attended two procedures in theatres which enabled us to observe the complete World Health Organisations (WHO) surgical safety checklist pathway. We saw all staff being fully engaged with team/safety briefings, sign in, time out and de brief. Swabs, needles, instruments and sharps were counted to prevent foreign body retention and subsequent injury to the patient. The count was undertaken by two members of staff, a registered perioperative practitioner or senior health care assistant appropriately trained/scrub trained. The service audited WHO checklist compliance by observing 13 patients each month through their theatre journey. For May 2019, the service carried out two audits and data showed compliance was 87% and 98% respectively. Where actions for improvement were identified these were either shared with individuals concerned or discussed with the relevant teams during meetings.

There was a screening tool and pathway for the management of sepsis. Sepsis is a serious complication of infection. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. The service had implemented the sepsis six pathway in line with guidance from the Sepsis Trust. The wards had a sepsis box, which contained the equipment and medicines staff needed to promptly initiate the sepsis six bundle.

The ward held early morning handovers from the night staff to the day staff. These ensured the safe handover of patients and allocation of work was completed. Any issues from this handover would be picked up at the hospital wide safety huddle. We saw the ward handover which was attended by the ward nursing staff, ward clerk, resident medical officer (RMO) and pharmacist.

Theatres also had a morning safety huddle in the theatre, this was attended by all theatre staff on shift for that day and included recovery, critical care and resuscitation staff. This huddle identified who was allocated to which theatre and what level of resuscitation training they had. Each list and theatre team were discussed and any equipment issues, staffing, breaks and who would cover them. Staff were also given a 48-hour flash report. This set out learning from other Spire Healthcare hospitals and included never events/ serious incidents. These meetings were recorded for staff to refer to later if needed.

The RMO was on duty 24 hours a day and was available on site to attend any emergencies. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care. The RMO and staff told us consultants were responsive and supportive. In an emergency, staff would request an ambulance to transfer the patient to the local acute NHS emergency department.

From April 2018 to March 2019, the hospital reported 10 unplanned transfers to the local acute NHS trust. We saw detailed investigations were completed for the unplanned transfers, with learning identified and actions taken where indicated, to minimise the risk of recurrence and enhance patient safety.

The hospital's resuscitation team was reviewed at the daily operational meeting. We saw each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and runner.

On the wards and in theatres, there was always a member of staff who was trained in advanced life support and immediate life support.

The hospital undertook practice emergency scenarios on both the wards and in theatres. These were run by resuscitation officers and received well by the staff.

Upon discharge, patients were given the ward telephone number to ring in the event of any issues or to ask questions. All patients were phoned two days and 30 days post-surgery to check on their progress. Telephone enquiries were documented and filed in the patient's notes and further appointments were made if required.

Nursing and support staffing

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

Managers calculated and reviewed the number and grade of nurses, operating department practitioners and healthcare assistants needed for each shift in accordance with national guidance. The hospital used a safer nursing care tool.

Weekend staffing reviews took place each Friday afternoon. If any gaps in staffing were identified or changes to acuity scores required additional nursing staff, staff would be sought from either the nurse bank, shift swaps to another day or the use of pre-approved agency nurses.

Planned activity for the hospital was reviewed by managers on a weekly basis so that substantive and bank staff could be flexed according to activity and patient acuity when needed.

The operating department used guidance set out by the Association for Perioperative Practice related to safe staffing levels. Theatre staffing levels were also based on nationally recognised guidelines such as the Association of Anaesthetists of Great Britain and Ireland and the British Anaesthetic Recovery Nurses Association. Each theatre was staffed with one team leader, two qualified and one unqualified member of staff.

Medical staffing

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

Patient care was consultant-led. Consultants were available for advice and to review admitted patients. They provided 24-hour on-call cover for patients post-operatively. The consultants hand book stated consultants needed to reside a distance from the hospital appropriate to the level of cover they were expected to provide. Where the journey time exceeded 45 minutes a formal risk assessment would be completed.

If the named consultant was unavailable at any time while they had patients admitted to the hospital, they arranged appropriate alternative named cover by another consultant in the same specialty. There was a buddy system in place which was found to be effective.

Anaesthetists were expected to be available for 48 hours after surgical procedures in case a patient, whom they had anaesthetised, became unwell.

All consultants who worked at the hospital did so under practising privileges. This is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in a private hospital or clinic.

Immediate medical support was available 24 hours a day, seven days a week. This was provided by RMOs who were employed through an external agency. The RMO slept on site and worked a shift pattern of one week on and one week off.

Records

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

All patient records were paper based and were kept in a secure location on site for six weeks following the end of treatment or discharge and then archived off site. These records could be retrieved within 24 hours.

Patient records showed a multidisciplinary collaborative approach to patient care and records were well maintained. We reviewed five sets of patients records and found there was a good standard of record keeping. All paper records were legible, contemporaneous, and signed. Management plans and daily ward rounds were clearly documented, and evidence of escalation and NEWS 2 recordings were clear.

Clear pathway documents were used throughout the patient pathway. Risk assessments were completed from the start of the patient's pathway in pre-operative assessment through to admission.

There were surgical pathways which included preoperative assessments. The assessments were carried out in line with National Institute for Health and Care Excellence (NICE) guidance. We reviewed a sample of these and found they were completed thoroughly.

Nursing staff completed a discharge summary letter for the patient's GP. This gave details of the operation performed, the consultant responsible, any medication required as a continuation of their care and any follow-up requirements. These letters were given to the patient to take to their GP.

Medicines

Good

Surgery

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. A comprehensive medicines management policy was in place, which covered obtaining, prescribing, recording, handling, storage, security, administration and disposal of medicines. Staff we spoke with were familiar with the policy and aware of their roles in managing medicines safely.

The pharmacy team had a presence in each core service. Staff on the ward and in each department visited were aware of the team and their roles and reported excellent communication.

Pharmacists attended multidisciplinary team meetings across the hospital and the daily 10 at 10 operational meetings.

Medicine records were completed appropriately including details of allergies and medicines reconciliations. Audits were completed monthly of patient's medicine records by pharmacy staff. Medicines were stored securely, and access appropriately controlled.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw pharmacists spoke to patients on the wards and in day-case areas about their medications before admission and those prescribed whilst in the hospital, including medications prescribed for them to take home.

Medicines were stored securely, and access was restricted to authorised staff. We saw no medication was left unattended. Staff carried out daily checks on controlled drugs (CDs) and medication stocks to ensure medicines were reconciled appropriately. CD destruction kits were available, and staff could describe how they would destroy them.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. The treatment rooms where medicines were stored were air-conditioned, which meant the temperature could be maintained within the recommended range (below 25°C). Room and fridge temperatures were checked daily and stored within the correct temperature range.

All emergency medication boxes that were kept on or near the resuscitation trolleys were in tamper evident boxes. Records showed that daily checks of medicines stock on the resuscitation trolleys were performed to ensure that they were fit for use in accordance with hospital policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw an effective reporting culture within the pharmacy department and saw that incidents, including near misses, were routinely reported. Medicine incidents were reported through the hospital's electronic reporting system. Staff could describe how safety alerts are received, disseminated and how actions are assured.

Incidents

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

Staff knew what incidents to report and how to report them. The hospital used an electronic reporting system to report all incidents. Staff told us they were encouraged to report incidents and felt confident to do so.

From July 2018 to June 2019, the hospital reported 416 clinical incidents and 102 non-clinical incidents. Each incident was reported and investigated in accordance with the hospital's policy for incident management. All clinical incidents were categorised according to their level of patient harm; the majority were graded as low or no harm.

From July 2018 to June 2019, the hospital notified the CQC of one serious incident. Serious incidents were investigated by staff with the appropriate level of seniority, such as the director of clinical services and managers of departments. Managers debriefed and supported staff after any serious incident. This was evident from the investigation reports we reviewed and conversations we had with staff.

The hospital had one never event from July 2018 to June 2019 and this was in surgery. 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 the corporate Spire Healthcare Limited newsletter, which shared learning regarding serious incidents or never events across the organisation.

Any incidents assessed as low or with no patient harm were reviewed locally. All incidents requiring further investigation and graded high and serious would have a root course analysis completed. These were reviewed by a Spire Healthcare Limited central incident review working group and could not be signed off locally until reviewed by this group.

Staff understood the duty of candour. They were open and honest and gave patients and families a full explanation if and when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

The RMO was aware of how to report and record an incident but had not had to report one yet. They described the duty of candour as being honest and truthful in care and management of patients, being open about risk and patient's safety.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were reviewed daily and we saw they were discussed at daily staff huddles and the 10 at 10 daily meeting.

We saw lessons were learnt from incidents, for example the pharmacy team had provided interactive workshops and medicines management training as drop in sessions for all nursing staff, following medicines incidents.

Clinical Quality Dashboard

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

The hospital monitored safety through a quarterly clinical scorecard. The scorecard reported on 47 clinical indicators such as pain scores, complaints, infection control and pressure ulcer incidence.

The scorecard was completed by all the hospitals in the Spire Healthcare organisation which meant that the hospitals could benchmark against each other. The score card was red, amber, green rated. Green ratings meant the hospital was performing at or above target for the indicator. Spire Thames Valley Hospital was performing at or above target level.

All staff we spoke with were aware of the score card and understood its benefits; we saw the 2019 quarter two score card displayed on notice boards.

The scorecard was discussed at head of department meetings and analysed for areas of improvement. This was then fed back to the local teams.

Are surgery services effective?

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.

In this section, we also cover hospital-wide arrangements such as the use of current-evidence based guidance and how they ensure staff are competent to carry out their duties, in the relevant sub-headings within the effective section. The information applies to all services unless we mention an exception.

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

There was an effective system to ensure policies, standard operating procedures and clinical pathways were up-to-date and reflected national guidance. Most policies were updated by Spire Healthcare and disseminated to each hospital. Policies we reviewed were all within the

review date. Policies were current and based on professional guidelines, for example, National Institute for Health and Care Excellence (NICE) and Royal College of Anaesthetists guidelines.

Evidence based care started for patients during their pre-operative assessment. For example, patient records showed they were assessed for the risk of venous thromboembolism (VTE) on admission, throughout their stay and on discharge. This was in line with NICE guideline [NG89] Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

Compliance with NICE guidance was monitored and action taken when required by the medical consultants. There was evidence in the meeting minutes this was discussed at the medical advisory committee meeting with action points noted and followed up. For example, the non compliance to monitoring of the patient's temperature during an anaesthetic was discussed. Actions were being taken to address the issue, including the review of equipment used, prompts to remind staff of the need for this to be completed and re audit. Audit results in 2019 showed an improved compliance rate from 32% in quarter two to 80% in quarter three.

Staff used surgical pathways which were in line with national guidance. This included for example, integrated care pathways specific for a day case procedure. The day case pathway included the predicted American Society of Anaesthesiologists classification.

Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. Our review of patient records, guidelines and clinical pathways, and discussions with staff confirmed care was delivered in line with national guidance and standards.

Staff followed guidance regarding the recording and management of medical implants, such as hip implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central database. We saw evidence of this in the notes we reviewed. Relevant paperwork was completed at time of insertion of implant and was documented in the National Joint Registry by theatre staff within 24 hours of the procedure. The service also participated in the national spine and breast registries.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Hospital policies were equality impact assessed to ensure guidance did not discriminate against those with protected characteristics as set out in the Equality Act 2010.

Nutrition and hydration

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

Patients were advised about appropriate pre-operative fasting during their pre-operative assessment and lengths of fasting times reflected where patients were on the theatre list. Information was given verbally at the pre-operative assessment and in writing. Pre-operative staff would email the wards and the kitchens should a patent attend the clinic and have a food allergy or a specific dietary requirement.

Staff used the nationally recognised Malnutrition Universal Screening Tool to assess, monitor and record patients' nutrition and hydration needs. This was in line with NICE [QS15] Patient experience in adult NHS services.

Patients waiting to have surgery were kept 'nil by mouth' in accordance with national safety guidance. This was to reduce the risk of aspiration during general anaesthesia. Staff told us of new guidance from the Royal College of Anaesthetists, where patients are allowed 10mls of water every hour up to their admission into theatre. We saw this in practice during the inspection.

Admission times were generally staggered so that patients were fasted for the minimum amount of time. Patients nutritional status was discussed during the daily safety briefing and anaesthetists requested 'pre-operative nutritional drinks' for patients who would be waiting over two hours for their surgery. We saw this happened during team briefs.

Recovery and the ward areas ensured the effective management of nausea and vomiting. We saw staff enquire about patient's appetites and offer anti-sickness medication for patients who reported feeling nauseated.

We also saw how staff returned to check the medication had worked and if necessary offer an alternative anti-sickness medicine. For patients able to take their own fluids, drinks were available on bedside tables and within reach.

Specialist support from staff such as dieticians was available for patients who needed it.

Patients recovering from surgery had jugs of water within reach. These were regularly refilled. Staff completed hourly care rounds for each patient and checked they had a drink.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management to ensure following surgery patients were given effective pain relief.

Patients were asked about pain in the pre-assessment consultation. Anticipatory pain relief was prescribed, and we saw this in the patient records we reviewed and being administered in the operating theatre. Information was given to patients pre-operatively to explain what sort of analgesia they could expect to receive during their operation. This included explanations of epidural, spinal, general and patient controlled analgesia.

Quarterly audits were undertaken to ensure staff were recording patients pain levels in recovery and on every set of observations on the ward. Audit data provided for quarter one and quarter two in 2019 were 93% and 96% respectively against a target of 95%.

We heard staff asking patients if they had pain and after administering analgesics returned to check if they were effective. Patients completed an inpatient survey and were asked if they thought hospital staff had done everything to control their pain.

Patient outcomes

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

The service participated in relevant national clinical audits. The hospital had a comprehensive yearly audit schedule covering all clinical areas, environmental issues and customer relations. The schedule outlined if an audit was organisationally or externally required, a recommended audit or stipulated as required in a Spire Healthcare Limited policy.

Local audits were managed by the hospital at a local level and all audits were discussed when relevant at the monthly clinical effectiveness meetings. Minutes from the meeting were shared during the governance meetings.

The clinical scorecard enabled the hospital to benchmark its clinical performance indicators against other Spire Healthcare Limited hospitals. The scorecard compared the audit results to the hospital's target, Spire Healthcare Limited network results, the previous quarters score and showed if the service/audit had improved.

The hospital participated in some national audits to monitor patient outcomes including the elective surgery Patient Reported Outcome Measures (PROMs) programmes, Public Health England infection control surveillance, and the National Joint Registry (NJR).

The also hospital submitted data to the Private Healthcare Information Network (PHIN).

Information was collected on all replacement operations and monitoring of these registries ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects. This allowed for longer term national reporting of outcomes.

The hospital submitted data to PROMS, which helped the NHS measure and improve the quality of care patients experienced during and after elective surgery. In the PROMS survey, patients were asked whether they felt better or worse after receiving the following operations:

- Hip replacements
- Knee replacements

The PROMS data showed that the hospital was not an outlier and overall most patients reported an improvement in how they felt after their surgery. The hospital did not currently collect PROMS data for patients having cosmetic surgery.

The hospital reported surgical site infections (SSI) and the aim of this national surveillance programme was to enhance the quality of patient care. This was achieved by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.

The hospital monitored any unplanned transfers of care to another hospital, readmission to the hospital and returns to theatre. All occurrences were logged on the hospitals incident system and investigated. Any deteriorating patients who may require a higher level of treatment were transferred to the local NHS Trust for the most appropriate care. As the hospital is not registered to provide any urgent or emergency services, patients or visitors who may be unwell in the outpatient service were not admitted to Spire Thames Valley but rather they were transferred to the local NHS Trust.

During the reporting periods of April 2018 to March 2019, the hospital reported out of 4,777 planned attendances there were;

- 10 unplanned transfers to another hospital.
- 14 unplanned re-admissions to the hospital (within 28 days of discharge).
- 10 unplanned returns to the operating theatre.

The hospital was working towards being Joint Advisory Group on Gastrointestinal Endoscopy compliant.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed four staff files and found they all contained relevant information, such as up-to-date disclosure and barring service checks, references, curriculum vitae and evidence of registration with the Nursing and Midwifery Council, Health and Care Professions Council or General Medical Council. Data submitted showed 100% of eligible staff had completed revalidation with their professional body.

Competencies were required for different roles within the hospital and included drug administration, wound care and use of ward and theatre equipment. The competencies were recorded in a booklet, scored, with space for reflective assessment, which was completed prior to sign off. We saw evidence of completed competencies for staff in the service.

Consultants and anaesthetists worked under a practising privileges agreement, which gave them the authority to undertake private practice within the hospital. Granting and maintenance of practising privileges was governed by the Consultant Handbook (Clinical Policy 16). The hospital director and the medical advisory committee (MAC) were actively involved in the reviewing and granting of practicing privileges. A review of MAC minutes demonstrated this was discussed.

There was evidence practicing privileges were suspended when the required information was not provided, and that business needs and capacity were considered for new applications. There was also evidence to show possible new procedures were discussed including the information required prior them being introduced.

Practising privileges for consultants were formally reviewed biennially. The review included all aspects of a consultant's performance such as appraisal, revalidation, volume and scope of practice, examples of continuing practice development, any adverse occurrences involving the consultant and any areas of concerns brought to the attention of the MAC.

As of June 2019, 201 doctors were granted practising privileges to work at the hospital.

Three consultants had their practising privileges removed or suspended during the reporting period. One consultant had their practising privileges removed following an investigation by the GMC into clinical concerns. The remaining two had their practising privileges reinstated after they submitted appropriate documentation as required by the Spire Healthcare Limited Consultant Handbook.

The quarter two governance report reported 100% of consultants were complaint with the submission of mandated documents.

RMOs had their competencies assessed, and mandatory training provided and updated by their external agency provider. They worked in line with guidelines and a handbook to ensure they were working within their sphere of knowledge. They had a yearly appraisal completed by their external agency provider and a clinical mentor supported them.

Managers arranged for all new staff to have a full induction tailored to their role and a local orientation to their department before they started work. Dependant on their role, some new staff worked initially in a supernumerary capacity. This allowed them to understand their new environment before having full responsibility for their role. For example, ward nurses were classed as supernumerary for at least the first two weeks of their employment. New theatre and ward staff were assigned a mentor to support them.

Managers supported staff to develop through yearly, constructive appraisals of their work. As of June 2019, data provided by the hospital showed 100% of hospital staff had received an appraisal.

Staff told us that they found the appraisal process helpful. For example, pre assessment staff told us they were supported to complete Preoperative Association Competency Based courses, accredited by The Preoperative Association.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff were given the time to attend departmental meetings and huddles.

Staff were supported to reflect, improve and develop their practice through education and meetings with their managers. Staff told us that managers had an open-door policy and felt they addressed any issues promptly.

Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the hospital. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff had completed mandatory training and received an induction before they commenced duties. This was confirmed by bank staff we spoke with. They told us they regularly worked at the hospital and were familiar with local working practices.

Multidisciplinary working

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

We saw effective team working in all areas of the hospital, multidisciplinary team (MDT) meetings, handovers and briefings took place regularly to ensure safe care and treatment was delivered to the patient. There were daily ward and theatre huddles of consultants, the RMO, physiotherapists, pharmacists and ward staff to review care records, identify any deteriorating patients, discuss pain and mobility for example.

Each department had a daily huddle to discuss specific issues within that department. The hospital then held a daily 10 at 10 operational meeting. It was attended by the senior management team, the RMO and a representative from each department, including theatres, ward, pharmacy, outpatients, physiotherapy, catering, facilities and patient services.

Staff told us they had an MDT team meeting at midday where all patients were reviewed with the nurses and physiotherapists. There was an agenda to this daily review and it included assessing diet and fluids, mobility, any recovery issues, and a discharge review.

All staff told us they had good working relationships with consultants and the RMO. We saw good interactions between all members of the team. The nursing team, RMO, pharmacist and physiotherapists were present on the ward daily and reviewed patients' together as a team.

Patient records we reviewed confirmed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists and occupational therapists.

Staff working in the pre-operative assessment clinic started the conversations about discharge. For those patients having day surgery, this included having someone to

collect them and patients were asked to arrange this prior to admission. Patients who may require help after discharge were encouraged to start arranging this as early as possible.

Oncology patients were discussed in a multidisciplinary team meeting at a local NHS trust, and this provided opportunity for peer review and benchmarking. Oncology nursing and medical staff monitored and recorded individual patient outcomes at review and at further chemotherapy treatment cycles.

Seven-day services

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

The hospital only undertook elective surgery, and operations were planned in advance. The exception to this was if a patient was required to return to theatre due to complications following a procedure.

Theatres sessions were held between 8am to 8:30pm Monday to Friday and from 8am to 6:30pm on a Saturday as service demanded. The ward operated seven days a week to accommodate surgery patients who required nursing over the weekend.

Services at the pre assessment clinic took place from Monday to Friday. Evening clinics were also available to support patients who were unable to attend during the day due to work or other commitments.

Staff could call for support from doctors 24 hours a day, seven days a week; consultants were always on-call for patients under their care. Patients were seen daily by their consultant, including weekends. If the consultant was not available, they arranged cover by another consultant. We saw this communicated to ward staff. This was a requirement of their practising privileges. The RMO and ward staff had a list of contacts for all consultants and anaesthetists for each patient.

Once discharged patients could phone the ward staff for advice, and they could contact the consultant via their secretary if required.

The pharmacy was open from 9am to 5pm, Monday to Friday. If a patient required medicines out of hours, the RMO and a registered nurse went to the pharmacy department and checked out the medicines together.

Health promotion

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

The hospital had relevant information promoting healthy lifestyles and support.

A wide range of leaflets were available throughout the hospital for patients regarding their care and health. These were Spire Healthcare Limited own information and information from a variety of health charities. In the pre-assessment clinic there were leaflets from the Royal College of Anaesthetists on getting; fitter, better and sooner.

Staff had developed a 'Think Drink' campaign, for both patients and staff. Developed for patients as better hydration improves infection outcomes following surgery. For staff, this was part of a healthier living campaign promoted by the hospital.

Staff supported patients to maximise their independence following surgery by using the enhanced recovery after surgery programmes to enable patients to be actively involved in their recovery.

Part of this pathway included encouraging patients to be as healthy as possible before their planned operation. For example, staff asked patients a series of questions about their lifestyle such as smoking and drinking status. Patients were given advice about smoking cessation when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew who to contact for advice. There was an effective up-to-date consent policy for staff to follow.

Should a patient living with dementia or learning disabilities be identified at pre-assessment clinic, a 'best interest' meeting would be considered. The patient and their family or carers are invited into the hospital to meet with the staff. They could meet the specific member of the

theatre team who would be collecting them from the ward and taking them to theatre, and the nursing staff from the ward who would be looking after them post operatively. This was to ensure they got to know the team and had familiar faces they recognised when they were admitted. They could visit the theatre and ward areas and see which bedroom theirs would be.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records we reviewed showed consent was obtained in accordance with hospital policy. We saw an audit for consent gained in medical records for June 2019 and compliance was 100%.

We saw consent being obtained for one patient prior to their surgical procedure. The consultant explained all the risks, gave the patient time to ask questions and spoke in non-medical jargon.

We were told patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure, in case they wanted to change their mind. This was in line with national guidance.

All staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). As of September 2019, 102 staff had completed training in MCA and DoLs.

Are surgery services caring?

Good

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

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw examples of staff taking measures to ensure patients' privacy and dignity were always respected. Curtains were drawn when required and doors were closed.

Staff were extremely motivated to deliver care that was kind and compassionate. They anticipated the needs of their patients and ensured their needs were acknowledged and met. We saw how staff took the time to interact with people who used the services and those close to them in a respectful and considerate way in theatres and on the wards.

Staff spoke with patients and their carers in the way which protected the patient's privacy and dignity.

A patient told us that the staff always knocked on the door before entering their room and we observed this at the time of our inspection. We saw staff spoke with patients discreetly to maintain confidentiality.

Staff did not merely react to patient needs or requests, they consistently assessed their needs and strived to build personal relationships, so they could understand their patients' needs and preferences. Staff demonstrated a genuine desire to enhance the patients' experience and to ensure their needs were met and exceeded.

Patients said staff treated them well and with kindness. We spoke with six patients, who told us staff were kind and caring, they could not fault the service. They said that they had received excellent care and their hospital experience was positive. Patients said that all staff were pleasant, and they helped to make them feel relaxed. Theatre staff made them feel looked after.

We asked patients if there was anything that would improve the care that they had received, and all patients answered 'no, it is of the highest standard, and I couldn't ask for more.'

'Compassion in Practice' training was included as part of the hospitals mandatory training. As of June 2019, 99.5% of staff throughout the hospital had completed the training.

Emotional support

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

Good

Surgery

Staff gave patients and those close to them help, emotional support and advice when they needed it. We found where patients were anxious about the procedure they were admitted for, staff gave extra care and responded compassionately to put the patient at ease. We saw patients on the ward, in the anaesthetic room and in recovery being reassured by staff that were empathetic when patients were nervous or anxious.

A patient told us that they were very nervous about having an anaesthetic, the nurses on the ward were aware and had responded to this to calm the patient. The patient told us 'staff were first class in the anaesthetic room'.

The hospital had a chaperoning policy and staff knew how to access it. Nursing staff went with patients while they were having procedures or were being examined by consultants. Staff told us they had time to spend with patients to reassure them and provide emotional support.

Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. Patients told us staff were "brilliant" and "nothing was too much trouble."

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. For example, we saw staff discussing a patients' home situation and included this in conversations regarding their discharge planning.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients reported that they had all been provided with clear information about their treatment and care by the consultant and nursing staff, with opportunities available to ask further questions for clarification. Patients felt that they were fully supported in making decisions regarding their treatment and that they had all that they needed to know for this.

Patients told us nurses explained what they were doing and asked for permission before they did anything. Patients said medical staff explained plans for their treatment and provided opportunities for them and/or their family members to ask questions when needed.

Patients told us they were given choices regarding their treatment options. We saw the team discussing medicine choices with a patient to ensure they were on medicines that were right for them. Physiotherapists discussed post-operative care needs with patients and relatives to ensure a smooth and safe discharge home.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were a variety of ways patients and families could give feedback. There was the friends and family test, this was sent electronically to the patients two days after discharge, they could access the hospital website and their social media site to leave feedback.

All patients were complimentary about the way staff treated them. We saw staff introduce themselves to patients and explain to them and their relatives, care and treatment options.

Patients who paid for their treatment privately, told us costs and payment methods were discussed with them before their admission.

Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. The hospital recognised how important relatives were to the rehabilitation and recovery of their patients and allowed flexible visiting.

Are surgery services responsive?

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.

Good

Surgery

In this section, we also cover hospital-wide arrangements such as service planning and learning from complaints, in the relevant sub-headings within the responsive section. The information applies to all services unless we mention an exception.

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The hospital provided elective surgery to self-funded, privately insured and NHS patients for a variety of specialities, this included bariatrics, breast surgery, cardiology, cardiac, general surgery, gynaecology, orthopaedics, vascular, cosmetic, spinal and urology surgery.

The hospital worked with the local Clinical Commission Groups (CCGs) and the local acute NHS trust to plan services to meet the needs of the local population.

The CCGs monitored the hospital's performance for NHS patients at quarterly contract meetings. The hospital had an admissions and discharge policy which was version controlled and in-date. This detailed the criteria for NHS patients that could be safely treated at the hospital. The criteria was agreed with the CCG that commissioned NHS care at the hospital.

During the reporting period of July 2018 to June 2019, 92% of the hospital inpatients services were provided to non-NHS funded patients and 8% to NHS funded patients.

All patients were treated equally whether they were self-funded, privately insured or NHS funded. The service only received planned admissions. Patients' with specific needs such as learning disabilities, other disabilities or mental capacity issues were identified at pre-assessment. This meant appropriate arrangements could be made to meet individual needs prior to admission.

The hospital had service level agreements with a local acute NHS hospital to provide additional services they were unable to provide themselves. This included the supply of blood products and some pathology services.

Managers ensured that patients who did not attend appointments were contacted. The pre-assessment clinic would contact patients who did not attend and made another appointment. If there was further non-attendance, then they were referred back to their GP.

Meeting people's individual needs

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

The pre- operative assessment process identified patient's needs prior to their admission, using specific screening tools. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

The pre-assessment lead nurse gave us an example of how they tailored clinic appointments depending on the patients' needs such as anxiety. For example, a patient was worried about post-operative pain and becoming addicted to pain killers. The nurse was able discuss the concern with the patient and allay their fears meaning they went ahead with the treatment and received effective post-operative care.

Patients with mobility difficulties accessed theatres and the ward via a lift. The corridors and doors were wide, which meant wheelchair users could get through easily.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. Patients with complex needs had their discharge planned in advance.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. All staff we spoke with had a great understanding of these documents and had received training from the dementia lead for the hospital.

Staff showed us a dementia box they had created for patients living with dementia. It contained items that would make the patient's stay in hospital easier such as clear signs and a calendar clock, cup and saucers, and various items and activities to keep patients occupied and relaxed.

There were a variety of leaflets available for patients living with dementia including topics such as continence, falls and pressure ulcer care.

Staff also showed us an Accessible Information Standard box to support patients with additional communication needs. It contained items which would make the patient's stay in hospital easier such as a magnifying glass, braille admission pack, communication cards and a mobile hearing loop.

The hospital had specialised bariatric equipment to care for and treat obese patients (who have a body mass index exceeding a healthy range) and we saw electronic hoists ready for use.

Access to translation services could be arranged by telephone or face to face for those patients whose first language was not English. Staff were aware of the service and reported no delays with access.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus were coded to indicate meals that were gluten free, foods that were easier to chew, vegetarian and vegan options, or meals suitable as part of a healthy balanced diet.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Monthly diagnostic waiting times and activity reports were submitted to the commissioning NHS trust.

There was no formal mechanism such as the NHS referral to treatment targets for private patients. However, we saw there were no waiting lists and patients were generally seen within one to two weeks from their referral.

Discharge planning started at the pre-operative assessment stage. The length of the patient's expected stay was discussed, and this helped patients plan for any additional support they might require at home.

Pharmacy staff conducted daily ward rounds and prioritised the review of urgent take home medication to allow patients to be discharged quickly.

The pre-assessment clinic staff told us that text reminders were sent to patients in advance of their appointment. Patients would also be telephoned if they did not attend to ascertain the reason and to see if any adjustments could be made to help them attend.

NHS patients were referred to the service by their GP via the NHS e-referral system. These referrals were screened to ensure patients were appropriate for the services and facilities provided at the hospital.

The speciality services commissioned by the local Clinical Commission Groups (CCGs) and delivered by the hospital such as bariatric surgery, cardiothoracic surgery, complex spine surgery had their waiting times managed by the referring NHS trust.

It was reported that all NHS electronic referrals followed an 18-week elective surgery pathway with the hospital compliance target of 92%. The hospital had achieved a 97% compliance at the time of our inspection, with patient choice being the largest cause for extension of the pathway.

Patients we spoke with confirmed they were given a choice of appointment times and could schedule procedures at a time convenient to them. A patient we spoke with chose to have their care and treatment at Spire Thames Valley, this was due to the specialist consultant that operated there.

The service monitored the number of cancellations and procedures which were only delayed or cancelled when necessary. During the reporting period, there had been nine cancellations due to non-clinical reasons. All affected patients were offered another appointment within 28 days of the cancelled procedure.

An on-call theatre team was available to attend any emergency readmissions to theatre. Anaesthetists would only leave the site once the patient was stable and staff were satisfied the patient was safe. Additionally, in the event of a patient deteriorating and requiring higher levels of care, the patient was transferred to the local NHS trust via ambulance.

Good

Surgery

The service understood the different needs of the people it served and acted on these to plan, design and deliver services. For example, disabled parking spaces and toilets were available and there were lifts to all floors.

Learning from complaints and concerns

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

Complaints were managed and overseen by the hospital director with clinical complaints overseen by the director of clinical services. Administration support ensured reports were tracked, shared with relevant staff and ensured timescales for responses were adhered to.

A review of minutes confirmed complaints data and learning was presented at the medical advisory committee, clinical governance committee, clinical audit and effectiveness committee and discussed in team meetings where relevant. Learning from complaints was shared with staff through the complaints and feedback monthly newsletter.

The patient experience committee reported to the clinical governance committee and reviewed complaints for any trends and provided a more focused review for learning and action.

The number of complaints including the number of escalations were also monitored. The aim was to close all complaints within 20 working days and compliance was monitored and reported via the clinical scorecard with a target of 75%. Latest data (July to September 2019) shows the hospital exceed this target with 80% of complaints responded to within the policy guidelines.

For particularly complex complaint investigations taking longer than 20 days, a holding letter was sent to the complainant explaining the situation. This was sent every 20 days until a full response was provided.

A review of four complaints confirmed time lines were adhered to. The initial acknowledgment letter included an invitation for a face to face meeting to discuss the complainant's concerns. Response letters included information on how to escalate the complaint if the complainant was not happy with the response.

The hospital clearly displayed information about how to raise a concern or complaint in public and patient areas. Concerns and complaints could be made in a variety of ways including in person, by telephone, letter, email, text, patient survey and social media. All patients received a 'patient guide' which had details of how to make a formal complaint, called 'please talk to us'.

All patients who stayed overnight were telephoned two days and 30 days after their procedure to ensure they were recovering well and were asked for feedback about the service. If any issues were raised during these phone calls, staff would attempt to resolve them. If they were unable to, they would escalate the concerns to the senior team to manage.

During the reporting period of July 2018 to June 2019, there had been 36 complaints reported to the hospital, we did not receive a breakdown of those which related to the surgical core service.

Are surgery services well-led?

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.

In this section, we also cover hospital-wide arrangements such as, leadership, the management of risks and governance processes, in the relevant sub-headings within the well-led section. The information applies to all services unless we mention an exception.

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

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the

priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a clear management structure with defined lines of responsibility and accountability. The hospital's senior management team consisted of the hospital director, who had overall responsibility for the hospital, a director of clinical services, finance and commercial manager, operations manager and business development manager.

The hospital had been going through a period of change with a new hospital director, who was away from the service at the time of the inspection. The role was being covered on a part time basis by an existing hospital director from a nearby Spire Healthcare hospital. In addition, the role of director of clinical services was filled by one of the corporate directors of clinical services. This was due to a vacancy in that position. The hospital had recruited a replacement and were waiting for the individual to start.

There was a lot of respect from staff for the interim director of clinical services and the work they had undertaken to strengthen the assurance processes and the general support they had provided all staff.

The medical advisory committee chair and heads of department supported the senior management team. Each head of department reported to one of the senior managers. For example, heads of department in the surgery service reported to the director of clinical services. The ward and theatres were led by ward and theatre manager.

Staff told us leaders were well respected, visible, approachable and supportive. Departmental managers worked clinically and provided clinical cover for sickness when required. Ward and theatre staff worked effectively together.

The hospital director held a daily meeting for managers from all areas, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Managers cascaded the key messages from the huddle at local staff meetings.

The hospital director and director of clinical services attended regular meetings with their counterparts at other Spire and NHS hospital sites and with Spire Healthcare's executive team. They told us there was effective working relationships across sites and corporate support was readily available. We met corporate staff on site during our inspection.

Vision and strategy

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

Spire Healthcare had an overarching vision to be recognised as a world class healthcare business. The overarching mission statement was 'To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care.' The groups values were driving clinical excellence; doing the right thing; caring is our passion; keeping it simple; delivering on our promises and succeeding and celebrating together.

The internal purpose was described as 'making a positive difference to our patients lives through outstanding personalised care.'. This was developed by the executive team following a review of available information which included the staff survey. The initial purpose was presented to Spire Healthcare senior leadership conference and we were told their feedback was listened to and the purpose changed to the one quoted here. The purpose was being rolled out to the hospitals.

The new internal local strategy was being developed from the purpose. Hospital staff were to be part of this process. A session with staff was planned and their thoughts and feedback would be gathered on things to stop, things to continue and things to start. This information would be used to help build the strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients. This vision was underpinned by; strength in clinical governance, an open reporting and safety culture with continuous learning to improve the patient experience and offering.

Good

Surgery

All staff we spoke with were aware of and felt involved in the vision and strategic objectives and understood how these related to their individual performance.

All staff we spoke with told us they were proud of working at Spire Thames Valley Hospital and the visions and values were displayed in clinical areas.

New staff told us they were made aware of the provider's vision and values at induction and this was reinforced through the appraisal programme.

Staff we spoke with felt overwhelming pride in how they provided care for patients. Staff talked about their dedication and the commitment of teams to provide the best patient experience.

Culture

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

Staff we met with, were welcoming, friendly and passionate. It was evident that staff cared about the services they provided. Staff were committed to providing the best possible care to their patients.

Staff told us that they enjoyed working in the department and felt supported by their departmental managers. Department managers told us that they had an open-door policy and they were proud of their staff and their departments.

A consultant told us "I am really happy here nice small hospital, good feel almost like family, culture happy to be open, have been open about making changes and accommodating." A second consultant told us the nurses were caring and very good, they believed the consultant group was 'very harmonious' with less consultants than a big hospital meaning there was less rivalry, they described the hospital as a 'small cohesive hospital.'

There were cooperative, supportive and appreciative relationships among staff. They worked collaboratively, shared responsibility and resolved conflict quickly and constructively. The director of clinical services held regular meetings with department managers. They felt that this kept them well informed. They discussed the risk register, staffing levels and any feedback from audits and meetings. The managers in turn held meetings with their staff groups. Staff felt they were kept up-to-date and were made aware of changes needed within practice. We saw positive and supportive relationships between the leaders, consultants and staff at all levels and from all departments.

Staff, patients and families were encouraged to provide feedback and raise concerns without fear of reprisal. Where errors had been made or where a patients' experience fell short of what was expected, apologies were given, and action was taken to rectify concerns raised. When incidents had caused patient harm, the duty of candour was applied in accordance with the regulation.

There was a freedom to speak up guardian (FTSUG) who staff knew they could approach confidentially about concerns and poor practice. Most staff we spoke with said they would not have any concerns in contacting the FTSUG if required. The FTSUG had regular meetings with the hospital director to discuss any concerns and had direct access to the Spire Healthcare FTSUG.

Staff knew about the service's whistleblowing policy and said they felt they would be supported by senior managers to express their views about the service without fear or threat of retribution.

Staff success was celebrated. The hospital had recently introduced staff excellence awards, to recognise an individual and/or team who had gone above and beyond.

Data was collected and submitted to comply with Workforce Race Equality Standards (WRES). All independent healthcare organisations with NHS contracts are contractually obliged to take part in the WRES. Providers must collect, report, monitor and publish their WRES data and act where needed to improve their workforce race equality. All Spire Healthcare Limited hospitals fed this information to head office as data submitted to NHS England came from provider level and not location level.

Governance

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

Good

Surgery

There were established and effective governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard high standards of care. The hospital's governance and assurance framework were supported on site and by Spire Healthcare, such as medicines management, infection control, and health and safety. Each committee had terms of reference which were reviewed annually. The committees met regularly and fed into the medical advisory committee, and corporate clinical governance and safety committee.

At the time of our inspection, the governance lead role was being covered by the interim clinical director with support from other key members of staff. The three key areas of responsibility had been divided with the pharmacy manager overseeing the management of incidents; the hospital administrator overseeing the management of alerts with support from the central governance team; the central audit co-ordinator monitoring the audit programme and providing a prompt when things needed to be completed.

A review of all the hospital meetings had been completed by the interim clinical director. We were told all meetings now followed the standard Spire Healthcare agenda format and the hospital administrator was now the main minute taker at hospital leadership and governance related meetings. This change had been implemented in recognition that some minutes were not reflective of the discussion and decisions made at the meetings. This was also intended to ensure standardised minutes of a good quality were produced.

A review of the quarter two quality report showed it contained detail relating to quality and risk. The report was presented in the five domains safe, effective, caring responsive and well led. A traffic light system was used to highlight areas where improvement was required for example the hospital was rated yellow for quarter two for agency spend which was at 5. 91% when there was a target of 5% or less.

The clinical leadership group met monthly and discussed clinical incidents, accidents and near-misses. It also discussed medicines management, patient safety issues and reviewed new policies and procedures. Any action arising from the meeting were placed and tracked on an action log.

The clinical audit safety and effectiveness (CASE) meeting was chaired by the clinical director. CASE meetings took place monthly. The group reviewed incidents where there was a clinical concern and would escalate issues to the clinical governance meeting. The prime focus of this meeting was described as a review of audit outcomes.

The hospital held a quarterly infection control committee meeting, which was attended by the lead infection control nurse, microbiologist and representative from each department within the hospital. The interim director of clinical services was the director of infection prevention and control. We saw minutes from the infection control committee which included, policy updates, decontamination issues, infection control incidents, audits and training.

Consultants wanting to introduce a new procedure had to follow an established and agreed pathway. They had to set out the risks and benefits to patients of the procedure, as well as the costs. There was involvement from the sterile services department and the stores department. The report had to detail any research about the effectiveness and benefits of the procedure and set out how the procedure could be audited. The final sign off came from the director of clinical services, hospital director, and a representative from the medical advisory committee.

Practicing privileges is a term used when doctors have been granted the right to practice at an independent hospital. The policy included the granting of practising privileges, and roles and responsibilities. The hospital director and medical advisory committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in MAC meeting minutes of discussion about renewing or granting of practising privileges. Most consultants also worked at other NHS trusts in the area.

There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network. They also collected Patient Reported Outcome Measures (PROMs) data for certain surgical procedures, such as hip and knee replacements.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene,

health and safety and patient pathways. Audits were completed monthly, quarterly or yearly by each department depending on the audit schedule. Results were shared at relevant meetings such as governance meetings.

The service participated in national audits including the National Joint Registry, Patient Reported Outcome Measures and the Friends and Family Test.

Managers maintained a governance dashboard which reported on clinical activity, workforce and compliance with a wide range of safety and quality indicators covering incidents, audit outcomes, infection prevention and control, patient experience and medicines management. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available.

All areas in the surgical division held team meetings. Monthly ward meetings were held for all the ward staff to attend. Ward minutes were reflective of the five domains of safe, effective, caring, responsive and well-led. Information was recorded in reflection of these and covered such things as incidents, training, medicines, audit results, complaints and patient feedback.

The hospital director met regularly with the chair of the medical advisory committee. Senior staff met with the hospital director at the health and safety risk committee meeting to review the performance of the surgical services. The outcome of quality reviews was communicated at handovers and by emails, newsletters and staff/public notice boards.

Managing risks, issues and performance

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

There were clear and effective processes for identifying, recording and managing risks. Each department had a local risk register, alongside a hospital-wide risk register.

Top risks described by the hospital leadership team included no clinical lead, lack of Joint Advisory Group accreditation for endoscopy impacting on the commissioning of the services of the endoscopy department; no governance lead and safe staffing. These risks were reflective of those captured on the hospital risk register.

A rapid response meeting took place every two weeks, this meeting focused on incidents including serious incidents management and complaints to ensure investigations and outcomes were progressing and remaining on track.

Clinical safety and risks were considered daily through a safety huddle, which involved staff from all areas where care was delivered. These meetings provided an opportunity to share out roles and responsibilities, including the lead role for emergency situations, should they arise.

The ward and theatre department maintained a risk register which was reviewed and discussed at staff meetings. Concerns were rated and prioritised against a set of clinical indicators to ensure those which presented a higher risk to patient care were prioritised. At the time of our inspection, all risks were categorised as low.

The hospital had a formal risk register, which clearly stated the date added, the department to which it related and the risk owner. Risks were described along with the key controls and assurances. Where there were gaps in the controls these had been stated. We noted risks were rated and updated with progress notes and the next review date was identified.

Spire Healthcare produced and circulated a safety update bulletin as an avenue for sharing information with staff and as a way of ensuring they stayed informed about safety issues. We saw this displayed on notice boards and that an abridged version was shared with the consultant body. It covered areas such as policy updates, drug alerts, national document updates/ clinical briefs, shared learning and good practice and a list of the latest national healthcare guidance.

We asked how risks were added to the risk register. We were told if a risk needed to be escalated, the service would need to complete a risk assessment and this would be reviewed by the clinical governance team. There was a concern that staff who did not recognise a potential or actual risk would not necessarily escalate risks. Meaning senior leaders may not be aware or be able to review possible risks within the hospital.

Good

Surgery

To monitor the quality of care and promote the early detection of any emerging risks there was a central audit program managed by Spire Healthcare. For example, we were told there had been a high proportion of near misses in medicine management which would be picked up as an audit topic. We were also told any new National Institute for Health and Care Excellence (NICE) guidance would have a national audit set against it. Examples given were fasting and venous thromboembolism risk assessment and management.

There were local safety standards for invasive procedures in place within theatre in line with national guidance. These were displayed on the notice board for staff to see and detailed in the standard operating procedure document.

Staff told us they received feedback on risks, incidents, performance and complaints in a variety of ways, such as the daily operational meeting, noticeboards, social medial platforms and newsletters.

Managing information

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

Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. Nursing and medical patient records were combined within the same record. This meant all health care professionals could follow the patient pathway clearly.

Systems were in place to gather, analyse and share data and quality information with staff, key stakeholders and the public. The hospital had access to local information and other Spire Healthcare hospital information to benchmark services.

The service had a website where people could access information about the surgical procedures available and which would be useful when visiting the hospital.

Staff had access to the intranet to gain information relating to policies, procedures, professional guidance and training.

Staff across the hospital described information technology (IT) systems as fit for purpose. A range of IT systems were used to monitor the quality of care.

An electronic staffing safe care tool was used by the hospital to analyse staffing ratios against the acuity of patients. This information was collected twice daily at the point of care, to monitor, manage and report on safety.

There were arrangements to submit relevant data to national audit programmes. The provider had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

The hospital shared information with the local clinical commissioning group in relation to NHS patients such as waiting times and returns to theatre.

With regard to accessible information standards, there were plans to set up some training on caring for people. There was a communication tool for staff to use and for people with a learning disability a care passport. For those people who answer the phone, there was crib sheet to follow if a communication deficit was identified. This would then be escalated to the department the patient was to visit. Staff had access to a British sign language interpreter and a braille interpreter. If a patient had additional needs this would be identified and recorded on the patient system with an alert placed on the patient's notes. The hospital information booklet was available in braille and one about pain and pain management was under development. A smiley faces pain scale was available for use for those patient's unable to communicate their level of pain with words.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought in various means, including the Friends and Family Test, social media, and the hospital website. Patients' were encouraged to give feedback on the quality of service they received.

Good

Surgery

The patient survey was accessible via the Spire Healthcare on line system. Patients received an email or text which invited them to complete the survey. We were told there were paper copies for children. Patients could request a call back which would be undertaken in the first instance by the hospital administrator. The discharge survey for June 2019 was positive for likelihood to recommend the hospital, the hospital being the patient's first choice next time and that they met and exceeded the patient's expectations. There were high scores of over 93% relating to the staff, such as staff being attentive and the staff understanding their needs. The lower scores of 85% and 83% related to the quality of food and the patient's room, and 86% for the admission experience. It had been recognised the hospital needed to focus on the admission process.

The hospital operated a "You Said We Did" engagement initiative with patients, seeking their views on how to improve the service. This included introducing changes to the menu offered to patients.

The service had made a commitment to undertake employee engagement, which included focussing on service quality and engagement with the executive leadership and senior management. For example, we were told a great deal of work was undertaken around communication since the last inspection. Daily huddles were given as an example of how sharing information was now much more widely carried out.

Staff reported that there was good engagement from their managers and from the senior leadership team, which we also saw during our inspection. From the conversations we had with staff, it was clear staff were engaged in the service and hospital development. Staff told us they felt confident to raise concerns and were encouraged to come up with ways in which the service could be improved.

A staff forum took place quarterly, information provided showed this included an update on progress against the strategy; results of the customer survey; staff recognition where staff who had been named in feedback were recognised and actions taken in response to feedback from staff. To gather feedback, a staff survey was conducted and the senior management team held monthly 'your time' sessions. We saw comments from these sessions were captured and actions taken. For example, a positive recognition session was now included in huddles and meetings and a staff comment box was now available in the staff canteen.

We were told a consultant's survey also took place, but we did not see any results. Consultants received a weekly update newsletter and we saw this included training, an update from the hospital director or the medical advisory committee chair; information about consultant documentation and updates relating to new or amended guidelines. The document we reviewed included information on hospital acquired venous thromboembolism, antibiotic work instructions and the use of the prescription chart.

Staff stated they felt encouraged, supported and helped with professional revalidation. Staff had access to study days and were encouraged to develop their skills.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

There was a focus on continuous improvement and quality. Leaders were responsive to concerns raised and performance issues and sought to learn from them and improve services. The service had learnt from our last inspection and acted to address concerns raised in our last report.

There were practices on wards and in theatres to review performance and identify how their services could be improved. Improvement plans were displayed along with action improvement plans.

Incidents and good practice from the Spire Healthcare organisation's other locations was shared as learning material for staff to prevent similar incidents happening at the service.

The service produced 48-hour flash reports to share best practice to encourage improvement. The 48-hour flash reports were shared throughout every hospital within the group. Each hospital had to acknowledge it had read and distributed the report to the local teams.

Good

Surgery

The hospital supported the enhanced recovery programme including pre-assessment of health, fluid management, and early mobilisation. Physiotherapy was available several times a day, Monday to Friday, to contribute towards enhanced recovery.

The provider ran a staff reward scheme called 'Inspiring People.' Nominations were received from all hospital staff and each month one member of staff was selected to receive a gift voucher in appreciation of what they had achieved. Staff could also nominate colleagues to the annual Spire Healthcare award scheme.

Good

Services for children & young people

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

Are services for children & young people safe?

Good

Children and young people's services were a small proportion of hospital activity. Children and young people were only seen in outpatients and diagnostic and imaging departments. The hospital did not offer medical or surgical services onsite for children and young people.

We rated safe as **good.**

Mandatory training

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

The mandatory training for staff was comprehensive. This ensured they could meet the needs of children and young people and staff.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

Training information showed all staff complied with their mandatory training which included paediatric basic life support.

Staff told us they were given time to complete online mandatory training at work and attend face to face training. We saw a spreadsheet monitoring compliance which senior staff used to remind staff to complete training.

Staff were aware and trained for assessing sepsis which was mandatory. A visible teaching board about sepsis located by the nurses' station displayed latest guidance, policies and information which referred to children and young people where appropriate.

For our detailed findings on mandatory training, please see information under this sub-heading in the outpatient's report.

Safeguarding

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

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the services

All members of outpatient, diagnostic imaging and physiotherapy staff had received safeguarding children training level 3, which is recommended for staff working with children and young people. Staff said that if child or young person failed to arrive for an appointment three

times, they raised a safeguarding alert, to look at the safety of the young person. The hospital had a safeguarding lead who was training to level 4 in both adults and children's safeguarding. This was in line with national guidance.

The outpatient safety board displayed who the safeguarding lead and champions were for the hospital. Up to date policies on safeguarding for children were available to all staff on the hospital's intranet.

Female genital mutilation (FGM) was included in safeguarding training and staff were aware of their responsibilities if they identified a patient who had undergone FGM.

There were chaperone signs throughout the outpatient department advising how to access a chaperone should patients wish to do so. Staff in the outpatient department undertaking chaperoning were nurses and health care assistants. Staff were aware of the chaperone policy. All staff had undertaken the competencies for chaperoning.

For our detailed findings on safeguarding, please see information under this sub-heading in the outpatient's report.

Cleanliness, infection control and hygiene

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

Outpatient and physiotherapy staff received infection prevention and control training as part of their mandatory training package. We saw that 100% of staff had completed this training, with 100% of staff having completed the practical element of this training.

All clinical and waiting areas we visited were visibly clean and tidy. We saw completed cleaning checklists dating back three months for all outpatient areas, as well as bright 'I am clean' stickers on equipment with information about when it was last cleaned.

Disposable curtains in consultation and treatment rooms were dated when they were put up and when they were due to be changed. Personal protective equipment (PPE), such as gloves and aprons, were readily available to staff.

There were hand wash basins and hand sanitisers in the consultation and clinic rooms in the outpatient department and hand sanitisers were in the corridors. Posters with illustrated hand wash instructions were placed above each basin.

We saw staff adhering to bare below the elbow guidelines and being compliant with recommended hand hygiene practices.

We observed a child and young person (after obtaining consent) undergoing an ultrasound scan and an MRI. Staff wiped equipment clean in front of the patient's guardians before using the equipment and washed and sanitised their hands appropriately.

All clinical areas contained domestic waste and clinical waste bins. Clinical waste was disposed of in yellow bins and the lids were closed when not in use.

We saw that sharps bins in use were correctly assembled, signed and dated and not overfilled. Waste emptied by clinical staff was stored in locked dirty utility rooms and collection was arranged through housekeeping. Waste awaiting collection by an external healthcare waste management company was stored in a holding bay area, which had clinical and domestic waste bin holders.

Spill kits for managing accidental spills of bodily fluids or biohazard fluids were stored in the dirty utility rooms.

Environment and equipment

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

Children, young people and their families could reach call bells and staff responded quickly when called.

The service had suitable facilities to meet the needs of children and young people's families.

The service had enough suitable equipment to help them to safely care for children and young people.

The outpatient's and diagnostic imaging departments were tidy and suitable for the services offered. The reception area was spacious and there were two seating arrangements.

There was a nurse call system in all consultation, treatment rooms and toilets, linked to nurse IT screens in the reception areas and corridors. Consultants used the call bell to call for assistance or for the chaperoning service, for example.

We saw housekeeping staff used the correct colour of waste bags for clinical and domestic waste. Waste was disposed in a secure area in all locations and there was a separate area for disposing of clinical waste.

All the sharps bins inspected were properly assembled, labelled and signed and dated in line with best practice and filled below the line indicated on the bin.

We saw that all equipment checks in the outpatient's department were up to date. Staff maintained a reliable and documented programme of checks including electrical safety testing and servicing. All the equipment we inspected had maintenance stickers showing they had been serviced in the last year. For example, overhead lights in the minor procedures room and laser equipment.

The minor procedures room had a surgical trolley, overhead lighting, clean and dirty areas, stock cupboards and a trolley for nursing staff to lay out equipment that would be needed. The space was suitable for minor procedures.

A tamper evident resuscitation trolley was available containing emergency equipment to be used in the event of a patient cardiac arrest for children and young people. There were also separate tamper evident medical bags for children. We saw that the equipment on the resuscitation trolley had been checked daily and daily check logs were signed and up to date. We found the trolley to be sealed, with clearly labelled drawers for airways; breathing; circulation and medicines, alongside a list of what was in each. The attached sharps box was assembled, signed and dated in line with best practice.

Clean and dirty utility rooms were locked, we saw that the rooms were tidy and well-arranged. All store rooms were tidy. Hazardous substances were locked in a COSHH (Control of Substances Hazardous to Health) Cupboard and handled in line with the control of substances hazardous to health regulations 2002.

Physiotherapy was carried out on the wards or in a small physiotherapy area, where there was limited storage for equipment. Staff told us there were plans to improve the physiotherapy department.

Assessing and responding to patient risk

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

Staff knew in advance the number of children and young people attending clinics that day. There were two attendees on each day of the inspection. On day two of the inspection there were 100 appointments of which only two were children or young people.

Generally, acutely unwell children and young people would not visit the outpatient department. However, if a child or young person's condition deteriorated whilst in the department, there was always one resident medical officer (RMO) on site. Staff told us RMOs were responsive when called, depending on the urgency and need of patients on the wards.

Staff we spoke with were aware of a child and young person's needs and what to do in case they deteriorated. Staff were able to describe the procedure for dealing with a medical emergency relating to a child or young person.

Nurse staffing

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

There were no paediatric trained nurses employed in outpatients. A range of risk assessments were in place and nursing staff had paediatric lifesaving skills. It was unusual for children and young people to be unaccompanied however, support was offered to them and carers/parents from within existing staff numbers.

For our detailed findings on nurse staffing, please see information under this sub-heading in the outpatient's report.

Good

Services for children & young people

Medical staffing

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

A range of risk assessments were in place and medical staff had paediatric lifesaving skills. It was unusual for children and young people to be unaccompanied however, support was offered to them and carers/parents from within existing staff numbers.

For detailed information on medical staffing, please see information under this sub-heading in the outpatient's report.

Records

For our detailed findings on records, please see information under this sub-heading in the outpatient's report.

Medicines

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

The service rarely gave medicines to children and young people. However, the staff told us the following.

Staff provided specific advice to children, young people and their families about their medicines when needed.

Staff followed current national practice to check children and young people had the correct medicines.

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

For our detailed findings on medicines, please see under this sub-heading in the outpatient's report.

Incidents

For our detailed findings on incidents, please see under this sub-heading in the outpatient's report.

Are services for children & young people effective?

Children and young people's services were a small proportion of hospital activity.

At present we do not rate effectiveness for outpatient in acute independent hospitals but during our inspection we noted the following good practice:

Evidence-based care and treatment

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

Staff had access to local and corporate policies through the hospital intranet. Staff we spoke with knew how and where to access these policies and procedures to do their jobs safely. All policies and procedures we read were within their review date. For example; the procedure for the care of children and young people in Spire Healthcare was dated April 2019.

For our detailed findings on evidence-based care and treatment, please see under this sub-heading in the outpatient's report.

Nutrition and hydration

Staff gave children and young people enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.

Hot drinks and water were freely available to children and young people in the outpatients waiting area. Following a procedure, staff offered the snacks and drinks. Staff also offered children and young people biscuits when they were waiting for long periods of time.

Pain relief

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

Information and tools for assessing pain were available in the outpatient's department. There were different age appropriate assessment tools, some were pictorial with child friendly wording and for older children there was simplified wording. There was paediatric pain relief available and guidance on administering it.

For our detailed findings on pain relief please see under this sub-heading in the outpatient's report.

Good

Services for children & young people

Patient outcomes

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

Spire Healthcare Limited published a group wide quarterly CYP dashboard which included a variety of measures to benchmark performance and outcomes across the group.

The dashboard included hospital activity and was presented under the domains of safe, effective, caring, responsive and well led. This was easy to read, and we saw how these were displayed in the outpatient's department so staff could see their performance at a glance.

For our detailed findings on patient outcomes please see under this sub-heading in the outpatient's report.

Competent staff

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families

For our detailed findings on competent staff please see under this sub-heading in the outpatient's report.

Multidisciplinary working

For our detailed findings on multidisciplinary working, please see under this sub-heading in the outpatient's report.

Seven-day services

For our detailed findings on seven day services, please see under this sub-heading in the outpatient's report.

Health promotion

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

We saw various information leaflets on display aimed at children and families. For example, general information about healthy eating, mental wellbeing, keeping safe, internet guidance aimed at parents for keeping their children safe. There were books designed for younger children and their visit to the hospital illustrating what happened when an X-ray or other tests were being done.

For our detailed findings on health promotion, please see under this sub-heading in the outpatient's report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

We reviewed records and saw that consultants had gained consent from the parents and had involved the young person. Where the young person had not wanted the parents involved the staff assessed the young person using Gillick competence for children under the age of 16. Children under the age of 16 can consent to their own treatment if they can understand fully and appreciate what is involved in their treatment. This is known as being Gillick competent.

When a child or young person was not able to understand the treatment or tests, their parent or guardian had signed on their behalf. We reviewed three sets of records and all had appropriately completed consent forms.

For our detailed findings on consent and safeguards, please see under this sub-heading in the outpatient's report.

Are services for children & young people caring?

Not sufficient evidence to rate

Children and young people's services were a small proportion of hospital activity. We did not have enough evidence to rate this domain.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff communicated with children and young people in a kind and respectful way. One young person told us told us they were made to feel welcome, and all their questions were answered, and they felt fully informed about their scan.

Good

Services for children & young people

Children and young people we spoke with, had been introduced to all the healthcare professionals involved in their care. They described feeling confident and happy with the care and treatment they received.

For our detailed findings on compassionate care, please see under this sub-heading in the outpatient's report.

Emotional support

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

Staff made sure children, young people and their families understood their care and treatment.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported children, young people and their families to make informed decisions about their care.

Children, young people and their families gave positive feedback about the service.

Family members were encouraged to be with their children and young people and to stay throughout the treatment. We saw staff supporting both parents/guardians and the children and young person throughout their treatment allaying fears and anxiety where possible.

For our detailed findings on emotional support, please see under this sub-heading in the outpatient's report.

Understanding and involvement of patients and those close to them

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

Parents we spoke with told us it was "excellent" how staff involved them and communicated with them. They said their child was the focus and staff adapted the language they used to the child's level and gave time for their child to ask and answered their questions.

Children and young people we spoke with, told us they felt cared for and staff understood their individual needs.

For our detailed findings on involvement of patients and those close to them, please see under this sub-heading in the outpatient's report.

Are services for children & young people responsive?

Good

Children and young people's services were a small proportion of hospital activity.

We rated responsive as **good.**

Service delivery to meet the needs of local people

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

The outpatient department waiting area had a children's play area with a variety of toys, books and games for all ages. They were visibly clean, and the area was bright.

We saw that there was focused literature for children and young people. For example, how to manage mental wellbeing such as anxiety, that had been written by young people for young people.

For our detailed findings on meeting the needs of local people, please see under this sub-heading in the outpatient's report.

Meeting people's individual needs

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

Children and young people who used English language as a second language had access to a translation service. Staff we spoke with knew how to access this service and we saw referral information displayed in the nurse's office.

Good

Services for children & young people

Patients who had hearing loss and used a hearing aid could access hearing loops within the outpatient department when required.

For our detailed findings on meeting individual needs, please see under this sub-heading in the outpatient's report.

Access and flow

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

Managers and staff worked to make sure children and young people did not stay longer than they needed to.

Managers worked to keep the number of cancelled appointments/treatments to a minimum and they were rearranged as soon as possible

The children's and young people's service was flexible in the service it offered. For example, outpatient appointments were offered in the afternoons and at weekends, to enable attendance outside of school hours.

For our detailed findings on access and flow, please see under this sub-heading in the outpatient's report.

Learning from complaints and concerns

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

Children, young people and their families knew how to complain or raise concerns.

There were no specific complaints related to children and young people attending the services.

For our detailed findings on learning from complaints and concerns, please see under this sub-heading in the outpatient's report.

Are services for children & young people well-led?

Good

Children and young people's services were a small proportion of hospital activity.

We have rated this domain as good as it based on the outpatient's service which encompasses the services offered for children and young people.

Leadership

For our detailed findings on leadership, please see under this sub-heading in the outpatient's report.

Vision and strategy

For our detailed findings on vision and strategy, please see under this sub-heading in the outpatient's report.

Culture

For our detailed findings on culture, please see under this sub-heading in the outpatient's report.

Governance

For our detailed findings on governance, please see under this sub-heading in the outpatient's report.

Managing risks, issues and performance

For our detailed findings on managing risks, issues and performance, please see under this sub-heading in the outpatient's report.

Managing information

For our detailed findings on vision and strategy, please see under this sub-heading in the outpatient's report.

Engagement

For our detailed findings on engagement, please see under this sub-heading in the outpatient's report.

Learning, continuous improvement and innovation

For our detailed findings on learning, continuous improvement and innovation, please see under this sub-heading in the outpatient's report.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

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

The outpatient's department saw approximately 20,754 patients between 31 July 2018 and 30 June 2019, this included 966 children and young people aged 0 – 17years. We have reported on children and young person's services separately.

Mandatory training

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

The mandatory training cycle for Spire Healthcare Limited ran from January to December each year. Modules included information governance, health and safety, fire safety and infection control.

Mandatory training was delivered using a mixture of face-to-face training and e-learning.

Information provided to inspectors showed that the mandatory training completion rates for outpatient and physiotherapy staff except for information governance which was 82% and 67% respectively, due to being updated later than the other modules, were all 100% at the time of inspection. The staff had until the end of December 2019 to reach 100%.

Basic life support training was part of mandatory training for all outpatient staff. Data showed 100% compliance at the time of inspection. Registered nurses were trained in immediate life support.

The hospital operations manager had oversight over mandatory training of all outpatient staff and sent the staff reminders if necessary. Mandatory training completion was reviewed during regular one-to-one meetings with staff and during their appraisals. Staff told us they also checked online themselves to see if any training was due.

For our detailed findings on mandatory training, please see under this sub-heading in the surgery report.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

All members of outpatient and physiotherapy staff had received safeguarding adults training and safeguarding children training level two. Those that had regular contact with children were required to complete level 3. The service recorded that 18 members of staff were eligible for safeguarding children level three training, and all members of staff had completed this.

The outpatient safety board displayed who the safeguarding lead and champions were for the hospital.

Female genital mutilation (FGM) was included in safeguarding training and staff we spoke with were aware of their responsibilities if they identified a patient who had undergone FGM.

Staff told us they had received safeguarding training and would feel confident in how to report an incident should it arise.

Up to date policies on safeguarding for both adults and children were available to all staff on the hospital's intranet.

Good

Outpatients

There were chaperone signs throughout the outpatient department advising how to access a chaperone should patients wish to do so. Staff in the outpatient department undertaking chaperoning were staff nurses and health care assistants. Staff were aware of the chaperone policy. All staff had undertaken the competencies for chaperoning.

Cleanliness, infection control and hygiene

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

Outpatient and physiotherapy staff received infection prevention and control training as part of their mandatory training package. We saw that 100% of staff had completed this training.

All clinical and waiting areas we visited were visibly clean and tidy. We saw completed cleaning checklists dating back three months for all outpatient areas, as well as bright 'I am clean' stickers on equipment with information about when it was last cleaned.

Disposable curtains in consultation and treatment rooms were dated when they were put up and when they were due to be changed. Personal protective equipment (PPE), such as gloves and aprons, were readily available to staff.

There were enough hand wash basins and hand sanitisers available in all areas of the outpatient department. Posters with illustrated hand wash instructions were placed above each basin.

We saw staff adhering to bare below the elbow guidelines and being compliant with recommended hand hygiene practices.

We observed a patient (after obtaining consent) undergoing an ultrasound scan. Staff wiped equipment clean in front of the patient before using it and washed and sanitised their hands appropriately.

All clinical areas contained domestic waste and clinical waste bins. Clinical waste was disposed of in yellow bins and the lids were closed when not in use.

We saw that sharps bins in use were correctly assembled, signed and dated and not overfilled. Waste emptied by clinical staff was stored in locked dirty utility rooms and collection was arranged through housekeeping. Waste awaiting collection by an external healthcare waste management company was stored in a holding bay area, which had clinical and domestic waste bin holders.

Spill kits for managing accidental spills of bodily fluids or biohazard fluids were stored in the dirty utility rooms.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

The outpatient's department was seen to be tidy and suitable for the services offered. The reception area was spacious and there were two seating arrangements.

There was a nurse call system in all consultation and treatment rooms and toilets, linked to screens in the reception areas and corridors. Consultants used the system to call for assistance or for the chaperoning service, for example.

We saw housekeeping staff used the correct colour of waste bags for clinical and domestic waste. Waste was disposed in a secure area in all locations and there was a separate area for disposing of clinical waste.

All the sharps bins inspected were properly assembled, labelled and signed and dated in line with best practice and filled below the line indicated on the bin.

All equipment checks in the outpatient's department were up to date. Staff maintained a reliable and documented programme of checks including electrical safety testing. All the equipment we inspected had maintenance stickers showing they had been serviced in the last year. For example, overhead lights in the minor procedures room and laser equipment.

The minor procedures room had a surgical trolley, overhead lighting, clean and dirty areas, stock cupboards and a trolley for nursing staff to lay out equipment that would be needed. The space was suitable for minor procedures.

A tamper evident resuscitation trolley was available containing emergency equipment to be used in the event of a patient cardiac arrest. There were also separate tamper evident medical bags for children. We saw that the equipment on the resuscitation trolley had been checked daily and daily check logs were signed and up to date. We found the trolley to be sealed, with clearly

labelled drawers for airways; breathing; circulation and medicines, alongside a list of what was in each. The attached sharps box was assembled, signed and dated in line with best practice.

Clean and dirty utility rooms were locked we saw the rooms were tidy and well-arranged. All store rooms were tidy. Hazardous substances were locked in a COSHH (Control of Substances Hazardous to Health) Cupboard and handled in line with the control of substances hazardous to health regulations 2002.

Physiotherapy was carried out on the wards or in a small physiotherapy area, where there was limited storage for equipment. Staff told us there were plans to improve the physiotherapy department.

Assessing and responding to patient risk

There were systems and processes to assess, monitor and manage risks to patients.

Staff knew in advance which patients were attending clinics that day. All new patients filled in a health questionnaire. Patients requiring additional assistance or support were highlighted in the electronic patient file and on the daily list of attendance. Reception staff would escort patients to the appropriate outpatient area if required.

Generally, staff we spoke with told us that acutely unwell patients would not visit the outpatient department. However, if a patient's medical condition deteriorated whilst in the department, there was always one resident medical officer (RMO) on site. Staff responded promptly to any sudden deterioration in a patient's health.

An audit of procedure checklists in the outpatient's department showed that all the correct checks had been completed for the procedures reviewed.

Physiotherapists saw post-operative patients where risks had been identified and offered support for women's health.

Nurse staffing

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

Managers regularly reviewed and adjusted nurse staffing levels and skill mix. The hospital had a its own nurse bank, many of the bank staff had worked or still worked at the hospital. If needed, the department could request additional staff from the bank and tended to request regular staff as they were familiar with the department, which provided greater continuity to patient care.

The nurse in charge managed the rotas and the rotas and notice board clearly indicated where staff were working and which consultant they were assisting.

The operations manager was aware of the planned clinics in advance usually a month, and then provided staff accordingly. The rotas were available for staff to see and the manager and nurse in charge managed any unplanned absences.

Within outpatients there was a nurse in charge overall and a nurse or healthcare support worker allocated for each consultant clinic. The nurses and consultants were supported by administration staff on the main reception desk.

There were two full time physiotherapists and five bank physiotherapists who supported weekend cover and ward work.

Medical staffing

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

The outpatient department had access to senior medical staff who could provide clinic appointments across a range of specialities. Resident medical officers were available to provide medical cover to the outpatient department should there be an emergency.

For our detailed findings on medical staffing, please see under this sub-heading in the surgery report.

Records

Staff kept detailed records of patients' care and treatment.

We reviewed five patient records, and found them to be clear, up to date, stored securely and easily available to

all staff providing care. Patients records were written by hand then added to an electronic record. They had been signed and dated by the consultant in line with best practice.

The records were seen to include all patient information. We saw the records had details of all tests carried out, patient medicines, medical order history, all assessments and reports. The allergy status of all patients was recorded. Pain scores were recorded where relevant and a treatment plan was recorded. Consent was obtained for all procedures within the records reviewed. In addition, staff recorded pre-procedure vital signs and the start and finish time of the procedure.

We observed that the electronic record system was secure, and witnessed staff logging in to access the patient's records. In addition, we observed staff logging out when they finished accessing the electronic system.

There was a safe system for the transportation and management of records. Paper notes were transferred from the record store in a locked trolley to protect privacy. They were not seen to be left on desks and the trolley was directly passed to the assisting nurse for security. The records were removed from the consulting rooms as soon as the consultant had completed their appointments.

Physiotherapy staff explained that their patient records included outcome measures for example, knee bends achieved, or the number of stairs climbed. Photocopies of post op instructions were made available for patients to keep.

Medicines

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

The pharmacy service was based on site within the outpatients waiting area and was open Monday to Friday 8.30am to 4.30pm, and on Saturday 9am to 1pm. Consultants who prescribed medicines for patients did so on a hospital prescription, and patients could take their prescription to the pharmacy department to be dispensed.

Stationery used for prescribing was stored securely and managed appropriately. There was a signing in/out process with medical staff having to sign for a prescription pad, this was checked by a nurse.

Medicines were stored securely in cupboards in a locked room in the department. Medicines that required refrigeration were stored in a dedicated refrigerator where the temperature was checked daily to check it was within the correct limits.

Nursing staff knew the actions to take if the fridge temperatures were not within an acceptable range. Room temperatures where medicines were stored were checked and recorded daily. These measures ensured the medicine's potency. The outpatient's department did not keep controlled drugs in the department. Registered nurses held the keys to the medicines cupboard which was in line with legal requirements.

Random samples of medicines and IV fluids were checked and found to be in date. Stock boxes that were close to their expiry date were seen to be pulled to the front of the cupboard to ensure rotation.

Emergency cardiac arrest and anaphylaxis medicines were kept on the resuscitation trolley in clearly marked grab boxes and were checked daily. Anaphylaxis is a life-threatening allergic reaction that requires immediate treatment.

For our detailed findings on medicines, please see under this sub-heading in the surgery report.

Incidents

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

There had been zero never events reported relating to the outpatient department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff we spoke with were aware of how to report an incident using the hospitals electronic reporting system. They were also clear about what constituted an incident and would require reporting. They told us they received

feedback on trends within the hospital. Senior staff shared information about incidents and learning at handovers, on the staff notice board and at meetings. We attended a meeting where information was shared with the senior management team and department managers. Senior staff attended meetings every day and discussed incident trends that had occurred across other Spire Healthcare hospitals also.

Outpatient and physiotherapy staff had training in the electronic incident reporting system as part of their mandatory training package. Staff we spoke to told us they were confident in how to use the reporting system and that they had received training on it. We saw a record showing 100% of staff had completed this training.

Staff we spoke with were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

For our detailed findings on incidents, please see under this sub-heading in the surgery report.

Are outpatients services effective?

At present we do not rate effectiveness for outpatients in acute independent hospitals but during our inspection we noted the following good practice:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Current National Institute for Health and Care Excellence (NICE) guidance was a standing agenda item within the clinical governance meeting that was held monthly. This highlighted new or updated guidance that would be relevant to the departments.

Policies were developed in conjunction with national guidance and best practice evidenced from professional bodies, such as the National Institute for Health and Care Excellence (NICE). All the guidelines we reviewed were easily accessible on the hospital's intranet and were up to date. For example, staff in physiotherapy described a NICE guideline that had been changed regarding lower back pain. This had significant changes compared to the previous guidance, including the removal of the practice of acupuncture from the guideline.

The department undertook clinical and non-clinical audits weekly and monthly. These included infection prevention and control, medicines management, procedure checklists and documentation audits.

The service also had a local audit programme that included a chaperone audit, waiting times and hand hygiene audits.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Hot drinks and water were freely available to all patients in the outpatients waiting area. Following a procedure, staff offered the patients snacks and drinks. Staff also offered patients biscuits when they were waiting for long periods of time.

For our detailed findings on advice given to patients at pre-assessment such as fasting prior to a minor operation or procedure, please see under this sub-heading in the surgery report.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Consultants assessed patients in their clinics and administered or prescribed pain medication accordingly. Patients received local anaesthesia for minor procedures performed in the outpatient department.

The hospital's resident medical officers could be used to assess patients and prescribe pain relief when patients required urgent attention.

Staff told us as part of the pain risk assessment staff asked patients how much pain they were in before the procedure, during and afterwards and ensured

appropriate pain relief was administered. After the procedure a nurse confirmed the advice from the consultant about wound care and pain relief before the patient went home.

The physiotherapy department monitored pain levels as part of their consultations, and we saw these documented on the electronic patient records. We spoke to patients in physiotherapy who confirmed that they were asked about their pain levels during their physiotherapy consultations. Staff confirmed they asked patients to tell them when an exercise was causing discomfort and they observed patient's non-verbal communication for signs of discomfort.

Patient outcomes

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

Whilst the outpatient department did not specifically monitor patient outcomes, the other specialties such as surgery contributed towards Patient Reported Outcome Measures (PROMS) to assess the quality of care delivered to patients in hip and knee replacements.

The physiotherapy service routinely monitored patient outcome measures such as range of movement, pain scores and quality of life measures to establish the effectiveness of treatment. The effectiveness of the outcomes could be monitored through the physiotherapy records system.

Blood tests, diagnostic test results and consultant records could be viewed on the electronic systems by staff.

For our detailed findings on patient outcomes, please see under this sub-heading in the surgery report.

Competent staff

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

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Appraisal rates for nurses and healthcare assistants who worked within the outpatient department were 100%. Appraisals and continuous professional development (CPD) were tracked on an online system. We were shown examples of staff's clinical and business objectives, CPD and any other personal development they had identified to undertake over the coming year.

Nursing staff and health care assistants, we spoke with, confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant to their roles. For example, they had undertaken training and competency assessments on new equipment.

New staff were given an induction pack and wore a badge to show they were new. The pack included, departmental structure, opening times, parking arrangements, wellbeing and uniform. A four, eight- and 12-week review was completed with their line manager. New members of staff told us it was useful and gave them enough information to help them during their first weeks of work.

The operations manager kept an electronic training record and the overview demonstrated which training that staff were in date and those who were approaching their refresher date.

In the physiotherapy department, we saw personal competencies that the physiotherapy assistant was in the process of completing. They included fitting patients with crutches and post-operative shoes. We saw other examples of personal development reviews and objectives.

Multidisciplinary working

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

Regular daily and monthly multidisciplinary meetings were scheduled to ensure the hospital staff worked together for the benefit of all patients.

Nursing staff confirmed they had good working relationships with consultants and could easily ask for help. They maintained good relationships with the

physiotherapy and imaging teams. They had quick access to diagnostic test results, which were saved on the electronic system and were accessible to all staff in the outpatient's department.

There was a bariatric (weight management) clinic where dietitians, consultants and specialist nurses worked together to benefit the patient.

For our detailed findings on multidisciplinary working, please see under this sub-heading in the surgery report.

Seven-day services

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

As the outpatient or physiotherapy departments did not provide urgent or acute services, it was not available seven days a week. Most clinics were planned to operate between 8am and 9pm Monday to Friday with additional clinics running on Saturday mornings.

For our detailed findings seven day services, please see under this sub-heading in the surgery report.

Health promotion

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

The service had relevant information on display, promoting healthy lifestyles in the outpatient's and physiotherapy department. For example, smoking cessation clinics, healthy eating, and what to do if you suspect you have diabetes

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff we spoke with were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit. Staff told us they had not come across a patient who lacked capacity. Staff could demonstrate an understanding of the hospital's policy but told us they had not had to put this into practice.

Staff had access to best practice guidance and local mental capacity policies in the department. Overall, 100% of outpatients and physiotherapy staff had completed the Mental Act Capacity and Deprivation of Liberty Safeguarding training.

Staff were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity, to consent to their care and treatment. Our review of eight medical records showed well documented consent forms were completed. Staff could tell us how to support patients who lacked capacity or were experiencing mental ill health to make their own decisions.

Are outpatients services caring?

Good

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

Compassionate care

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

Patient, family and friends' feedback was positive. For example; we saw comments such as, "Thank you so much for all your care and attention. You have been amazing", "Just to say thank you for everything. I could not have got through the last few weeks without your care and kindness. "Thank you for your professional, courteous, friendly helpful and reassuring nursing whilst I was being examined."

We saw staff treat patients and visitors with warmth and care. We observed staff interactions with patients; they were courteous, professional and demonstrated compassion to all patients. We saw staff stopping to speak with patients and visitors and directing them to the right locations.

Staff introduced themselves to patients and all staff wore name labels on their uniform which enabled patients and visitors to easily identify which staff member was providing their care/support.

Good

Outpatients

Patients said they were happy with the care provided and that they were treated with dignity and respect. Patients who went through minor operations said the operation went smoothly and was arranged to their convenience. Patients described the care provided as "exceptional".

Clinic rooms had 'engaged/vacant' signs on the doors and we observed staff knocking and waiting before entering clinic rooms. Patients told us that they felt their privacy was always respected during their appointment.

Emotional support

Staff provided emotional support to patients.

Staff provided emotional support to patients, families and carers to minimise their distress. Chaperones were available if requested. There were posters displayed in the waiting areas and in consulting rooms advising patients they could request a chaperone.

Staff told us upsetting or unexpected news was delivered sensitively and in appropriate private surroundings. The service had nurse specialists who provided emotional support for example at breast clinics.

Reception staff told us they sometimes saw patients who appeared anxious due to the nature of their visits. They told us they approached them and directed them to staff who could help. We saw staff routinely spoke with patients in the reception area to help with any concerns they had.

Chaperone posters were seen outside all clinic rooms in outpatients and in physiotherapy.

Understanding and involvement of patients and those close to them

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

Patients and their relatives said they were involved in their care and were given explanations about their treatment. They said staff explained procedures and obtained their consent before any treatment. Patients told us the consultants were thorough, they spent time explaining procedures to them and they felt comfortable and reassured. They felt they were given clear and adequate information. We observed staff introducing themselves to patients before assisting them.

Patients told us they did not feel rushed during their appointments and that they had the opportunity to ask questions. Physiotherapy patients were given a longer initial consultation to ensure they had time to ask questions following their assessment.

Patients told us they were given an expected timescale and likelihood for their recovery; this was helpful to them as it helped them to manage their expectations. Physiotherapy patients told us that they were offered exercise reminders sent to them via email, as there was a lot to remember during their appointment time. They were also told that they could reply via email if they had any questions or queries regarding the exercises given.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

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

Staff told us that patients were usually seen promptly following their referral. Patients were given the next available appointment with their chosen consultant. Patients confirmed they had not waited long for their appointment.

We observed a relaxed atmosphere in the outpatient area. The waiting areas provided plenty of seating and clinics were running on time. Clinics ran in the outpatient department between 8am and 9pm Monday to Friday, and on Saturdays until 1pm. This allowed patients who worked office hours during the week to attend at a time that suited them, and we spoke with patients who confirmed they were able to get appointment times that suited their needs.

There were a range of physiotherapy clinics available including hand, women's health, orthopaedic and musculoskeletal.

For our detailed findings on service delivery to meet the needs of local people, please see under this sub-heading in the surgery report.

Good

Outpatients

Meeting people's individual needs

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

The physiotherapy department offered longer initial appointments to patients to allow time to fully assess the patient and to allow time to ask questions. We spoke to patients who told us that they felt listened to, not rushed and able to ask questions during their consultations.

We reviewed five sets of notes of patients who had undergone a minor operation or procedure in the outpatient's department. There were details of the procedures why they had been undertaken and the outcome. Follow up treatment and future appointments were also included.

The main waiting area in the outpatient's department had a hot and cold drinks machine, television and a range of newspapers, magazine and information leaflets to read. There was also an area for children who were waiting containing toys and activities to help whilst they were waiting for their appointment.

The hospital provided translation services if needed. There were information posters in multiple languages, advising patients what was available for them.

The hospital had a dementia policy in place. Staff had undertaken training in dementia awareness however, staff informed us they rarely had instances of patients attending living with dementia or learning disabilities in the outpatient's department.

Access and flow

People could access the service when they needed it and received the right care promptly.

Reception staff welcomed visitors to the hospital and directed them to the right department. We saw staff assisting patients to find the correct area of the hospital for their needs.

Patients were referred to the outpatient's department by their GPs, or they could self-refer. Patients could book an appointment by submitting a form online or by making a telephone call. Patients were offered the most convenient appointment with their preferred consultant.

All eight patients we spoke with said it was easy to make an appointment and were seen quite quickly on their arrival at the department.

Learning from complaints and concerns

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

There had been one complaint made regarding the outpatient's department outpatients in the 12 months prior to the inspection, this had been responded to as per Spire Healthcare complaints policy which was initial contact within 48 hours then a full response in 28 days.

Patients, relatives and carers knew how to complain or raise concerns. Feedback leaflets and comment cards were available in the department to encourage patients to give their feedback and report concerns.

Staff understood the policy on complaints and knew how to handle them. Staff said they tried to resolve complaints informally. However, if patients wanted to raise it further, they escalated complaints to the patient experience manager. We saw evidence that any learning from complaints were used to improve the service.

These were displayed on the noticeboard under 'you said, 'we did'. For example: 'You said you wanted your voice heard and be involved in the future of the hospital.' 'We did – regular patient forums.' 'You wanted to be able to have a CT scan at Thames Valley.' 'We did – a CT service was available twice a month.'

For our detailed findings on learning from complaints and concerns, please see under this sub-heading in the surgery report.

Are outpatients services well-led?

Good

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

Leadership

Good

Outpatients

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

There were clear lines of leadership and accountability. The outpatient's manager had worked at the hospital for 21 years and took over the responsibility of the outpatient department 18 months ago. They reported to the director of clinical services who reported to the hospital director. The outpatient manager managed the nurses and healthcare assistants.

The physiotherapy manager had been in post for two and half years and reported to the director of clinical services as a direct line manager and had support from regional physiotherapy leads for clinical supervision.

Staff spoke highly of the management in the outpatient and physiotherapy department and described them as supportive and having an 'open-door' policy. Staff we spoke with gave examples of when they had been supported by the management for long term health conditions and managing their return to work.

For our detailed findings on leadership, please see under this sub-heading in the surgery report.

Vision and strategy

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

Spire Healthcare had an overarching vision to be recognised as a world class healthcare business. The overarching mission statement was 'To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care.' The groups values were driving clinical excellence; doing the right thing; caring is our passion; keeping it simple; delivering on our promises and succeeding and celebrating together.

All staff in the department had personal objectives as to how they would support delivery of the vision in the department. Staff appraisals considered objectives linked to the hospital strategy, hospital targets, departmental improvements and targets. Staff were also measured against how well they demonstrated the hospital values and behaviours.

Whilst there was no specific vision for the outpatients and physiotherapy departments, there was a departmental strategy in place. We spoke to managers who described growing and improving their services and the managers were reviewing this for 2020.A session with staff was planned and their thoughts and feedback would be gathered on things to stop things, to continue and things to start.

For our detailed findings on vision and strategy, please see under this sub-heading in the surgery report.

Culture

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

Staff told us they felt supported as individuals in their roles but also as part of the wider hospital team. Examples of this included support being offered to staff from other departments, and staff from different roles working together to achieve their outcomes.

Healthcare assistants reported being well supported by nursing colleagues, and housekeeping staff spoke of being supported by administrative staff and other colleagues. Staff described the culture being an improvement from previous roles they had worked in and feeling happy to be part of the hospital.

Staff told us that they had access to a counselling service, and that this was a useful benefit of working at the hospital.

For our detailed findings on culture, please see under this sub-heading in the surgery report.

Governance

Good

Outpatients

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

Monthly reports were produced for the clinical governance group meeting. These included data on incident trends and themes, number of complaints, patient experience results, new or updated hospital policies and NICE guidance. The managers of the outpatients, physiotherapy and pathology department all attended these meetings. An annual governance report was produced which detailed the data over the previous year.

Incidents were a standing agenda item on the outpatient team meeting minutes, but none were reported or discussed in the meeting minutes we saw.

Data provided to us prior to the inspection indicated that no incidents had been reported for the outpatient department within the past year.

For our detailed findings on governance, please see this sub-heading in the surgery report.

Managing risks, issues and performance

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

There was a hospital risk register. There were no risks specific to the outpatient's department however, it had been noted that the physiotherapy service was limited in the service it offered as there was no gym.

For our detailed findings on managing risks, issues and performance please see this subheading in the surgery report.

Managing information

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

Outpatient notes were paper based and stored securely on site.

For our detailed findings on managing information, please see this subheading in the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

This included comment cards and the use of a dedicated outpatients department and imaging service survey which had been introduced for 2019 across all of Spire Healthcare Limited hospitals.

The outpatient department ran a patient feedback survey but the response rates for this were low, although the feedback returned was very positive. The physiotherapy department sent out feedback forms via email to patients which resulted in an average of 25% response rates. Comments included 'thank you for the assistance' post-surgery and the advice that had been given.

The outpatient team met once a month for team meetings and when needed. The monthly team meeting was held in two shifts to ensure that all staff were able to attend. We saw minutes from these meetings that had a standard agenda and staff had the opportunities at the end of these meetings to raise concerns, issues or updates.

For our detailed findings on engagement, please see this subheading in the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Good

Outpatients

The operations manager told us there was work taking place looking at 'what staff values are' in the outpatient's department. The work was to take place in small teams to discuss what they wanted to keep as a department and to write their own departmental purpose.

For our detailed findings on learning, continuous improvement and innovation, please see this subheading in the surgery report.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We previously inspected outpatients jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Mandatory training

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

Staff working with radiation were trained in the regulations, risks and use of radiation and had signed the local rules relating to the appropriate areas in which they worked.

The service ensured staff administering radiation were appropriately trained to do so. Those staff without training received adequate supervision in accordance with legislation set out under Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) to work in the radiation field. We saw records which confirmed this. This ensured staff could safely perform examinations involving radiation to keep patients safe. We also saw evidence to indicate all staff had confirmed they had read the local rules.

Staff we spoke with said they completed mandatory training. Data provided by the service showed all staff in diagnostic imaging were up to date with their mandatory training. The service manager monitored uptake of staff mandatory training through a spreadsheet they maintained which was expired, due and in date and the service manager prompted staff if they were due an update. All mandatory training was to be completed by end of December 2019.

Safeguarding

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

Imaging staff completed safeguarding adults and safeguarding children level 2 training annually, as two of their mandatory training modules. In the department, 96% staff had completed this training. In addition, eight imaging staff had completed level 3 safeguarding children training to support providing services to patients under 18 in the department. Staff understood how to protect patients from abuse. Reception staff were clear if children accompanied patients to appointments, the patient was to be asked to ensure they had someone to care for the children while they had their appointment.

There were safeguarding adults and children policies available for staff to access electronically. Staff were aware of who to contact if they had safeguarding concerns or to gain additional advice from. For example, the hospital safeguarding lead. Staff were aware of their responsibilities if they identified a patient who had undergone female genital mutilation.

Chaperones were required for all intimate procedures and hospital policy was to routinely offer a chaperone to all patients. Privacy and dignity was maintained for intimate procedures with locks and signs on doors and a private changing area.

Cleanliness, infection control and hygiene

Good

Diagnostic imaging

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

Ninety seven percent of staff working in the diagnostic imaging service had completed infection prevention control and hygiene training during 2019.

We found clinical and patient waiting areas were visibly clean and free from dust and debris. There were cleaning schedules in place. We saw staff clean equipment at the start of each day and in between patient use, using sanitising wipes for surfaces and equipment.

The hospital had staff to provide cleaning services for low and high-level cleaning and general areas. Radiography staff were responsible for cleaning equipment before and after patients. We saw a daily cleaning checklist on display which showed daily cleaning had taken place.

A hospital environmental cleaning audit showed overall high standards of cleaning were maintained. Monthly hand hygiene audit data provided by the service showed compliance with hand hygiene ranged between 98% and 100%. During the inspection, we saw staff were compliant with bare below the elbows regulations and had long hair tied up.

Staff said when treating patients who had a communicable infection (such as tuberculosis, flu or diarrhoea), staff ensured their investigation was prioritised to reduce time spent with other patients.

Where possible, staff booked these appointments for the last appointment of the day, as scheduled cleaning took place at the end of the day.

Personal protective equipment, such as gloves and aprons, were available to staff. We saw appropriate use of gloves during a clinical intervention.

Clinical and non-clinic waste bins were in the rooms to allow differentiation of waste.

There were hand sanitiser dispensers placed in prominent positions throughout the diagnostics and imaging department to encourage use by staff and patients. We observed staff use the hand sanitisers appropriately.

Cleaning materials were not stored in the department. Cleaning staff conveyed the cleaning materials on a trolley to the department when they were needed.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

There was an equipment inventory list which included the age and service dates. The equipment was labelled with service test stickers to indicate when the next service was due.

Staff undertook intimate ultrasound scanning investigations using probes. The service cleaning procedures clearly described how the probes should be cleaned, in line with standards set by the Royal College of Radiographers. Records showed staff had cleaned the probes in accordance with hospital procedures and national guidance which recommends a manual wipe system and record of traceability (Health and Safety Executive Guidance for decontamination of semi-critical ultrasound probes: semi-invasive and non-invasive ultrasound probes 2017).

All equipment had labels which indicated the date the item had been cleaned. For example, in the ultrasound rooms we saw equipment (including the ultrasound machine) had a label dated November and the date it was cleaned. The cleaning checklist on the wall indicated cleaning took place.

Staff confirmed there were handover sheets for equipment to record the safe handover of equipment before and after maintenance.

The radiology department had working radiation warning signs outside all rooms for safety and to prevent unauthorised access.

Rooms were clearly identifiable and controlled areas were highlighted. This helped to reduce the risk of patients or visitors inadvertently accessing radiation restricted areas. There was an electronic digital lock to enter the magnetic resonance imaging (MRI) room to prevent unauthorised entry of persons, who had not been de-metalled, into the MRI area with an active magnet.

Good

Diagnostic imaging

Resuscitation trolleys were available in the outpatient's department which included diagnostic imaging. We reviewed the resuscitation trolley and saw the records of daily checks, including defibrillator and suction equipment.

Each treatment room had details displayed of what activity took place in the room (radiation risk assessments/local rules).

The service clearly labelled MRI equipment and devices. This was in accordance with Medicines and Healthcare Products Regulatory Agency 2015 recommendations. Staff labelled equipment in the MRI area. For example, the wheelchair was labelled as 'MR Safe'.

Staff wore lead aprons where appropriate, which staff screened annually to ensure they were not damaged. Staff also wore radiation exposure devices which the radiation protection advisor (RPA) analysed monthly to ensure staff were not over exposed. A dose reference level chart was displayed on the wall specific to each area and showed the recommended dose limits.

The service had support for their picture archiving and communication system which was the system used to store patient images. In the event of a system failure, this would impact on service availability. Staff told us the radiologist could view images but would be unable to report on them until the system was restored. However, this was a rare occurrence.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

All inpatients were assessed before staff transported them to the department for a computerised tomography (CT) or MRI scan to ensure they were in a stable condition to be subject to the scan.

Staff were aware of what action to take if a patient became unwell before, during or after a scan. The action taken depended on the specific situation and staff provided examples which showed they would take appropriate action. All rooms were fitted with emergency bells to alert other staff of concerns.

Basic life support training was part of mandatory training for diagnostic imaging staff. Data showed 98% compliance across the department with this training.

The department had a full set of Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2017. IR(ME)R procedures and standard operating procedures as required under the Regulations. The Health and Safety Executive (HSE) regulate the Ionising Radiations Regulations 2017. Local rules appendices, relevant to the specific rooms, were on display in accordance with procedures. All areas which utilise medical radiation in hospitals are required to have written and displayed local rules, which set out a framework of work instructions for staff.

The service had designated and clearly identifiable radiation protection supervisors available to provide guidance and support to staff in each area.

The service had a designated radiation protection advisor, who was accessible. They provided support and guidance and said they were confident the service managed risks well.

Local doctors and consultants referred patients to the service. The radiology administration team checked the referral for completeness and would contact the radiographer if they had any concerns.

Staff we spoke with demonstrated they were familiar with escalation procedures. For example, they would contact the radiologist on site or the resident medical officer (RMO). If they were concerned about a result, they would speak to the radiologist who would contact the referrer to discuss the result.

Staff we spoke with said it was a rare occurrence for patients to be violent or aggressive. However, staff were aware of how to manage a situation where a patient acted in an aggressive manner. For example, they would speak to them calmly, invite them to a private area and call for assistance.

There was an effective process for the assessment of patients who may be pregnant. Posters were displayed in the changing rooms and toilets with a message in different languages to alert patients that if they suspected they were pregnant to speak with staff.

Staff used a checklist to assess any potentially pregnant patient prior to any investigation. Patients verbally confirmed, then signed and dated on a form to confirm they were not pregnant.

Good

Diagnostic imaging

To safeguard patients against experiencing the wrong investigations, staff followed best practice which was in line with the legal requirements of IR(ME)R. 'Have you paused and checked?' a list of six checks which included: P =Patient, A = Anatomy, U = User checks, S = Systems and Settings, E = Exposure, D = Draw to a close.

- Patient identity
- Correct body area
- Confirm the examination is being completed at the right date and time
- Select correct patient identification
- Confirm no clinical reason the exposure should not proceed
- Add image comments or flags as appropriate

Radiography staff screened patients who required contrast media for pre-existing conditions or allergies. This was in keeping with the National Institute of Health and Care Excellence (NICE) acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration. Contrast media are substances which increase the contrast of structures or fluids within the body and are used in certain types of radiological investigations. Staff reported the procedure for the collapse of a patient in MRI was to call the crash team and to remove the patient from the MRI scanning room as quickly as possible.

Fire procedures took account of special precautions with regards to the procedure for quenching the magnet in case of fire (quench is the sudden loss of superconductivity when the temperature of the magnet is raised). Staff conducted an evacuation simulation exercise to ensure they were ready to respond in such an emergency.

Radiographer staffing

The service had radiographer staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The service was not fully staffed with radiographers, with two vacancies having been advertised.

The staffing rotas showed all services were provided with bank staff filling gaps. The staff told us they had needed to use agency staff in the two weeks prior to the inspection but this was the exception and usually they did not use agency staff. Staff said the department was able to ensure they allowed adequate procedure time for patients.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The department had access to specialist consultant radiologists, and they held set sessions in the department every week or month. Each radiologist only worked within their specific scope of practice and expertise, thus ensuring the service had specialist radiologists.

Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants applying for practising privileges were considered and approved by the Medical Advisory Committee. Most consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.

The provider reported that during the preceding 12 months, there had been no instances in which a radiologist had their practicing privileges revoked or suspended. The hospital had a buddy system to provide access to other radiologists for advice and support when needed and to cover for absences such as holidays to avoid delayed services.

Staff we spoke with told us radiologists on call were readily available and easy to contact. This was usually a general radiologist. Radiologists reported scan results between 9am to 5pm. There was no routine reporting after 5pm.

Records

Staff kept detailed records of patients' care and treatment.

The department primarily used a paper referral system which was scanned onto the radiology imaging system. An IT system was used for maintaining patient records, uploading images and accessing images remotely. Results and reports were available electronically to radiology staff and referrers.

If required patients were given a copy of their MR and CT images on a password protected disc. The report was emailed, posted or faxed to the referrer, depending on their preference.

Radiographers could access previous images if needed through a secure password protected system.

The service provided electronic access to diagnostic results. This ensured radiologists reported on all diagnostic investigations in a timely way, ideally within 24 hours of the investigation. For out-of-hours MR scans, an on-call radiologist could access the scan results securely. The radiologists we spoke with said the system allowed high quality scans to enable remote reporting.

Staff logged out of the computer screens ensuring patient information could not be viewed by patients or visitors walking past the room.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

Within the MRI areas, staff stored contrast media and all medicines in locked cupboards with keys held securely. We randomly spot checked eight medicines containers, and they were all labelled and in date.

We saw staff had signed when they used these contrasts and they evidenced they had received relevant training and were competent to meet the conditions identified with their use.

For our detailed findings on medicines please see this subsection in the surgery report.

Incidents

The service managed patient safety incidents well.

Staff were aware of their roles and responsibilities for reporting safety incidents and 'near misses', both internally and externally. Staff told us all incidents of avoidable over radiation were reported to the senior staff. These were discussed and assessed to see whether the incident was reportable under IR(ME)R.

Staff said they received feedback from incidents they reported. They were also discussed at monthly department meetings. The hospital produced a monthly governance newsletter, which included learning from all incidents.

From September 2017 to September 2019, the diagnostic imaging service did not report any never events. A 'never event' is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death.

Are diagnostic imaging services effective?

We do not rate effective in diagnostic imaging

Evidence-based care and treatment

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

The service used national diagnostic reference levels (DRLs) for each piece of scanning equipment that produced radiation. DRLs are used as a guide to help promote improvements in radiation protection practice. They can help to identify issues relating to equipment or practice by highlighting unusually high radiation doses.

Staff followed a process to ensure all magnetic resonance imaging (MRI) and computed tomography scans (CT) were "protocoled" by a consultant radiologist. Protocols are a pre-defined set of imaging sequences designed to optimally assess a specific region or regions of the body.

This ensured that patients received an appropriate sequence of scans available, whilst also minimising their total exposure to ionising radiation. For other diagnostic imaging procedures, the service used pathways and protocols that were evidence based and available on the hospital intranet.

The service took account of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. This included all specialities within diagnostics.

We reviewed a range of clinical and operational policies and procedures. The clinical policies reflected current

national guidance. New guidance was disseminated by the hospital governance team to department heads. The operations manager was responsible for reviewing policies relevant to their department and ensuring they were regularly reviewed or updated in line with national guidance.

Staff had access to policies and procedures on the shared drive. Staff showed us they could confidently and quickly access the policies.

There were policies to ensure staff did not discriminate against patients. Staff were aware of the policies and gave examples of how they followed guidance when carrying out care and treatment. Staff told us they would escalate any concerns and seek further guidance if necessary. Staff received training in equality and diversity as part of their mandatory training modules.

Radiographers followed evidence based protocols for scanning of individual areas or parts of the body. Radiographers we spoke with were confident to discuss protocols with consultants if they felt the consultant had chosen the incorrect protocol.

The mobile CT had dose modulation capability to ensure the radiation dose was optimised. This was so patients did not receive any more radiation than needed.

The service did not offer individual health assessments. Staff said referrals to the service had a clinical justification and they would check with patients to avoid unnecessary investigations.

Nutrition and hydration

Staff advised patients on food and drink restrictions in accordance with the investigation.

The referring doctors advised patients whether they had any food or drink restrictions at the time of referral. The administration staff would call patients the day prior to their appointment and confirm food/drink restrictions. Patients were also provided with leaflets and information for the specific investigation.

Water and hot beverages were available in the main waiting area for patients and visitors. We saw staff offered patients drinks before and between appointments if they were in the small waiting area in the imaging department.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Radiology staff did not use pain relief medicines in diagnostic imaging. However, staff said they would consider the patient's pain and comfort levels. For example, they would discuss with ward staff if a patient was due to have a scan and allocate a time in relation to the patient's scheduled pain relief to reduce the patient's discomfort during the scan.

Staff ensured patient comfort prior to completing all investigations. For example, by repositioning the patient if possible, or the use of pillows or a foot rest. We observed staff reassure patients during investigations to take account of their comfort.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

The results of the annual radiation dose audit (October 2018), which compared the average patient dose with the local dose reference level, showed 100% compliance for CT, X-ray and breast imaging.

Staff peer reviewed a sample of their colleague's images to ensure quality and recording.

For our detailed findings on patient outcomes, please see this subsection in the surgery report.

Competent staff

The service made sure staff were competent for their roles.

The imaging service manager conducted appraisals for all staff in the service. Staff we spoke with said they had participated in an appraisal in the previous 12 months.

Consultant radiologists working at the hospital had practising privileges which gave them the authority to undertake private practice within the hospital. The hospital practising privileges review process was biennially and included a review of the consultant's scope of practice. This ensured the hospital had oversight of their ability to practice.

The manager maintained a record of staff competency assessments on modalities and equipment. We also saw an up-to-date record of radiographers Health and Care

Good

Diagnostic imaging

Professions Council registration (HCPC). This was in line with the society of radiographers' recommendation that radiology service managers ensure all staff are appropriately registered. None of the imaging staff had been audited by the HCPC.

All the radiographers were senior radiographers who were skilled in diagnostic services offered by the service.

Multidisciplinary working

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

The diagnostic service provided a breast pathway, where patients could access a consultant, have the diagnostic investigation with the results and further treatment arranged. The radiologists attended a breast multidisciplinary team meeting monthly.

The service worked well with its colleagues in outpatients and on the ward to ensure that there was always a service available.

Seven-day services

The service operated over a seven-day period with the availability of on call radiologists to perform emergency diagnostic scans.

The diagnostics service was open 8am to 9pm, Monday to Friday, and 8am to 1pm on Saturday. Outside of these times, radiographers and radiologists were available through an on-call system. They attended the hospital within 30 minutes.

For our detailed findings on seven day services, please see this subsection in the surgery report.

Health promotion

There was health promotion material available across the diagnostic department.

There were health promotion materials for patients to access in the department, such as bone health, diabetes and breast care.

For our detailed findings on health promotion, please see this subsection in the surgery report.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff completed training on consent and the Mental Capacity Act (MCA) as part of their mandatory training modules.

We saw the service correctly used a magnetic resonance imaging safety consent form to record the patients' consent, which also contained their answers to safety screening. Staff documented consent on the patient's electronic care record. Discussions included a description of the investigation, the possible side effects and the recovery period. Staff gave patients the opportunity to discuss concerns or queries prior to confirming consent.

Policies on deprivation of liberty and mental capacity were available on hospital's shared computer files. Although staff had received training on mental capacity, they said it was unlikely they would see patients who lacked mental capacity in their service. However, they were aware of what to do if they had concerns about a patient and their ability to consent to the scan.

Are diagnostic imaging services caring?

Good

We previously inspected outpatients jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Compassionate care

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

Staff demonstrated a kind and caring attitude to patients. This was evident from the interactions we witnessed on inspection and the feedback provided by patients. Staff introduced themselves to patients and took time to put the patient at ease.

There was a reception desk for imaging. The patients booked in and were then directed to wait in the X-ray

waiting area where staff would collect them for other imaging. The MRI scanner was located on the ground floor and the hospital provided CT services twice-monthly via a mobile scanning unit.

Posters informing patients about chaperones were on display throughout the department.

Staff said they took the time wherever possible to interact with patients and their relatives. We observed staff taking time to speak with patients in a respectful and considerate way.

Patients we spoke with were generally very satisfied with the care they received. They made comments including: "Really quick- got call same day for CT scan", "Happy". There was one negative comment from a patient about staff, we spoke with the patient on the day of the inspection and they said issues had been resolved.

Emotional support

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

Staff supported patients through their investigations, ensuring they were well informed and knew what to expect.

Staff provided reassurance and support for nervous and anxious patients. They demonstrated a calm and confident manner to relax patients.

Staff also encouraged patients to bring in their own music for relaxation and to bring someone with them as support.

We observed staff provided ongoing reassurance and commentary to the patients during the MR scan; they updated the patient on how long they had been in the scanner and how long was left.

Understanding and involvement of patients and those close to them

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

Patients we spoke with told us they were involved with decisions about their care and treatment and were aware of what the next steps were. We saw staff relayed information at a pace suitable to the patients' needs.

Patients received a CD of their images to forward on to their doctor who had made the referral, if requested.

Are diagnostic imaging services responsive?

Good

We previously inspected outpatients jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Service delivery to meet the needs of local people

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

The service provided evening and Saturday appointments to accommodate the needs of patients who were unable to attend between 9am and 5pm Monday to Friday.

Free parking was available at the hospital and staff parked off site to ensure there were spaces for patients.

The environment included seating areas, adequate toilets and good availability of refreshments. There was access to free WiFi for patients and visitors.

There was a walk-in service for plain film imaging and the service offered open access for CT and MRI scans from all GPs.

Appointments were flexible to meet the needs of patients and they were available at short notice.

The imaging department had a small changing room and lockers for patients to securely store valuables whilst they were having their scan. The MR department had a separate waiting area for patients, or they could wait in other waiting areas near refreshments.

Meeting people's individual needs

Good

Diagnostic imaging

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

If patients had to wait more than five minutes after their appointment time, staff informed patients and explained the delay. If the service had to cancel a clinic such as ultrasound, staff informed patients immediately and offered the next available appointment that was suitable for their needs.

We saw staff spent enough time as the patient needed to explain the procedure. Staff commented it was valuable to be able to spend time with patients without feeling too rushed. All patients we spoke with commented they did not feel rushed through their procedure.

Patients attending the diagnostics service were normally only there for a short time and did not require food. There was complimentary tea and coffee and drinking water.

Patients with mobility issues had the option to enter the MRI scanning room on an MRI safe trolley or wheelchair. All waiting areas across the department were large enough to accommodate wheelchairs and patients with mobility issues.

The service took account of the accessible information standard by identifying and recording communication needs at the time of booking the appointment. There were mobile hearing loops available and the service had access to a telephone translation service. There were also books for children to use to assist staff, guardians or parents on explaining what procedure they were having. In addition, there were picture aids and easy read literature available.

Staff had received training in equality and diversity as part of their mandatory training and staff were expected to demonstrate these values throughout their work. Staff called patients the day before their appointment and asked if they had any special needs which the service needed to be aware of and made any necessary adjustments.

Access and flow

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

GP's and consultants in the hospital, referred patients to the service. Administration staff made appointments in person or by telephone at a time and date agreed by the patient. Data showed the service had a low proportion of patients who did not attend for their appointment, approximately 1% over the last two years.

Some patients came directly from a consultation with their doctors and had their scans undertaken on the same day. Staff asked other patients to come back later in the day, or the next day, depending on appointment availability.

Administration staff said patients were normally seen within five minutes of their appointment. If patients were expected to wait more than five minutes, staff would speak to them to explain. Appointments were booked with enough time between them. The clinics usually operated on time.

Information showed waiting times were short and appointment times were closely adhered to. We saw this during the inspection and from the feedback received from patients. Over 90% of patients who responded to the patient satisfaction survey said they were seen early or on time.

The hospital aimed to have radiology reports available to the referrer within 24 hours of the scan taking place. Information provided showed the service achieved an average report turnaround within 24 hours. This was within their target of 24 hours.

Learning from complaints and concerns

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

Good

Diagnostic imaging

The complaints log from 2017 to October 2019 showed three complaints related to the imaging department. We saw they had been managed within the hospitals 28 day policy and had been resolved to the complainant's satisfaction.

The operations manager attended a weekly governance meeting where complaints were discussed, with an aim of closure of complaints within 28 days. This ensured that every complaint or incident had the correct clinical or head of department assigned for investigation, and any immediate action was taken quickly.

Information for patients on how to make complaints was readily accessible on the hospital website and leaflets on providing feedback and complaints were available in the department.

Are diagnostic imaging services well-led?

Good

We previously inspected outpatients jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There were clear lines of leadership and accountability.

The radiography manager had been in post for two years and reported to the director of clinical services as a direct line manager but had support from the regional radiography lead for clinical supervision.

Staff spoke highly of the radiography department and described themselves as supportive and a great team.

For our detailed findings on leadership, please see this subsection in the surgery report.

Vision and strategy

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

Whilst there were no additional visions or strategy for the radiography departments, we spoke to senior staff who described growing and improving their services.

The provider reported that individual specialties were not required to have a local strategy, often due to the size of locations; it was acknowledged that each location had a hospital wide vision and strategy. Staff could describe the vision for the hospital. They also described the wider values of Spire Healthcare.

For our detailed findings on vision and strategy, please see this subsection in the surgery report.

Culture

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

Staff we spoke with said it was a great place to work and they felt valued and respected. We were told "everyone is so helpful and happy, which makes working here a pleasure".

Staff were aware of the whistleblowing policy and felt able to approach and discuss any concerns with the manager.

For our detailed findings on culture, please see this subsection in the surgery report.

Governance

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

Monthly reports were produced for the clinical governance group meeting. These included data on incident trends and themes, number of complaints,

patient experience results, new or updated hospital policies and NICE guidance. The managers of the outpatients and imaging departments attended these meetings. An annual governance report was produced which detailed the data over the previous year.

Data provided to us prior to the inspection indicated that no incidents had been reported for the imaging department.

For our detailed findings on governance, please see please see this subsection in the surgery report.

Managing risks, issues and performance

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

There was a hospital risk register. There were no risks specific to the imaging service on the risk register.

Daily infection prevention and control audits were carried out across the diagnostic imaging suite. Audit results demonstrated consistent 100% compliance across the six clinical areas including x-ray, CT, MRI, mammography and the fluoroscopy suite.

The provider submitted examples of hand hygiene competency assessments which had been completed for two members of staff. The assessments captured the five motions of hand washing as described by the World Health Organisation. In addition, the competency framework sought to consider the theory and importance of health professionals undertaking appropriate and effective hand hygiene in a clinical setting.

A quarterly jewellery and uniform audit was undertaken in August 2019 which demonstrated staff in the diagnostic imaging service were 100% compliant with Spire Healthcare uniform policy. This was consistent with our observations during the inspection.

For our detailed findings on managing risks, issues and performance**,** please see this subsection in the surgery report.

Managing information

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

Imaging records were fully electronic, and staff could analyse the information inputted on the system to monitor patient outcomes and staff performance.

For our detailed findings on managing information, please see this subsection in the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

To engage with patients the department used comment cards and the use of a dedicated outpatients department and imaging service survey which had been introduced for 2019 across all of Spire Healthcare Limited hospitals.

The imaging team met once a month for team meetings and when needed. The monthly team meeting was held in two shifts to ensure that all staff were able to attend. We saw minutes from these meetings that had a standard agenda and staff had the opportunities at the end of these meetings to raise concerns, issues or updates.

For our detailed findings on engagement, please see this subsection in the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The operations manager told us there was work taking place looking at 'what staff values are.' Work is to take place in small teams including the imaging department, to learn what they want to keep as a department and they are going to write their own departmental purpose.

Good

Diagnostic imaging

For our detailed findings on learning, continuous improvement and innovation, please see this subsection in the surgery report.

Outstanding practice and areas for improvement

Outstanding practice

- The oncology service had been awarded a Macmillan Mark of Quality Environment (MQEM) for achievements in quality for cancer care environment.
- The oncology service was awarded an Exemplar award by the provider's group clinical director and had been recognised for excellent care and service for cancer patients in 2018.
- Staff were extremely motivated to deliver care that was kind and compassionate. They anticipated the needs of their patients and ensured their needs were acknowledged and met. We saw how staff took the time to interact with people who used the services and those close to them in a respectful and considerate way in theatres and on the wards.
- Staff did not merely react to patient needs or requests, they consistently assessed their needs and strived to build personal relationships, so they could understand their patients' needs and preferences. Staff demonstrated a genuine desire to enhance the patients' experience and to ensure their needs were met and exceeded.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider raising the awareness of risk and how to report it with all staff.