Spire Healthcare Limited

Spire Bristol Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- Our rating of critical stayed the same. We rated it as good.
- Our rating of children and young people's services stayed the same. We rated it as good.
- We rated outpatients as good.
- We rated diagnostics as good.

However:

- Our rating of surgery went down from good to requires improvement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Critical care	Good 	Our rating of this service stayed the same. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service mostly 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 provided effective care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients and had access to the information they needed. 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 service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The

Summary of findings

service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Documentation of care and treatment patients received in the critical care unit was not clear and easy to find.
- Documentation of care and treatment patients received in the critical care unit was not clear and easy to find. Boxes were stored on the floor in the storeroom. Documentation of care and treatment patients received in the critical care unit was not clear and easy to find. Staff knew about incidents, but learning was not always shared effectively with staff in team meetings.
- Staff knew about incidents, but learning was not always identified and shared effectively with staff.
- The hospital did not always monitor the effectiveness of care and treatment for some procedures in a manner that enabled benchmarking patient outcomes with other and similar services.

The critical care unit provided enhanced care to patients admitted for elective surgery who require a period in critical care immediately after their operation. The service also provided an outreach service to inpatient wards in the hospital.
The critical care unit had two designated critical care beds with the option to use a further bed space in the adjacent post anaesthetic care unit.
There had been 224 admissions to the critical care unit in the 12 months prior to our inspection.
We last inspected the critical care unit in 2016 when it was rated as 'good' across all five domains. We found some progress on the service improvement recommendations we highlighted in our last report but there was still more work to do.
Critical care was a small proportion of hospital activity. The main service was surgical services. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

We carried out a site visit on 17 February 2022 and followed this up with additional interviews the week commencing 28 February 2022.
We spoke with nine staff and nine patients. We reviewed two patient records and looked at policies and procedures relevant to the critical care unit.

Diagnostic imaging

Good

We have not previously rated diagnostic imaging as a single service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and 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 diagnostic processes. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of 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 supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services.

Summary of findings

However:

- Changes in the senior team and a reliance on agency staff led to some inconsistencies in understanding and application of policies and audits.
- Leaders ran services well using reliable information systems although this was not always shared with, and understood by, all staff.

Between February 2021 and January 2022, the service carried out 21,552 scans.
The diagnostic imaging service provides nine modalities: computerised tomography (CT), magnetic resonance imaging (MRI), X-Ray, mammography, fluoroscopy, ultrasound, echocardiography, and interventional radiology. The service provides diagnostic imaging to patients referred privately, through their insurance, and from the NHS. The department provides imaging support to surgical inpatients. 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 main service.

Outpatients

Good

We have not previously rated outpatients as a single service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised

Summary of findings

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 service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Outpatients services were delivered from a dedicated department with 27 consulting rooms and two treatment rooms. The service included a specialist ophthalmology service and worked with the diagnostic imaging service to provide a breast clinic. A wide range of clinical specialties were available, including gynaecology, orthopaedics, and dermatology. Services were led by consultants, nurses, and healthcare assistants.
A dedicated physiotherapist outpatient team provides care across 10 key specialties, including sports therapy, musculoskeletal therapy, and isokinetic rehabilitation. A physiotherapy gym was located on site.

Summary of findings

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

Services for children & young people

Good

Our rating of this service stayed the same. We rated it as good overall because:

- The service was responsive to children and young people's individual needs. 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 were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities.
- Staff treated children and young people with compassion and kindness and respected their privacy and dignity.

However:

- There were not separate waiting areas for children and adults in line with best practice at the time of inspection. While the service had single-use activity packs available for young children, the service had not taken steps to ensure the environment and atmosphere was as young people friendly as possible. Before the COVID-19 pandemic the service had child-friendly chairs and a play area available in outpatients. These had been removed for infection control reasons and had not been re-instated at the time of the inspection.
- While staff assessed most risks to children and young people, venous thromboembolism (VTE) assessments were not always completed in line in line best practice for post-pubertal children or children over 40kg.
- The service was unable to demonstrate monitoring and improvement of patient clinical outcomes. While managers monitored the short-term outcomes of surgery for children and young people, Managers did not have processes to monitor the longer-term clinical effectiveness of care.

Summary of findings

- The service did not have a process for recording of consent in relation to refusal of blood products at the time of the inspection.

We rated this service as good overall as although effective was requires improvement, safe, responsive, and well-led were rated good. We did not have sufficient evidence to rate caring at this inspection as, although we spoke with staff about the care they provided to children and young people, we were unable to speak with children and their families during this inspection due to low levels of activity.
Children and young people's services are a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. During the inspection we spoke with two staff - the children's service lead a paediatric nurse. There were no other children and young people's services staff on site at the time of inspection. We reviewed five records. We were unable to speak with any children and young people during the inspection due to low activity levels at the hospital. We requested but were not provided with contact details of children and young people and their families to contact and discuss their care.

Surgery

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- There was little evidence of the service monitoring they used the findings to make improvements and achieved good outcomes for patients. There was very minimal evidence of improvements by benchmarking with other similar services. We could not identify where the outcomes for patients were measured, monitored, assessed, or improved.
- Key recruitment documents regarding some senior staff were not available as required by Schedule 3 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Although key services were available out of hours not all staff understood how to access them.

However:

Summary of findings

- The service had enough appropriately trained staff to care for patients and keep them safe. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept accurate care records. The service managed safety incidents well and learned lessons from them.
- 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.
- People could access the service when they needed it and did not have to wait too long for treatment.

We rated this service as requires improvement overall because although safe, caring, and responsive were rated good, effective and well led were rated as requires improvement.

Summary of findings

Contents

Summary of this inspection — Page

Background to Spire Bristol Hospital — 12

Our findings from this inspection

Overview of ratings — 14

Our findings by main service — 15

Summary of this inspection

Background to Spire Bristol Hospital

Spire Bristol Hospital is a large independent acute hospital part of the Spire Healthcare Limited group. The service provides care for patients in the South West of England.

The hospital provides surgical, outpatients and diagnostic services, critical care and services for children and young people.

The hospital has a registered manager, Mr Phillip Curran, who has been the registered manager since March 2020. The service is registered to provide the following regulated activities:

- Services in slimming clinics
- Family planning services
- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products

The service was last inspected in September 2016 and was rated good overall with good in all five key questions.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve

Surgery

- Results of local and national audits must be assessed to identify potential improvements to patients' outcomes. Regulation 17 (2) (a)
- Information must be available in relation to each such person employed. Recruitment information was not available in relation to some senior staff at the service, including – but not limited to - the hospital director. Regulation 19 (3) (a, b).

Critical Care

- The service must maintain securely an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided. Care and treatment provided in the critical care unit was not clearly documented in patients notes and the service did not carry out any audits for assurance of the quality of record keeping. Regulation 17 (2) (c)

Summary of this inspection

Children and young people's services

- The service must assess, monitor and improve the children and young people's service to monitor patient clinical outcomes. Regulations 17 (2) (a)

Action the service SHOULD take to improve:

Surgery

- The service should promote the formal arrangement for accessing pharmacy advice out of hours, so all relevant staff are aware of it.
- The service should consider how to make sure all relevant staff are aware of how to access to radiology support remotely out of hours.

Critical Care

- The service should review the storage of boxes to ensure the floor can be easily cleaned.
- The service should consider reporting of all cardiac surgery outcome measures to national audits to enable benchmarking with other providers.
- The service should consider ways in which it can improve the standard agenda for team meeting and consider including learning from audits, risks, incidents and complaints as standard agenda items.

Outpatients

- The service should facilitate a more appropriate environment for children and young people visiting the department.

Diagnostic imaging

- The service should continue to improve completion of training for all staff responsible for responding to crash calls on accessing the department.
- The service should establish assurance of the effectiveness of agency staff inductions.
- The service should work to make sure up to date CT protocols are readily available and accessible by staff at the point of delivery.
- The service should work with staff in X-Ray to establish assurance they understand and act on the results of reject analysis audits. The service should consider processes to ensure all staff are fully up to date with quality assurance processes.

Children and young people's services

- The service should review the outpatient environment to ensure it is child-friendly and children are seen in an area separate from adults in line with best practice.
- The service should review and improve processes to carry out VTE risk assessments for post-pubescent and children over 40Kg or monitor compliance with VTE assessments in children and young people's services to comply with national guidance.
- The service should consider the provision available to support the mental health and wellbeing of children and young people while in hospital.
- The service should consider reviewing child-friendly resources so there is appropriate information available for all surgical procedures carried out to inform consent.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Requires Improvement	Good	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Services for children & young people	Good	Requires Improvement	Insufficient evidence to rate	Good	Good	Good
Surgery	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Good	Requires Improvement	Good	Good	Good	Good

Good

Critical care

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

Are Critical care safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. Records showed 98% completion of all required courses. Staff said it was easy to access mandatory training, which was provided both electronically and by face-to-face training for practical skills.

Medical staff received and kept up to date with their mandatory training. Most medical staff completed mandatory training at their main place of employment. The service checked medical staff mandatory training, through the review of practicing privileges process. The resident medical officer completed mandatory training through the agency they were employed through.

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.

Staff received training in adult safeguarding and child protection at the level required of their role. Records showed 89% staff had received level 2 adult safeguarding training appropriate to their role and 93% of staff had completed child protection training at level 2 in line with national guidance. Team leaders were aware of who needed to complete their training to meet the hospital's end of year (March 2022) compliance target of 95%. Following the inspection, the service shared further information to confirm the end of year target had been reached.

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. Safeguarding information was displayed in staff areas to ensure escalation of concerns were not delayed.

Good

Critical care

Cleanliness, infection control and hygiene

The environment and equipment were visibly clean on the day of the inspection. The critical care unit was clean and had suitable furnishings which were clean and well-maintained.

Daily cleaning/equipment safety check records were up to date. Staff followed a schedule for cleaning bed spaces, equipment and the general environment. However, we noted boxes were stored on the floor in the storeroom which would make cleaning difficult.

Staff had access to enhanced PPE when aerosol generating procedures were carried out. Enhanced PPE was available to staff if they preferred to wear this in areas where aerosol generating procedures were carried out. We noted there were no signs to alert staff that aerosol generating procedures may be carried out in the critical care unit to enable staff to make a decision about wearing enhanced PPE.

Compliance with infection prevention and control audits were carried out regularly. Data showed compliance was above 95% over the last 12 months across seven metrics. The service monitored hospital acquired infections and data showed there had been no hospital acquired infection for patients in critical care in the last 12 months.

Environment and equipment

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

The design of the environment followed the current national guidance. A critical care bed had been removed to ensure there was enough room around the bed to meet with national guidance. Each bed space had adequate monitoring equipment and additional devices such as infusion pumps to facilitate prescribed infusion of medicines. Staff told us they had all the equipment they needed to provide safe care and treatment.

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 an Operational Policy for the Intensive Care Unit (2021) which included a non-admission criterion. This was a list of conditions that could not be treated and cared for in the critical care unit.

Staff did not use a national tool (early warning score) to record observations. Observations were recorded at least hourly on specifically designed ICU charts. Staff we spoke with were aware of how and when to escalate concerns about patients. Staff continuously observed patients and identified changes in their conditions. Patients in the critical care unit were connected to continuous monitoring devices which alerted staff to any changes in patients clinical well-being. Staff escalated deteriorating patients to the resident medical officer (RMO) for critical care and to the on-call intensivist. All RMOs in critical care were trained in advance life support and had advance airway management skills.

There was a service level agreement to support prompt transfer of patients to the acute NHS critical care services if needed.

The critical care unit provided an outreach service to support staff on general wards who escalated concerns about deteriorating patients. The outreach service was provided by staff who had experience and additional skills in assessing a deteriorating patient. Staff provided advice and support to ward staff and escalated concerns to medical staff. This

method of working was included in the unit's operational policy, which stated the critical care unit would provide a 24-hour outreach service. However, the staffing establishment did not include nursing staff to provide this service and could only be delivered if there was enough staff rostered to work. When this was not possible, there was a resident medical officer onsite 24 hours a day to complete assessments and provide relevant advice.

Staff completed risk assessments for each patient at the pre-operative assessment, but it was not evident this was reviewed again when patients were admitted to the unit.

Staff knew about and dealt with any specific risk issues. Staff had access to specific care pathways such as the sepsis pathway, to ensure patients who had symptoms of sepsis received prompt treatment.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Staff knew about patient risks. There were effective handovers and safety huddles and nurses received a bed side handover specific to the patient they were looking after.

There were effective arrangements for medical handovers. Resident medical officers (RMOs) received a handover at the beginning of their shift.

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.

The service had enough nursing and support staff to keep patients safe. There were 22 (16.6 whole time) registered nurses working in the critical care unit. Turnover was low and the two members of staff who had left in the last 12 months had stayed on the bank to work occasional shifts. Staffing of the unit was reviewed quarterly and rotas were planned in line with booked elective surgery cases. There was a plan to increase the staffing template to allow for the critical care unit to be staffed 24 hours per day and seven days a week.

Staffing levels and skill mix exceeded national guidance. Staff were supported to undertake post registration qualifications in critical care. Records showed 71% of staff had completed accredited additional training in critical care.

Managers limited their use of bank and agency staff and requested staff familiar with the service wherever possible. However, higher than usual staff absences due to the COVID-19 pandemic meant more bank and agency staff had been used to cover shifts and to maintain safe staffing levels. On all but one shift in January and February 2022, the hospital had achieved the national recommendation of 80% of staff in critical care being permanently employed despite the challenges of the pandemic.

Medical staffing

The service had enough medical staff to keep patients safe.

Since the last inspection, a new medical staffing model had been implemented. The unit had an on-call consultant intensivist 24 hours seven days a week. Out of hours, consultants could attend within 30 minutes if required. An on call cardiac intensivist remained on site overnight following cardiac surgery lists. There was a critical care resident medical officer (registrar level) on duty 24 hours, seven days a week when patients were admitted to the critical care unit. If there were no patients in the unit, RMOs were on call and could attend within 30 minutes if required. Staff said they could always access medical support when needed.

Good

Critical care

Staff told us consultants reviewed patients twice a day in line with national guidance, but this was not always recorded in patient records. An audit was carried out in July 2021 which showed the review had only been recorded in two of four patient records that had been reviewed. As a result, consultants had been reminded to record patient reviews. Following the inspection, the provider shared a further audit in October 2021 showed confirmed 100% compliance with twice daily consultant reviews

There was a group of RMOs who worked on a rota around their NHS jobs to cover the hospital. The RMOs were registrar level doctors and had experience and extended skills in critical care. Staff we spoke with said this worked well and it was rare that shifts were not covered. The RMOs completed an induction to the service when they started working on the unit.

Records

Information about care and treatment was not always clearly recorded and there were no regular audits to monitor the effectiveness of clear recording in patient notes. However, records were stored securely and easily available to all staff providing care.

Staff used paper-based patient records and staff could access them easily. However, information about care and treatment patients received in critical care was not always clearly recorded. We reviewed two patient records during our inspection and found information was not always recorded and it was difficult to ascertain when the patient had been admitted to critical care. There was a 'critical care unit admission' booklet but this was not completed in one of two records and the discharge information was not included in one of the patient records. Staff used the surgical care pathway to document care, but this did not include specific sections for staff in critical care to document the care and treatment patients received. The service did not carry out documentation audits and could therefore not evidence that care and treatment was recorded effectively.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient records followed the patient when they transferred from the critical care unit to the ward and staff escorted the patient to the place of discharge to ensure accurate handover of records and patient care and treatment information. If patients were transferred to NHS hospitals, a copy of all the notes were made which followed the patient.

Records were stored securely. Patient records were stored on a trolley in the bed space of each patient, so staff had immediate access to them. Staff stated records were always in sight of staff and access to the unit was restricted by a swipe access door. Computers were password protected.

Medicines

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

Staff followed systems and processes when prescribing, administering, recording and storing medicines. Medicines records were complete and contained details about the prescribed dose, how often they should be given it and how it should be administered.

Staff followed systems and processes to prescribe and administer medicines safely. For example, there were effective process to make sure prescribed antibiotics were reviewed regularly by a microbiologist to ensure it was the right medicine and that it was not given for longer than it was needed.

Good

Critical care

Medicines were mostly stored in line with guidance and under the right conditions. However, fluids for intravenous (into a vein) infusion, were stored in a storeroom accessed from within the unit which was unlocked on the day of our inspection. Following the inspection, the service shared a new risk assessment considering effective controls and the need to enable rapid access when patients were admitted to the unit.

Incidents

Staff recognised and reported incidents and near misses and managers investigated incidents.

Staff knew about incidents that had happened in the hospital and of significant incidents in other Spire locations. 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.

All staff knew what incidents to report and how to report them. Staff told us they used an electronic incident reporting system which was quick, simple and easy to use. Staff confirmed they received feedback when they reported an incident. The RMOs used a closed WhatsApp group to share and learn from incidents. This information did not contain any patient identifiable data but ensured RMOs were kept informed.

There had been an increase in the number of incidents reported by staff. Leaders told us there was a positive culture of being open and honest about and learning from incidents. Incidents were investigated by senior nurses/team leaders who had received training in how to investigate incidents and complaints. Staff knew about significant incidents in other Spire hospitals.

Staff were aware of what duty of candour (DoC) meant. Duty of candour is a statutory duty to be open and honest with patients when things go wrong causing or having the potential to cause harm and offer an apology.

Staff met to discuss the feedback and look at improvements to patient care. Staff confirmed learning from incidents was discussed and some meeting minutes we reviewed confirmed this. However, learning from incidents was not a standard agenda item at staff meetings.

There was evidence that changes had been made as a result of feedback. The service had purchased a device to print small patient labels to ensure blood specimens were correctly labelled.

Managers debriefed and supported staff after any serious incident.

Are Critical care effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

See also the surgery report.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance.

Good

Critical care

There was an effective process to share monthly safety bulletins to all clinical staff. The safety bulletin was emailed to all clinical staff.

The critical care unit did not participate in the Intensive Care National Audit and Research Centre (ICNARC) data set. This was not mandatory but allows critical care units to benchmark data against other critical care units. The Spire Group collated data from other Spire critical care units on a central data base

There were effective processes to review readmissions and patient deaths. Staff told us these were discussed and reviewed in clinical governance meetings and in the medical advisory committee meetings.

Nutrition and hydration

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

Staff made sure patients had support with nutrition and hydration to meet their needs. There was suitable menu choice for patients with specific requirements and to meet preferences as far as possible.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded this on observations charts specifically designed to record observations on an hourly basis providing an accurate record of fluid input and output.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff assessed patient's malnutrition risks and took action to raise concerns if required. Staff had access to a dietitian who could provide advice and prescribe additional nutritional supplements if required.

The service was unable to support patients who required additional feeding techniques such as nasogastric feeding. If patients required such additional support, patients were transferred to an NHS hospital. However, no patients had been transferred for this reason alone in the past 12 months.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff could access advice from NHS hospitals if required but if patients needed ongoing support, they would be transferred to an NHS facility.

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. Patient records contained a section to ensure pain assessments were included. Staff had access to both verbal and non-verbal pain assessment tools.

Patients received pain relief soon after it was identified they needed it, or they requested it. Staff prescribed, administered and recorded pain relief accurately. Records showed regular pain relief was given as prescribed in the records we reviewed. However, we spoke with one patient who stated they were in more pain that they had expected and that this was impacting on their well-being and ability to mobilise following surgery.

Good

Critical care

There was a small specialist pain team who provided additional advice and support for staff in how to manage patients' pain.

Patient outcomes

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

The service collected data to benchmark against other Spire hospitals who provided similar services and had a critical care unit. The hospital did not participate in and report patient outcomes to the Intensive Care National Audit and Research Centre (ICNARC). It was felt that the service could not be benchmarked against NHS hospitals as the level of activity was much smaller and patients' risks were assessed before being accepted for surgery.

During the inspection, we reviewed data that showed there had been 15 unplanned transfers to NHS hospitals between January 2019 and May 2021 for patients requiring level 2 or level 3 care (enhanced care that is not usually provided at ward level). This was similar to two other Spire critical care units although these units had more critical care beds and therefore a potential for more patients to be admitted. The hospital transferred 43 level 1 patients to NHS hospitals in the same period and this was above the transfers for the other two Spire hospitals with critical care units. We were told there was a project to upskill nursing staff at ward level to care for patients who required higher levels of monitoring or were at risk of deteriorating. Transfers were reported as clinical incidents and investigated internally. The incidents were discussed in clinical governance meetings. For example, the minutes of the meeting held in January 2022 showed there had been eight transfers to NHS hospitals for post-operative complications. It was not clear how many, if any, were transferred from the critical care unit. Following the inspection, CQC received further information to explain two patients had been transferred to an NHS hospital following complications and in line with their service level agreement.

The hospital monitored how many patients required re-admitting to the critical care unit within 48 hours of discharge to the inpatient ward. From January to December 2021, there were16 patients who were readmitted. Staff told us each case was reviewed and discussed in clinical governance meetings to identify if there were any lessons learnt or service improvements that should be considered to reduce the number of patients who may need re-admitting in the future.

The hospital did not report all cardiac surgery outcomes such as cardiac surgery outcomes for coronary artery bypass graft surgery, to the Institute for National Centre for Cardiovascular Outcome Research (NICOR). However, data about other cardiac interventional procedures for cardiac arrythmias management was reported to national audits.

Managers shared and made sure staff understood information from the audits. There was a plan for staff to receive training on how to use the hospital's electronic audit management platform so that more staff could be involved with auditing. However, audit results were not shared routinely in team meetings to ensure staff understood the changes that needed to be implemented to improve compliance and deliver safe care and treatment.

Action plans were developed where audits had identified improvements could be made. Actions were assigned to individuals and implemented before they were closed.

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.

Good

Critical care

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were 22 registered nurses working in the critical care unit. Of these, 71% had a post-registration qualification in critical care nursing which exceeded national recommendations. There was a clinical nurse educator who was employed across the hospital to support the learning and development needs of staff.

Managers supported medical staff to develop. Most consultants had their main place of employment within acute NHS trusts and had their work appraised there. Consultants were employed by the hospital through practicing privileges and there was a process to share appraisal information between the service and the acute NHS trust. The RMOs in critical care were all speciality trainee doctors with intensive care experience and skills.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Records showed staff had received their appraisals. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers gave all new staff a full induction tailored to their role before they started work. New nursing staff had a three-month induction programme which included a period of working super-numerary

Poor staff performance was identified promptly and supported staff to improve. The manager was aware of how to manage poor staff performance to support staff to improve. Managers had access to corporate human resources support if this was required to ensure policy and procedures were followed.

Managers made sure staff received any specialist training for their role. Some equipment was rarely used such as a device known as a balloon pump, which may be used following cardiac surgery. The manager and clinical leads recognised there was a risk staff would not be able to, or feel competent to, use this device as it was used so rarely. The manager explained additional training was being organised for staff. In addition, the perfusionist (staff member who manages the physiological and metabolic demands of the patient during cardiac surgery) would stay onsite if a patient required additional support through the use of the balloon pump.

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 and effective multidisciplinary meetings to discuss patients and improve their care. Staff had access to physiotherapists and pharmacists onsite. Other healthcare professionals such as dietitians, occupational therapists and speech and language therapists could be arranged as required.

Staff told us they had good working relationships with consultants and were able to call them if they had any queries or concerns.

Seven-day services

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

Staff on wards could call for support from the critical care outreach team when the critical care unit was open. There was a designated member of staff assigned to this role but there was not an additional member of staff rostered to cover the outreach service. When the critical care team was not available staff could call the registered medical officer, who covered the inpatient wards.

Good

Critical care

Consultants led twice daily ward rounds, including weekends, when patients were admitted to the critical care unit. Patients were reviewed by speciality consultants depending on the care pathway.

Medical staff could refer patients for x-rays and CT scans during office hours. Out of hours and at weekends, these services operated an on-call services. Other diagnostic services such as magnetic resonance imaging (MRI) and echocardiology was available in office hours.

There was a service level agreement between the hospital and nearby NHS trusts concerning arrangements for transferred patients to an NHS facility for speciality or ongoing care. The agreements set out responsibilities for making arrangements but did not include criteria for the transfer of patients. All transfers were agreed by consultants at the hospital and at the receiving NHS hospital.

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.

Staff received specific training in how to assess mental capacity in addition to the annual safeguarding refresher training. Records shared with CQC following the inspection, showed 95% of the critical care team had completed this training. Staff received specific training on Deprivation of Liberty Safeguards to support them in effective decision making

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent was obtained at the pre-assessment stage when patients were booked in for planned surgery. We were told staff obtained verbal consent from patients admitted to the critical care unit for any interventions.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff did not receive specific training in Deprivation of Liberty Safeguards (DoLS). However, staff told us patients who required a DoLS were not admitted to the hospital.

Are Critical care caring?

Good

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

During the inspection, there were no patients admitted to the critical care unit, so we were unable to observe care given to patients. Following the inspection, we obtained consent to speak with nine patients about the care they had received there, and we looked at patient feedback.

Compassionate care

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

Good

Critical care

Staff told us they were discreet and responsive when caring for patients and took time to interact with patients in a respectful and considerate way. Staff built rapport with patients and showed their compassion in the way they spoke and interacted with patients. We spoke with nine patients who said staff treated them well and with kindness.

Staff said they understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients told us their needs were met when they were admitted to critical care unit.

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. One patient told us they reacted badly to a strong pain killer they were prescribed, and staff recognised this was distressing for them and immediately reviewed their medical prescription.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us staff drew curtains around the bed space to maintain dignity and privacy.

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. Patients and their next of kin confirmed staff had contacted them to provide updates about patients' condition following planned surgery.

There was no designated relative's room where staff could have private conversations with relatives. This had not been resolved since our last inspection in 2016 and was not in line with the Operational Policy for the Intensive Care Unit (2021). However, staff told us they could use an office within the department to speak to relatives. If relatives wished to stay in the hospital, they would be asked to sit in an allocated patient room on the ward. Staff kept patient's next of kin informed by telephone when required or to give an update.

Understanding and involvement of patients and those close to them

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

We spoke with nine patients. They were very positive about the care they received. They told us staff were kind and professional.

Staff made sure patients understood their care and treatment. Patients told us they felt informed about their treatment plan. However, some patients felt that they in hindsight would have liked more information about incidental care interventions and the possible side effects of those. For example, the possible side effects/complications of having a catheter.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this**.** Patients told us they received information about how to raise concerns or make a complaint, in the pre-assessment pack they received.

Patients gave positive feedback about the service. The service did not undertake patient satisfactory surveys for patients who were admitted to the critical care unit. However, all patients were asked to complete a feedback from, and information relating to critical care could be extracted from these. The hospital had collated 109 (48%) responses from

Good

Critical care

patients admitted to critical care from January to December 2021. The feedback was overwhelming positive with 105 patients describing the overcall care and treatment as 'very good'; the remaining four described the care as 'good'. Comments included: "Outstanding professional and compassionate", "At a time of worry & pain, I was looked after with the utmost care possible" and "treated with great care & commitment by all staff members".

Patient satisfaction survey (Friends and Family Test) data was submitted every quarter to the Spire Safety and Quality Risk Committee'. The response in Quarter 3 2021 (July to September) demonstrated that all (100%) patients, who provided feedback, thought care and treatment was 'very good'

Staff made sure patients and those close to them understood their care and treatment. Patients told us their next of kin had been contacted following surgery with an update. Staff enabled patients to speak with their next of kin on a unit phone if they did not have their own mobile phone. During and because of the COVID-19 pandemic, visitors were not routinely allowed in the critical care unit.

Are Critical care responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The service provided care and treatment for patients who were admitted to the hospital for planned surgery and needed critical care for a short period of time following surgery. Staff told us there were limited waiting times of one to two weeks for patients who were referred for private healthcare. All patient admissions were discussed in a weekly resource meeting. Staff discussed patients booked for surgery and who required critical care following surgery. Staff also discussed any specific patient needs such as if patients had a 'do not resuscitate' order or patients who had additional communication needs such as requiring an interpreter.

The service also provided critical care for patients whose condition deteriorated on the inpatient wards in the hospital. These patients were referred to the service by the resident medial officer and/or the outreach nurse.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had not been any breaches in the 12 months prior to our inspection.

Meeting people's individual needs

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

Staff told us they rarely looked after people with additional needs but gave examples of how they had made adjustments to meet the specific needs of patients. For example, patients who showed signs of delirium following surgery.

Good

Critical care

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Communications needs were assessed as part of the pre-assessment stage and discussed in a weekly resource meeting. This meant staff were aware if patients who were admitted to critical care had additional communication needs.

Staff had access to communication tools. The manager had introduced picture cards (laminated pictures of common actions to help patients communicate their needs such as being in pain).

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service provided critical care for patients who required a higher level of care for a short period of time after their surgery. Managers worked together to ensure there was a bed available for patients booked for surgery.

At times, patients whose condition deteriorated were admitted to the critical care units from the general ward in the hospital. Between February 2021 and end of January 2022, there were 36 unplanned admissions to the critical care united from the inpatient wards. Data showed 90% of these patients had been admitted within four hours from when the decision to admit had been made, in line with national guidance.

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.

See also the surgery report.

Patients, relatives and carers knew how to complain or raise concerns. Patients received information about how to raise a formal complaint or any concerns in their pre-admission pack. Information was also available on the hospital's website.

The service clearly displayed information about how to raise a concern in patient areas. We did not see any information about how to raise a formal complaint or raise concerns, displayed in the critical care unit. However, patients told us this information was shared in the pre-admission information they had received.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff but learning from complaints was not a standard agenda item for team meetings.

Good

Critical care

Are Critical care well-led?

Good

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

See also surgery report.

Leadership

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

There were communication pathways from the senior management team to staff working on the unit. Information was shared informally, by email or in meetings which were minuted for staff who were not able to attend.

Staff spoke positively about the unit's leadership and the hospital's senior leadership team. Staff told us leaders were supportive and accessible. Staff spoke of good leadership skills from people providing senior management at the hospital. Staff described them as being approachable and having a vision for the hospital but acknowledged this would take time to achieve. Staff told us the new senior leadership team had introduced a cultural move away from getting as many patients through the hospital as possible to an ethos of providing good patient outcomes and patient experiences.

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.

There was a corporate ambition to offer excellent standards of customer service, patient safety and clinical accountability. The critical care unit had a strategy for January to June 2022 which focussed on establishing a clinical workforce and provide safe and effective care. There was an aim to open the unit 24 hours a day and seven days a week to meet growing demand. Staff we spoke with were aware of the strategy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in 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.

See also surgery report.

Staff were positive and stated they were proud to work for the service. Staff felt supported, respected and valued.

There were regular staff meetings for nursing staff in the critical care unit. We reviewed minutes of the last three meetings (September 2021, November 2021 and February 2022). *The meetings did not follow a set agenda item and there was limited evidence that learning from audits, incidents and/or complaints was consistently discussed in these meetings.*

Good

Critical care

There were limited arrangements for where staff could take a break because of the impact of social distancing requirements during the COVID-19 pandemic. Staff used the canteen for their meal breaks, but not all the resident medical officers were aware of a designated room or office where they could sit when they were not required to be present on the unit.

Staff told us they felt able to speak up and raise concerns without fear of retribution. They were aware of who the freedom to speak-up guardian was and how to contact them.

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.

See also the surgery report.

There were effective governance structures to evidence the quality of care delivered. Information was shared twice a day in safety briefings to ensure all staff working in the critical care unit received essential information for the safe delivery of care. There were monthly clinical governance meetings which covered all services.

Staff were clear about the roles and responsibilities. Staff knew what was expected of them in their role and how to escalate concerns about clinical care.

The manager described an effective governance process to monitor, review and improve the quality of care delivered by the unit. There were monthly clinical governance meetings relating to critical care. These meetings reviewed incidents, outreach activity and audits carried out within the critical care unit. There was also a mechanism to capture positive outreach activity where a patient's deterioration had been addressed in a timely manner and ensured they received the right treatment at the right time via a service tracker.

There were quarterly morbidity and mortality review meeting which covered the whole hospital. All deaths, including deaths of patients who received care and treatment from Spire Bristol within 30 days of their death, were reviewed.

Managers submitted data to a quarterly critical care report which was reviewed by a corporate 'Safety and Quality Risk Committee'. This report looked at data from all five critical care units in Spire Hospitals across England. Data was used to benchmark across critical care units located in Spire Hospitals and where possible, reviewed in line with national data/ averages. However, there were limited comparable rates available to support this due to the elective nature of the service. The report from quarter 3 2021 (July, August and September 2021) showed there were 11 unplanned admissions to critical care which was similar to two other critical care unit. There were five patients readmitted to critical care within 48 hours of being discharged and this was higher than in any of the other critical care units in Spire hospitals. The provider explained that due to the outreach service, patients identified as needing higher levels of observation were admitted to CCU for one on one nursing care to avoid the need for a transfer to an NHS hospital It was not clear from the report how these had been reviewed to identify learning or service improvement opportunities.

Management of risk, 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.

Good

Critical care

See also the surgery report.

There were systems to manage performance effectively. Clinical audits outcomes were captured in an electronic database. This provided clear oversight for managers and senior leadership regarding compliance. Where audit results indicated an improvement could be made, an action was recorded. We saw actions had been reviewed and closed as required.

There was a hospitals risk register which covered risks concerning the critical care unit. There were no risks directly related to the critical care unit. However, staff told us the biggest challenge and the biggest risk to their business, was the footprint of the unit and limited space to increase service provision, and recruitment and retaining staff for additional hours of opening the unit. This was not listed as a risk on the hospital risk register.

Staff were aware of a business continuity plan in the event of unexpected events. This included processes to ensure the continuing supply of electricity from a generator in the event of an electricity outage. However, staff were not aware of regular testing of the emergency generator.

Information Management

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

The service collected reliable data about performance and analysed this to identify when service improvements could be made. Data collected and added to the Spire central data base was reviewed and validated by the ward manager and the clinical lead before being added to a monthly report which was presented to the Spire board.

Staff had access to policies and procedures which were mostly stored electronically. Staff said they could easily find the information they needed.

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.

See also the surgery report.

The service carried out patient satisfactory surveys to gather the view and experiences from patients. Information was used to identify where the service could be improved.

Leaders encouraged staff to share their views. There was an annual staff survey. Staff attended team meetings and received emails and newsletters about updates about the hospital. Information was displayed on noticeboards in staff rooms.

Learning, continuous improvement and innovation

All staff we spoke with were committed to continually learning and improving services.

Staff told us about, and demonstrated they acknowledged the value of, engaging with service improvement initiatives.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

We have not previously inspected diagnostic imaging as a single service. We rated safe as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. At the time of our inspection, 96% of staff were compliant with training requirements and annual refreshers. This was better than the provider's target of 95% and the senior team were supporting staff to access their remaining training before the end of the financial year in March 2022.

The mandatory training was comprehensive and met the needs of patients and staff. All staff undertook a programme of 14 modules covering essential clinical and non-clinical areas such as fire safety, manual handling, and infection prevention and control.

Managers monitored mandatory training and alerted staff when they needed to update their training. The imaging manager ensured staff had protected time to complete training.

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.

Staff received training specific for their role on how to recognise and report abuse. All staff completed safeguarding adults and children level two training and 98% were up to date at the time of our inspection. Clinical staff were required to complete safeguarding adults and children to level three in line with national intercollegiate guidance. The provider had encountered barriers during the COVID-19 pandemic with bringing people together for this training and had instead implemented virtual training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding policies included explicit references to protected characteristics and provided staff with signposting to relevant legislation and support services. This reflected the embeddedness of safeguarding in the working culture and daily practice.

Good

Diagnostic imaging

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff understood the role of the local authority safeguarding team and knew how to contact them in addition to the provider's safeguarding leads.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had two safeguarding leads trained to level four.

Staff followed safe procedures for children visiting the department. A paediatric nurse from the children and young people's service would always accompany a child in the department for care.

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The infection prevention and control (IPC) lead and housekeeping manager carried out weekly cleaning audits of each scan room and considered performance by each subspecialty. In the previous three months, all diagnostics services achieved compliance with provider standards of between 95% in ultrasound and MRI to 100% in mammography and CT.

The service performed consistently well for cleanliness. Staff carried out a monthly infection IPC audit that included hand hygiene and environmental cleanliness. In the previous six months the department achieved an average of 96% compliance. All staff were required to complete infection IPC training and 98% were up to date with this.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning checklists were available for each area or room in the department.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff changed PPE between patients, and we saw consistent use of antibacterial hand gel.

Staff included PPE assurance in IPC audits, which demonstrated consistently good standards of practice. In the previous six months staff achieved 96% compliance with provider expected standards.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. An IPC link worked in each department and maintained an information board for colleagues relating to the latest policy updates, changes in guidance, and committee meetings.

Environment and equipment

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

The design of the environment followed national guidance. The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design and with DHSC HBN 00/10 in relation to infection control in the clinical environment. Safety signage was clearly displayed throughout the department, such as illuminated warning signs for X-ray and MRI.

The nearest automatic external defibrillator and resuscitation trolley were clearly signed throughout the department.

Good

Diagnostic imaging

Staff carried out daily safety checks of specialist equipment. MRI staff used protocols programmed into the MRI machine to prevent errors. The team completed a daily and weekly quality assurance record review of head and neck coils used.

The service had enough suitable equipment to help them to safely care for patients. However, X-Ray equipment was near the end of its useful life and cassettes were worn and needed to be replaced. Staff told us a new digital radiography machine would be installed soon.

All machines in CT had been serviced within the previous year and staff had managed any discrepancies. The radiation protection advisor (RPA) had declared machines were useable and safe. However, some RPA written reports had not been received and staff said they were up to three months late. The senior team were following up the RPA for these documents.

Staff disposed of clinical waste safely. The service used service level agreements to manage waste streaming, including the storage and disposal of hazardous waste, in line with DHSC Health Technical Memorandum 07/01 (2013) in relation to the safe management and disposal of healthcare waste.

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

Procedures to support staff in responding promptly to any sudden deterioration in a patient's health were inconsistent. During a recent crash call, the resuscitation team were delayed in treating the patient due to problems accessing the department. We discuss this in more detail in the incident section of the report. Following the incident, the service carried out simulation exercises with staff to improve practice. Joint procedures between diagnostic imaging and the site resident medical officer required them to carry out a series of steps before transferring a patient suspected of experiencing a stroke to an emergency care centre. This was not in line with national guidance and had the potential to delay emergency treatment.

The mammography team reported scan results within 48 hours and used an immediate emergency pathway to escalate urgent cases to radiologists.

Staff told us they did not carry out reject analysis audits in X-Ray. After our inspection, the provider submitted data that showed reject analysis took place monthly, with an average rate of 6% in the previous five months. We were unable to establish why the service did not share results with staff.

Staff completed risk assessments for each patient, using a recognised tool, and reviewed this regularly, including after any incident. There was a safety mechanism that meant if a scan presented a safety risk to the patient, staff would stop the process and liaise with the referrer for more information.

Staff knew about and dealt with any specific risk issues, such as pacemakers or metal implants. Staff carried out a safety checklist before each procedure and discussed contraindications with patients. Staff used a three-point ID check for each patient in line with national best practice.

Staff shared key information to keep patients safe when handing over their care to others. This included when discussing scan results with referrers and when transferring patients to other hospitals or services.

Shift changes and handovers included all necessary key information to keep patients safe. The team met daily for a safety huddle before the clinic opened and reviewed specific risks. The team used the huddle to identify challenges to the smooth operation of the service, such as staffing pressures or probably bottlenecks in flow through the department.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. There were inconsistencies in understanding of inductions for agency staff.

The service had enough scanning and support staff to keep patients safe. A team of 22 staff, including six bank staff, provided care. This included subspecialty staff such as 11 X-Ray radiographers, six MRI radiographers, and one MRI radiographer and mammographer. Two healthcare assistants worked across the department providing a range of support to patients and colleagues.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. The service was operating at maximum capacity for the equipment and staffing available.

The manager could adjust staffing levels daily according to the needs of patients. The bank team provided flexible availability to support this approach.

The service had reducing vacancy rates with three full time equivalent (FTE) vacancies at the time of our inspection. The senior team described significant difficulties in recruitment and noted there was no provider-level plan to address this.

The service had low rates of agency staff usage. In the previous three months, agency staff provided the equivalent of 2.75 FTE cover in the X-Ray unit, which reflected 13% of overall staffing. This was the only modality in which agency staff regularly worked. The senior team noted ongoing difficulties in securing an suitable skill mix of agency staff across modalities.

We were not assured agency staff always had up to date specialist training. For example, two agency radiographers who worked in X-Ray had not used the type of equipment in place for over five years. While the staff worked safely and competently, the senior team had not evidenced any checks on equipment training.

As part of their induction, agency staff were required to complete competency documents for each room and worked with a supervisor until these were completed. This meant that if there was a model of equipment they were unfamiliar with, they would be fully trained prior to being permitted to work unsupervised in that room.

The provider audited compliance with radiation badges on a quarterly basis. This was a sample of all staff working on one day. While the audit reflected good practice, the occasional sampling approach meant the service could not be assured it included a good range of staff. For example, agency staff working on the day of our inspection said they had not been included in the most recent audit. This meant the senior team were not assured agency staff maintained acceptable, safe levels of radiation exposure

Agency staff we spoke with did not think they had undergone a full induction. However, after our inspection the provider sent us evidence that all agency staff had completed an induction. This presented a potential risk because we found inconsistencies in how senior staff monitored and implemented agency staff radiation monitoring. For example, there was no record of recent competency training on the service's computed radiography system. However, our observations found the agency team delivered very high standards of care to patients.

Good

Diagnostic imaging

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, and all staff could access them easily. Staff audited patient records for quality and safety standards on a quarterly basis. Audit data reflected consistently positive standards of practice and in the previous 12 months the team achieved 95% compliance.

Staff documented a clear conclusion in the diagnostic reports we looked at, which reflected the Royal College of Radiologists' reporting standards.

When patients transferred to a new team, there were no delays in staff accessing their records. The provider used an integrated system that meant some records were digital and some were paper based. Staff in any of the provider's network could access records when patients moved to their service and staff transferred records to NHS providers on request.

Records were stored securely. Digital systems were encrypted with restricted access and a dedicated medical records team managed paper records in an on-site, secure facility.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff used patient group directions (PGDs) to administer contrast when conducting scans. PGDs enable non-prescribing staff to administer specific medicines within pre-defined criteria for specific categories of patients. The provider identified a need to audit PGD processes in November 2021 and planned to introduce the process from July 2022.

Staff stored contrast safely in a locked cupboard. They monitored and recorded temperature daily and all contrast in the cupboard was in date. Consultants leading the ultrasound service stored steroid injections for treatment of conditions. They stored medicines securely and checked temperatures to ensure they remained within the safe range prescribed by the manufacturer.

Staff completed medicines records accurately and kept them up to date. They recorded contrast clearly in patient records.

Staff learned from safety alerts and incidents to improve practice. Medication incidents were rare, and staff recorded one in the previous 12 months.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them. 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 support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good

Diagnostic imaging

Staff knew what incidents to report and how to report them. The provider used a standardised electronic incident reporting system across all departments. This meant staff had straightforward access to a single system to report incidents, accidents, and near misses. In the previous 12 months staff reported 25 incidents, of which 20 were clinical and five were non-clinical.

The senior department team categorised incidents to identify themes and trends as part of risk reduction strategies. Radiology was the most frequent category of clinical incidents and reflected 50% of those reported with six additional categories including service failure (15%), treatment (15%) and falls (5%) or equipment failure (5%). Of the non-clinical incidents, three (60%) related to personal data and two (40%) related to health and safety.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The provider launched a video for staff that presented mistakes and errors in care that should be reported using the incident reporting system. This reflected positive practice and helped staff to visualise incidents to report that they might rarely experience.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The provider's incident management policy established the threshold to guide staff when to use the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. A recent incident involved a patient who had deteriorated in the department and required the attendance of the crash team. Emergency care was delayed because the team had difficulty accessing the MRI department due to safety restrictions. The senior team Implemented new access controls to prevent a recurrence.

Staff met to discuss the feedback and look at improvements to patient care. Staff implemented a range of improvements to operational and administration systems as a result of incidents. For example, the imaging team, breast surgeons, and nurses had worked together to launch a new communication standard between them to avoid overbooking in the mammography service. The service had recruited additional porters and administration staff and secured a new ultrasound machine to improve overall reliability.

Are Diagnostic imaging effective?

Inspected but not rated

We have not previously inspected diagnostic imaging as a single service. We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

The service provided most care and treatment based on national guidance and evidence-based practice. Managers did not consistently follow national guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service complied with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). This included physically and distinctively separate areas and pathways for patients based on whether they were undergoing scans with or without ionising radiation. The service displayed clear signage when IR(ME)R procedures were in progress, including illuminated signs.

Good

Diagnostic imaging

A radiation protection supervisor (RPS) was in post and staff knew how to contact them. The RPS maintained oversight of local rules, which guided staff in safe practice that met national standards. The RPS and senior imaging team had implemented protocols for non-medical referrals to the imaging service. This included training on safe processes for referring staff and with radiologists for accepting referrals.

The overarching clinical audit plan was standardised nationally by the provider. Twelve audits related to diagnostic imaging, which helped to benchmark practice against national standards.

Mammographers carried out a sample of 10 peer reviews every quarter as part of the service's work to ensure practice was in line with national standards. Peer reviews were comprehensive and involved a 13-point check of imaging quality. Peer reviews identified consistently good standards of practice with 99% compliance against expected standards in the previous 12 months.

Staff audited practice against the World Health Organisation (WHO) imaging and 'pause and check' standards. In the previous 12 months the service maintained consistent standards and compliance was between 88% and 100%.

The service was compliant with the Royal College of Radiologists guidelines and the radiation protection advisor (RPA) carried out an external audit every three years. The most recent audit took place in 2019. The RPA found overall good standards of practice and made 14 recommendations for improvement. The provider had acted on all recommendations and the next audit was due in late March 2022.

We were not assured of adequate compliance with national guidance in radiation protection procedures in relation to agency staff. Two agency radiographers were operating the X-Ray service and were not visibly wearing radiation measurement personal monitors. The radiation protection supervisor (RPS) told us they expected the agency to supply such devices. There were no checks to ensure such a safety measure was in place. We found the agency staff were carrying badges but had these in out of sight in their pockets. While there is no requirement for badges to be visible if a lead apron is not worn, the position of the service on this matter did not follow best practice. This was because relying on an agency to provide a personal monitor whenever staff worked in different hospitals meant there was no reliable way for a radiation protection advisor (RPA) to identify where an overexposure had occurred during six monthly monitoring.

The senior team kept local radiation dose reference levels (LDRLs) that could be compared to national levels (NDRLs), which is a process used to check optimal use of medical exposure. Local rules for X-Ray were up to date and readily available.

A consultant led the ultrasound service, which meant they authorised and consented procedures in line with British Medical Ultrasound Society (BMUS) policies.

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. Most pain experienced in the imaging department could be managed with painkillers available in the department.

Patients received pain relief soon after requesting it. Consultants were available on site to support with pain medicine administration.

Staff prescribed, administered and recorded pain relief accurately. They documented this in patient records and informed the referrer of the need for pain relief.

Patient outcomes

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

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. The service had a standard target for scan reporting of five days, which was in line with national practice. In the previous 12 months the service performed consistently better than the target with typically short turnaround times. This included an average turnaround time from scan to report of 2.2 days in CT and 1.8 days in MRI and X-Ray. Staff reported ultrasound findings on the same day as the scan.

Staff carried out audits in some modalities to check improvement over time. Radiologists provided consistently positive feedback to MRI staff regarding the quality of examinations. Turnaround times were between two and three days for contrast examinations and between four and five days for musculoskeletal (MSK) scans.

Managers used information from audits to improve care and treatment. Where errors occurred in the reconstruction of images, the service obtained a maintenance and performance check of the CT machine and carried out quality checks. These found results were within an acceptable range.

All protocols in use in the department were complete and up to date. A radiologist protocoled each patient undergoing a CT scan in line with IR(ME)R guidance.

Staff completed reports within 24 to 48 hours for contrast scans and within four days for non-contrast scans.

Quality assurance and audit standards for ultrasound reflected national best practice and consultants reported scans immediately.

The service was accredited as a national centre of excellence for breast care.

The service scanning criteria ensured the most appropriate staff always carried out each scan. For example, a radiologist justified and protocolled CT scans, a radiographer vetted MRI scans and radiologists carried out ultrasounds. This structure enabled scans to proceed safely and meant the team could raise the issue of inappropriate referrals quickly.

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. Senior staff supported and promoted specialist development. For example, a healthcare assistant was undertaking an assistant practitioner course to help them develop skills in the mammography service.

Good

Diagnostic imaging

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. The provider used a bespoke appraisal and supervision system called 'Enabling Excellence' (EE). This provided staff with an annual structure that support setting objectives, interim reviews and an end of year review. The process included peer reviews, such as for cannulation good practice.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The MRI team had trained colleagues from other modalities to safely carry out scans in line with national guidance. This helped to improve capacity and maintain stability in the department.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff maintained up to date training on the safe use of equipment in line with their professional registration and manufacturer guidance.

Managers made sure staff received any specialist training for their role. Radiographers maintained registration with the Health and Care Professions Council (HCPC).

Results from the latest staff survey indicated a need for improvement in developmental opportunities. For example, 50% of staff said they had opportunities to learn and grow in the previous year. This was 14% worse than the national result in the provider's survey. Similarly, 59% of staff said they felt encouraged to develop at work, which was 8% worse than the provider's national results. In response the imaging senior team prepared an action plan that involved encouraging the team to undertake study days and facilitate role adaptations.

Multidisciplinary working

Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held multidisciplinary meetings to discuss patients and improve their care. This occurred on an ad-hoc basis when staff planned care for patients with complex needs and when multiple professionals or agencies were responsible for a patient's care.

Patients could see all the health professionals involved in their care at one-stop clinics. This included the breast clinic where patients saw a consultant, nurse specialist, and imaging staff in the same appointment.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, staff liaised with referring officers and GPs to discuss scan outcomes and establish care plans.

Staff referred patients for mental health assessments when they showed signs of mental ill health such as depression.

The imaging manager had implemented a range of planning to expand multidisciplinary working. They planned to establish a multidisciplinary rapid diagnostic centre in late 2022 as part of the department's vision. The manager had arranged training for CT radiographers to administer beta blockers, which would enable the service to offer a combined CT and cardiac service.

Seven-day services

Key services were available to support timely patient care.

Good

Diagnostic imaging

Staff could call for support for diagnostic tests out of hours. Staff provided an on-call X-Ray and CT service overnight and provided routine weekend care. Out of hours, the service used an emergency teleradiology service to provide reporting and diagnostic support. This enabled staff to obtain diagnostic decisions without the benefit of a fully staffed department on site.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. Staff took particular care to provide health promotion support for patients who may be pregnant. This helped to protect them from harm.

Staff provided health promotion information and signposting to specialist services, such as for cancer support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Referring officers provided information to support staff delivering care with patients experiencing mental health issues. A resident medical officer (RMO) was always on duty in the hospital and supported the imaging team to manage mental health needs.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent was included in the MRI pre-scan safety checklist and in our observations, staff were thorough in their discussions with patients. For example, where patients had risk factors or contraindications, such as a pacemaker, staff took time to explain risks so that patients had a full picture before providing consent.

When patients did not have capacity to consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. A dedicated best interests group worked across the hospital to support departmental staff in meeting individual needs and obtaining consent when they had concerns about mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). This formed part of mandatory training. It was very rare for a patient with a DoLS authorisation to be cared for in the department. Staff maintained up to date awareness of legislation as good practice.

Are Diagnostic imaging caring?

Good

We have not previously inspected diagnostic imaging as a single service. We rated caring as good.

Compassionate care

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

Good

Diagnostic imaging

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. All staff completed 'compassion in practice' training as part of the provider's mandatory package. At the time of our inspection, 93% of staff were up to date with this.

Patients said staff treated them well and with kindness. Patient feedback was consistently positive. In the feedback survey one patient recently noted, "[Staff] who dealt with me in the imaging department were very kind and helpful." Another patient noted, "Everyone was polite and helpful."

Staff followed policy to keep patient care and treatment confidential. We observed staff act with discretion and protect people's personal information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients told us they felt respected by staff. One person said, "Everyone I've talked to was so approachable and caring."

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. Staff adhered to provider guidance when supporting carers or comforters to attend scans with patients. Staff recorded radiation doses for those present in line with Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) guidance.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The team used private, quiet spaces to carry out difficult conversations and made these available to patients and relatives on demand.

Staff undertook training on breaking bad news and how to demonstrate empathy when having difficult conversations.

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. We observed very high standards of compassionate care in the mammography service. Staff were sensitive, discreet and gave patients time to ask questions.

Staff maintained a faith room for patients to enable them to practice rituals whilst in the department.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed the MRI service and found staff were interactive in their approach and fully involved patients in the process. Patients said they were happy with the service.

Good

Diagnostic imaging

Posters in the department provided patients with information on when to expect results from the scans. Staff discussed this during each appointment and the posters helped reinforce the information.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patient feedback indicated good standards of practice. Recent comments in the patient survey included, "…the procedure was clearly explained to me", and one patient noted they received a, "…fast and clear explanation."

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff promoted the use of the provider's dedicated patient feedback portal, which provided patients and their loved ones with a variety of ways to communicate. The team's response to constructive feedback was nuanced and thoughtful. For example, positive patient feedback for the MRI service in January 2021 declined slightly and one patient noted they felt rushed through their appointment when the service had been busy. The senior team worked with staff to maintain usual standards of care during busy times to ensure patients were not impacted by pressures on the service.

Are Diagnostic imaging responsive?

Good

We have not previously inspected diagnostic imaging as a single service. 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.

Managers planned and organised services, so they met the changing needs of the local population. The imaging manager noted increasing demands for ultrasound and MRI and had prepared a business case to expand both services. The senior team worked with local NHS services to support their waiting lists by providing additional capacity.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Most specialist services in the hospital offered a one-stop service that enabled people to undergo diagnostic imaging, a consultation and blood tests in the same visit.

Facilities and premises were suitable for the services being delivered. Staff posted visual information around the department from relevant organisations. This provided patients with information on safety guidance, such as the safety of X-Rays.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. Staff noted this was a rare occurrence as care was usually planned in advance to incorporate such additional needs.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted to check their wellbeing and offer an alternative appointment.

The service relieved pressure on other departments when they could treat patients in a day and provided support to the inpatient surgical team in providing mobile imaging services.

Good

Diagnostic imaging

Bank staff provided cover in specific modalities, which improved reliability and capacity. For example, a bank mammographer enabled the service to move from a three-day service to a six-day service.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff undertook training to help them adapt care and communication to meet patient needs.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. The national imaging lead had prepared guidance for staff in planning and delivering care for patients who needed language interpretation. This supported staff to ensure they could obtain consent and fully explain complicated processes to patients through an interpreter.

Staff had access to communication aids to help patients become partners in their care and treatment. The provider coordinated communication aids and tools against the formats required to meet the national Accessible Information Standard.

Staff adapted communication tools to meet people's needs. For example, the provider had systems that enabled staff to use secure text messages and e-mails with patients.

Posters were displayed in the department with details of interpreting services translated into nine key languages spoken in the region.

The imaging team were dedicated to ensuring care and services were tailored and met individual preferences. For example, the administration team had introduced a new trial process to assist patients with needs relating to phobias such as needle phobia and claustrophobia. Where a patient disclosed such a need to the reception team, they used a discreet sticker on the patient request form to alert the radiographer. A similar system was already in use for patients with needs relating to dementia, language support, and physical disability.

Staff used the capabilities of scanning equipment to support patients and reduce anxiety. The ultrasound room had mood lighting and the MRI scanner had speakers that meant patients could listen to music.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Good

Diagnostic imaging

The service provided scans to a mix of private and NHS patients. The service required all patients to have a referral that indicated a clinical need for a scan and did not typically accept self-referring patients.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

The service monitored patient experience of waiting times from arrival in the hospital to being seen through a survey. Between February 2021 and January 2022, an average of 53% of patients said they strongly agreed with the statement 'I was seen on time'. This reflected a range of monthly results between 39% and 60%.

Managers worked to keep the number of cancelled appointments to a minimum. Staff proactively reported incidents relating to access and flow, such as service suspension. The senior team responded quickly to such occurrences and implemented improvements.

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 concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to manage them. The provider had a standard complaints policy that applied to all services. Staff spoke positively about complaints and how they provided an opportunity to learn and develop the service.

Managers investigated complaints and identified themes. In the previous 12 months the service received 39 complaints, which was 0.1% of all scans delivered.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The imaging manager was working with the administration team to improve pre-appointment information for patient to manage their expectations of time needed in the department.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Are Diagnostic imaging well-led?

Good

We have not previously inspected diagnostic imaging as a single service. We rated well led as good.

Good

Diagnostic imaging

Leadership

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

An imaging manager and deputy imaging manager led the day to day operation of diagnostic imaging. Individual services had a lead or named point of contact, such as the lead MRI radiographer. A new CT lead had joined the hospital two days before our inspection. They were working to support the modality team following the departure of their predecessor.

There had been a change of leadership in November 2021 and the new imaging manager was working to stabilise the team. A national clinical specialist for imaging worked at provider level and visited the department regularly to support the new manager and team.

Staff reported positive relationships with the leadership team in the 2021 staff survey and results were better than the national average across the provider's hospitals. For example, 92% of respondents said they felt supported by their manager, which was 11% higher than the national result.

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 new imaging manager had worked with the team to establish a departmental vision. This established aims and goals at key stages in 2022 and was benchmarked by achievements such as securing a second MRI machine or establishment of a rapid diagnostics centre.

We refer to the provider's overarching vision and strategy in our 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. Staff said the service had an open culture where they could raise concerns without fear although staff survey results contradicted this to some extent.

Staff had access to a comprehensive range of support in the event they needed to escalate a concern, including through an anonymous whistleblowing policy. This included access to a corporate concerns team and external, independent services. Staff spoke positively of this system and knew they could contact their local Freedom to Speak Up Guardian at any time.

However, results from the most recent staff survey indicated 75% of staff knew who their Guardian was, which was 17% worse than the provider's national average in imaging. In the same survey, 67% of staff said they felt comfortable raising concerns about safety or risks in the department. The senior team included these areas in an action plan for improvement.

Good

Diagnostic imaging

Results from the most recent staff survey, in 2021, indicated room for improvement in the culture. For example, 75% of respondents said they had trust and confidence in the CEO, which was 3% worse than the national average in the provider. In the same survey, 59% of staff said they were excited about the future of the provider, which was 11% worse than the national figure.

Some staff told us they felt modalities worked in silos and were disconnected from the rest of the department. For example, staff in CT, MRI, and X-Ray had different levels of understanding of local safety and quality monitoring procedures and appeared to be individual departments. This was reflected in the wide variances we found in staff understanding of policies and guidance.

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. Staff understanding of quality assurance was inconsistent.

The clinical governance team met monthly to review imaging standards of practice and audit results. This was more frequent than the provider's general standard of a quarterly meeting and took place at hospital level, with representation from each department and core service.

The provider had received approval to deliver services with ionising radiation from the Health and Safety Executive (HSE) in line with national guidance.

The provider's safety and quality review in quarter four of 2020 approved a proposal to bring the imaging service in line with Royal College of Radiologists (RCR) standards in NHS trusts by implementing the radiology events and learning meetings (REALM) process. The REALM framework is a national standard that facilitates discussions between radiologists to identify learning as part of continuing professional development. The safety and quality team had reviewed regional processes used by NHS trusts to adapt their model to the independent sector. The senior imaging team were working with radiologists to implement an adapted version of REALM that reflected the nature of the working environment, such as practising privileges. The team expected this process to develop during 2022 and had begun with new acceptance requirements for radiologists that required them to have a track record of engagement with REALM at their substantive NHS place of work.

National dose reference levels (NDRLs) were up to date in all areas. Local rules were displayed in CT and were in date although they did not include the name of the radiation protection advisor. The provider told us staff had access to the radiation protection advisor contact information through other displays in the department.

The senior team used a monthly safety alert bulletin to notify the whole team of information from the central alerting system (CAS) that would impact practice.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, they did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. They had plans to cope with unexpected events.

Good

Diagnostic imaging

The senior imaging team monitored risks on a quarterly basis within the provider's overarching risk register and management process. There were three key risks at the time of our inspection. These related to an increased risk of a data breach due to the positioning of a computer, a risk relating to equipment failure due to aging technology, and a risk of delayed access to historical patient records due to an outdated storage system. Each risk had a control measure in place and the provider was investing in new technology and capital replacement projects in 2022.

The radiation protection committee met annually. Meeting minutes for the previous three years reflected how safety and governance were embedded into service delivery and planning. The most recent meeting included a review of safety training protocols to include local rules and a review of the provider's updated radiation protection policy. The provider updated this in 2021 as part of a three-year cycle and mechanisms were in place to update the policy if national guidance changed in the meantime.

The senior imaging and site teams used a daily safety and operational dashboard to identify risks and challenges in the service. The most recent data from six audits, measured quarterly, formed part of the dashboard. Staff used these data to focus on areas for improvement and maintain standards in areas that performed well.

Quality assurance and risk management in X-Ray were inconsistent. There was a lack of oversight of the safety of agency staff and gaps in auditing processes. The staff working in X-Ray did not know how to carry out quality assurance processes relating the monitoring or local radiation dose reference levels (LDRLs) and we were not assured the senior team conducted such checks consistently.

The radiation protection supervisor carried out quality and safety checks on CT equipment and these checks were documented and audited regularly. After our inspection the provider carried out checks and told us the senior imaging team were fully aware of local governance. We were unable to establish why this differed from our findings on site.

Information Management

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.

All staff were required to complete information governance training and 98% were up to date with this. Staff used their training to work within the provider's data protection policies and ensure they avoided risks associated with data breaches.

Staff worked within the guidance of the provider's confidentiality code of practice. This ensured they protected patient identifiable data and acted with integrity when handling personal information. The data protection officer, senior information risk owner, and Caldicott Guardian provided advice and guidance to staff on demand.

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.

The provider carried out a staff survey in 2021 as part of an ongoing strategy of engagement and wellbeing and reviewed results and feedback at department level. This reflected good practice and meant staff at all levels could consider how to maintain or improve the working environment. Of the imaging team members who took part, 75% said they were

proud to work for the provider. This reflected an 8% improvement on the previous staff survey. However, results overall were 7% worse than the national results and reflected areas that needed significant improvement. The senior team had prepared an action plan to address poor results, including improving morale through actions such as study days, better use of rewards, team building exercises and advanced practitioner training. New leadership had implemented a new meeting schedule and daily safety huddles.

The most recent staff survey asked if there had been meaningful change in the previous year as a result of past feedback. Staff responded negatively and 42% said they felt changes had been implemented.

The provider had implemented new communication strategies with staff during a change of leadership process in November 2021. This had led to the temporary suspension of whole team meetings and the provider engaged with staff regularly to support them and keep them up to date. The new imaging manager was in the process of developing a new communication plan for 2022 that would enable the team to meet within the pressures on the service. The manager had restarted team meetings from February 2022.

Patient feedback was a standing agenda item in team meetings and minutes showed staff acted in response. At the time of our inspection overall feedback was high, with a 95% satisfied rate reported by patients.

Staff worked transparently with patients. For example, the imaging department publicised average reporting times each quarter and instructed patients how to follow up if they received no contact after five days.

The senior team described a good working relationship with local NHS health boards and said they worked together to improve capacity and flow through the regional health system. The team had service level agreements with other hospitals in the provider's network and provided reciprocal support in the event of equipment failures or other service disruption.

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 provider had introduced quality improvement training for all staff as part of their work with staff to be involved in service delivery and development. At the time of our inspection 95% of staff had completed this.

The imaging team had designed and implemented a framework that enabled MRI radiographers to offer a cardiovascular magnetic resonance (CMR) alongside the resident medical officers in the hospital. This enabled the service to operate five days per week without the need to pre-book a cardiologist and meant radiologists could offer greater flexibility for diagnostics appointments.

The service had made significant investment in new X-Ray equipment including a mobile machine, theatre c-arm, and a digital X-Ray room due for installation later in 2022. The new equipment would enable the service to increase capacity and reliability.

The service was in the process of implementing new technology to enable cardiac radiologists to carry out more thorough scans. Two cardiologists who worked in the service informed the decision-making process by using the outcomes of their research to ensure scanning processes were effective and based on the latest understanding.

Good

Diagnostic imaging

The service had procured a dedicated cardiac imaging workstation that helped to expand the services available to patients.

The provider had implemented new CT software called single energy metal artefact reduction (SEMAR) that enabled radiographers to more accurately report on the results of scans in patients with metal protheses, such as stents and pacemakers. Staff used this software alongside the latest adaptive iterative dose reduction (AIDR) 3D scanning system that enabled high-accuracy scans with minimal radiation doses.

The service had implemented the lean methodology to as part of a strategy to improve working efficiency. Staff had developed a system where all preparation procedure items, such as contrast cannulation, were stored together. This meant all items needed were in the same drawers or compartments and were labelled. This could avoid mistakes, stops waste, quickens procedures, and mad the process more streamlined.

The service had increased capacity for patients referred by NHS services for cancer imaging. The imaging manager aimed to develop the service into a centre for excellence.

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

We have not previously rated outpatients as a single core service. We rated safe as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. The provider had a 14-module package of mandatory training, which all staff completed on joining the service. They then completed refresher training annually or more often where guidance or standards changed. At the time of our inspection, 97% of staff were up to date. This was better than the provider's target of 95% and the senior team were supporting staff to complete remaining training to meet the end of year deadline.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The service provided pre-planned care, which meant staff would be aware of needs relating to learning disabilities and dementia in most cases.

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.

Staff received training specific for their role on how to recognise and report abuse. All staff were required to maintain safeguarding adults and children training to level two. At the time of our inspection 100% of staff were up to date. Designated clinical staff were required to complete training to level three in line with intercollegiate guidelines. All staff had taken initial training and the provider was working with partners to secure refresher training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff said they felt this was embedded in their induction, training, and policies and were confident they knew how to act in someone's best interests.

All staff were trained to act as a chaperone. The booking team offered chaperones to patients in advance of appointments and clinical staff could arrange them as needed on the day of an appointment. This helped to provide safety reassurance for vulnerable patients.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Two safeguarding leads were trained to level four and all staff we spoke with knew how to escalate concerns. Staff maintained up to date contact information for the local authority safeguarding team and knew how to contact them if they needed support in addition to the provider's team.

Staff did not always follow consistent safe procedures for children visiting the department. A paediatric nurse would usually accompany a child visiting the department, but this could not be guaranteed. Although the provider told us a separate waiting area was provided for children, staff on site said this was not always the case and children would sometimes need to wait in the main waiting area.

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff discussed infection prevention and control (IPC) issues before each shift in the daily safety briefing. Recent briefings reflected attention to detail, such as notifications when product availability or a local procedure changed.

The service generally performed well for cleanliness. All staff were required to complete IPC training and 95% were up to date with this.

Staff followed infection control principles including the use of personal protective equipment (PPE). Guides to the correct use of PPE were displayed in key areas and staff underwent training to ensure they used equipment correctly.

Environment and equipment

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

The design of the environment followed national guidance. The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design.

Staff followed national best practice in the tracking and traceability of cleaning of equipment used for ear, nose, and throat (ENT) procedures. Healthcare assistants (HCAs) played a key role in ENT equipment decontamination and undertook specialist competency training that enabled them to comply with manufacturer and national standards. The service was compliant with DHSC Health Technical Memorandum (HTM) 01/06 in relation to decontamination of flexible endoscopes. Staff carried out decontamination in utility areas clearly segregated as 'clean' and 'dirty' in line with best practice.

Staff disposed of clinical waste safely. The service used service level agreements to manage waste streaming, including the storage and disposal of hazardous waste.

Good

Outpatients

The service was compliant with DHSC HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste. Staff labelled sharps bins on first use, stored them off the floor, and ensured the aperture remained closed.

The head of department carried out a quarterly fire safety risk assessment. This included environmental checks as well as checks on staff knowledge about local procedures in the event of an evacuation. During our inspection we found comprehensive fire safety protocols and each team and area of the building had specific actions to take in the event of an alarm.

Staff carried out daily safety checks of specialist equipment. Equipment manufacturers carried out annual services on all equipment and staff arranged interim maintenance in the event of a technical problem. The outpatients manager stored comprehensive maintenance records and all items we checked were up to date.

The service had enough suitable equipment to help them to safely care for patients. Outpatients and physiotherapy outpatients each had resuscitation equipment for adults and children. This included automatic external defibrillators (AED), airway support equipment, and emergency rescue medicines. Signs depicting the location of the equipment were posted throughout the department and staff documented daily and weekly checks on equipment.

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 responded promptly to any sudden deterioration in a patient's health. They followed established escalation pathways depending on the nature of the problem.

Staff knew about and dealt with any specific risk issues. Staff demonstrated a good understanding of patient risk and how to act on uncertainties or concerns. For example, a physiotherapist described how they acted on 'red flags' during therapy sessions, which helped to identify needs such as areas of pain or safeguarding.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Clinical staff at all levels understood how to begin this process. All staff were trained in de-escalation techniques.

Staff shared key information to keep patients safe when handing over their care to others. This ensured continuity of care when people moved between services or received care from different staff in this service. For example, a significant proportion of work in outpatients involved caring for patients on a pathway that required diagnostic imaging and surgery. Consultants and surgeons worked closely together to ensure transfers between types of treatment were safe and informed by effective planning.

Shift changes and handovers included all necessary key information to keep patients safe. Staff included information on specific, individual needs during handovers. This reduced the need for patients to repeat requests to different members of staff.

Staffing

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

Good

Outpatients

The service had enough nursing and support staff to keep patients safe. Twenty staff delivered the outpatients service including nurses, HCAs, administration staff and consultants working under practising privileges.

Managers accurately calculated and reviewed the number and grade of nurses and HCAs needed for each shift in accordance with national guidance.

The manager could adjust staffing levels daily according to the needs of patients. The senior team demonstrated a proactive, responsive approach to recruiting staff to address specific needs or identified gaps. For example, the service had recruited a new HCA to support the ophthalmology clinic alongside four ophthalmology consultants and two nurses.

The service had low sickness rates. In the previous 12 months, outpatients reported a 4% absence rate, which included the impact of the pandemic.

The service used a dedicated team of bank nurses to support sustainability and capacity planning. The bank team maintained the same mandatory training, appraisal, and supervision requirements as permanent colleagues. Managers made sure all bank staff had a full induction and understood the service.

Consultants led specialist clinics with support from nurses and HCAs. Consultants worked substantively for other healthcare providers and delivered care and treatment under practising privileges with agreed time commitments to this clinic. A single point of contact consultant lead was always available when the service was open and provided consultants with on-demand support and guidance, such as with navigating external referral pathways and accessing specialist services for patients.

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, and all staff could access them easily. Records were paper based, and a dedicated medical records team supplied these in advance of a clinic.

Staff audited patient records for compliance with the provider's standards. The most recent audit found 100% compliance.

When patients transferred to a new team, there were no delays in staff accessing their records. Medical secretaries ensured referrals and shared documentation was processed in a timely manner when care was shared with other providers.

Records were stored securely by the medical records team. The team was based on site and ensured storage was safe and secure.

Medicines

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

Good

Outpatients

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. The team used learning from an incident to change the management of keys to access the area used to securely store prescription pads. The new process improved speedy access and security.

Staff carried out monthly medicines management audits to monitor storage and security. In the previous 12 months the audit demonstrated 94% compliance. This reflected a range from 79% to 100%. Staff took action to improve standards and consistency. For example, one audit found an expired medicine, which lowered the audit score. The team found this occurred during a change of staffing structure, which meant there were changes to allocations. They resolved the issue and the service returned to compliance.

Consultants reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. On site pharmacists provided medicine support on demand and the duty resident medical officer (RMO) was available for additional help.

Staff worked together to improve medicines management processes. The pharmacy team worked with the RMO and consultants to reduce reliance on urgent or unplanned prescriptions, which resulted in lengthy waits for patients during busy periods. The new approach meant doctors planned prescriptions in advance where possible, which helped to manage pharmacy capacity.

Incidents

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

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Staff knew what incidents to report and how to report them. They used the provider's electronic incident reporting system, which senior staff used to track, investigate, and progress learning from incidents.

Staff knew how to report serious incidents clearly and in line with the service's policy. The service reported no never events or incidents that met the criteria of the national serious incident framework in the previous 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

Staff met to discuss feedback and look at improvements to patient care. Staff reviewed all incidents to identify themes and opportunities for learning and changes in practice.

There was evidence that changes had been made as a result of feedback. For example, the administration team established closer working with medical secretaries to ensure they were appraised of clinic cancellations in advance.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and the provider clearly explained outcomes. The outpatients manager offered patients the opportunity to meet and discuss incident investigations on completion.

Good

Outpatients

Are Outpatients effective?

Inspected but not rated

We do not currently rate effective for outpatients.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider had a digital tracking system to document changes in policies and standard operating procedures. All staff had access to this, and the outpatients manager ensured staff maintained an up to date awareness.

The provider had a hospital-wide audit programme and the outpatients team participated in audits of relevance to the service. This included audits of emergency medical equipment, standards of patient records, pathology, and infection prevention and control.

Staff carried out audits to assess compliance with National Institute of Health and Care Excellence (NICE) guidance. This included the World Health Organisation (WHO) surgical safety checklist, which staff used during minor procedures to ensure safe practices. In the previous 12 months, staff achieved 100% compliance in all but one month when there was a drop in the correct use of the time out procedure. In response the theatre team delivered training to the outpatient team and introduced new documentation.

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. This was not common practice in outpatients and nurses followed the process if patients noted pain when they arrived in the department. Staff carried out a post-appointment wellbeing check with each patient, which included a check of pain. The team arranged appropriate follow-up such as a prescription for analgesia or a return hospital appointment.

Staff prescribed, administered and recorded pain relief accurately. Physiotherapists asked patients about comfort and pain during sessions. They supported patients with pain-relieving rehabilitation exercises and contacted appropriate clinicians where prescribed pain relief was needed.

Patient outcomes

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

Physiotherapists planned and delivered care based on protocols issued by consultants with each referral. Consultants provided a response within 24 hours where staff needed clarity or more information on a referral.

Good

Outpatients

Outcomes for patients were positive, consistent and met expectations, such as national standards. Physiotherapists used three outcome scales to measure the impact of care. Staff chose the most appropriate measure based on each patient's care plan. Staff used the results to improve patients' outcomes.

The service had standard operating procedures for unplanned transfers to other departments or services. For example, the team liaised with the inpatient ward nurse in charge to arrange unplanned readmissions. The resident medical officer reviewed the patient and ensured readmission was appropriate.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The pathology service carried out a rolling audit of turnaround times for in-house tests for outpatients. Across the key modalities of haematology, coagulation, and biochemistry, turnaround times were consistently within the provider's four hours target. In the previous 12 months, 97% of pathology was processed within four hours. Managers used information from the audits to improve care and treatment.

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. The hospital participated in the provider's national healthcare assistant (HCA) development programme.

Managers gave all new staff a full induction tailored to their role before they started work. Physiotherapists new to the service worked with two mentors during their initial period. A recent new starter said their induction had been, "very well thought through." The administration team spent half a day with each member of clinical staff new to the service to help them orientate themselves to local processes.

Managers supported staff to develop through yearly, constructive appraisals of their work. The provider used a bespoke appraisal and supervision system called 'Enabling Excellence' (EE). This provided staff with an annual structure that support setting objectives, interim reviews and an end of year review. Most consultants also worked in the NHS and underwent appraisal there. Where an appraisal did not incorporate independent practice, the provider required consultants to source a new appraisal that covered clinical services delivered at this hospital.

The provider and senior staff supported the learning and development needs of staff. Staff we spoke with said they were pleased with the opportunities for nurse apprenticeships and to complete National Vocation Qualifications. The results of the most recent staff survey indicated this view was not widely shared across outpatients although the senior team noted opportunities had been limited during the pandemic.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge although results of the most recent staff survey indicated this was an area in which staff would like to see more focus.

Multidisciplinary working

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

Good

Outpatients

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. This included meetings specifically to review individual patients and scheduled safety meetings to plan care and treatment. The breast care team held a meeting in advance of each clinic that reviewed consultant assessments, nurse-led care, and diagnostic results.

Patients could see all the health professionals involved in their care at one-stop clinics. Staff used referral pathways to ensure patients could see other professionals as part of care and treatment. This included referrals to physiotherapy services on site and to clinical specialists in other regional hospitals.

Staff referred patients for mental health assessments when they showed signs of mental ill health. The service did not offer a dedicated on-site mental health service and consultants referred patients to local independent or NHS services as needed.

Seven-day services

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

Both outpatients and physiotherapy outpatients operated six days per week, from Monday to Saturday. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

A pharmacy was based in the department and was open six days per week from Monday to Saturday. Outside of these hours staff had access to a 24/7 pharmacy on-call service.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

Physiotherapists provided patients with a tailored exercise plan after each consultation. This helped them to make the most of rehabilitation therapy and to progress their treatment. Staff provided this information in digital or printed formats based on individual needs.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. This worked well in practice. For example, we observed physiotherapists provide patients with guidance on exercise and energy levels and how to improve dry skin.

Staff took care to provide patients with useful information they could understand and not to duplicate or contradict information from others involved in their care. For example, we observed a physiotherapist note to a patient their operation scar was, "healing nicely", and asked if other staff had talked to them about this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood local escalation processes in the event a patient could not consent to care.

Good

Outpatients

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff audited compliance with consent processes quarterly. This was a hospital-wide audit that included outpatients. In the previous 12 months the audit found consistent practice, with compliance between 95% and 100%.

When patients did not have capacity to consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. A best interests group of multidisciplinary staff had formed in December 2021 and worked with colleagues to embed consent processes in line with NICE guidance for patients who lacked full capacity.

Staff made sure patients consented to treatment based on all the information available. The Medical Advisory Committee worked with clinical staff to identify best practice in consent for specific treatments, such as surgical injections that took place in outpatients.

Staff clearly recorded consent in the patients' records. This was a provider standard and staff had fully documented consent in all 12 outpatient records and all five physiotherapy records we looked at. Staff sought consent continually during appointments, such as when a nurse asked a patient if it was okay for them carry out a procedure.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). It was rare for the department to treat a patient being cared for under a DoLS authorisation and staff maintained knowledge and awareness as good practice.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Are Outpatients caring?

Good

We have not previously rated outpatients as a single service We rated caring 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. Compassionate care was embedded in service delivery. 'Compassion in practice' was a specialist module in the mandatory training package for all staff and 98% of the team were up to date with this.

Staff recognised that many patients sought reassurance about their treatment and progress but did not ask this directly. We saw staff were intuitive and adept in such circumstances and were skilled in predicting needs and questions. For example, a receptionist observed a patient who was fidgety in the waiting room and they understood the patient was nervous about their appointment. They spoke with the patient and kept them engaged until their appointment time.

Patients said staff treated them well and with kindness. In the previous 12 months patients reported consistently high standards of care in the outpatients survey, in which 92% of respondents described their care as excellent. This included consistent 100% satisfaction scores for physiotherapy services.

Staff followed policy to keep patient care and treatment confidential and demonstrated attention to detail with each patient's comfort level. For example, we observed a physiotherapist cover a patient's legs on the therapy trolley when they disclosed, they felt self-conscious about wearing clothes unusual for them.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Physiotherapists routinely discussed psychological wellbeing with patients during their rehabilitation therapy. Patients noted this as a positive element of the service in written feedback.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Senior staff provided reflection opportunities for staff after supervision observations. This was part of a strategy to maintain focus on patient satisfaction and standards of care.

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. During the pandemic the hospital operated a generic no visitor policy, which meant patients had to attended appointments unaccompanied. Staff waived this policy where a vulnerable patient would benefit from being accompanied by a family member or carer.

We observed two physiotherapy sessions and found an exemplary level of care. The physiotherapist spent time with each patient to discuss their progress and gave them time and space to ask questions. One patient was reluctant to engage in the therapy process and was unconvinced of the potential benefits. The physiotherapy took care not to make their decision for them and instead explained the various options including likely outcomes of different levels of therapy engagement.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff who led the one-stop breast clinic undertook specialist training in discussion difficult results and diagnoses. Staff described this as a positive element of the clinic but noted because they offered patients as much time as they needed to talk about results, delays could occur. This had a consequential effect on the next patient, who may be anxious about their consultation.

All staff we spoke with demonstrated a sensitive, caring approach to providing patients with emotional support. For example, a healthcare assistant described how they spent time with a patient ahead of a phlebotomy procedure because they feared needles. The member of staff described how they talked to the patient to understand the source of their fear and then put in place mitigation measures, such as providing a quiet and calm environment and talking to them for the duration of the process.

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. During the pandemic staff offered some clinics remotely using videoconferencing software. They ensured support and escalation processes were in place in the event a patient needed additional help and facilitated carers or family members to join the call if the patient was vulnerable or had additional needs.

Staff were positive, encouraging, and empowering the delivery of their care. In the eye clinic we found staff provided reassurance to patients undergoing cataract treatment and gave them health promotion advice and guidance. In

physiotherapy, we observed staff praise patients for completing their home exercises. They tailored this to the disposition and comfort level of each patient. For example, a physiotherapist said to one patient, “No-one is the same as you. You’re unique. We want to know how you’re doing, not in comparison to others, this is just about you.” This had a demonstrable, encouraging impact on the patient.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Feedback from patients indicated this was consistent across outpatients and physiotherapy. Comments from patients in relation to the physiotherapy team reflected their patience and clarity of communication. Staff were careful to support patients in a non-judgemental manner. For example, one patient noted they had not followed at-home care guidance and felt lazy as a result. The member of staff was compassionate, told the patient it was okay to be lazy sometimes, and then explained what else they could do to help.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The senior team measured the extent to which patients agreed with this through the feedback and survey portal. The outpatients team performed highly in this and in the previous 12 months, 92% of patients strongly agreed that staff had explained everything in a way they could understand. In the same survey, 84% of patients strongly agreed that information they received in advance of their appointment was easy to understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care. For example, one patient disclosed unplanned weight loss to a clinical member of staff. The member of staff thanked them for the disclosure and kindly noted this was often a difficult discussion. They explained to the patient how to get help with the weight loss, offered to assist with this, and told them they were always welcome to come back and talk about it.

Patients gave positive feedback about the service. The physiotherapy team monitored patient feedback using a digital portal. Staff sent each patient a link to the portal after each appointment as part of a strategy to maintain a continual understanding of their feedback. The most recent feedback indicated 91% of patients said their physiotherapist discussed treatment with them and 100% said their physiotherapists explained their treatment in a way they could understand.

Are Outpatients responsive?

Good

We have not previously rated outpatients as a single service. 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.

Good

Outpatients

Managers planned and organised services, so they met the changing needs of the local population. The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered. All areas were accessible step-free from the street or car park and there were baby changing facilities available.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff were proactive in arranging ad-hoc care for patients. For example, a patient attended the physiotherapy service and asked the physiotherapist to change a wound dressing. This was outside of the physiotherapist's training and they contacted an outpatients nurse who visited the department and carried out appropriate care. This was a seamless service and demonstrated effective coordination between staff and departments.

Managers monitored and took action to minimise missed appointments. Staff contacted patients who did not attend appointments to check their wellbeing and offer an alternative appointment. If the consultant was still in the clinic, staff spoke with them directly about the patient's contact. Where the consultant had already left, staff liaised with the medical secretary to ensure the consultant received an update.

Staff were proactive in seeking to provide new services based on local and regional need. For example, the service had purchased visual field equipment that enabled a nurse with an ophthalmology background to lead a bespoke clinic. The team had established a cataract clinic four days per week, which received immediate interest from the local population.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. A dementia lead and a learning disability lead provided support and guidance to staff throughout the hospital to help them meet people's needs. Staff were trained to adjust the environment for patients with a cognitive impairment and could use resources such as distraction tools or digital clocks to help patients.

Staff supported patients living with dementia and learning disabilities by using 'This is me' or 'My name is' documents and patient passports. Information was available in easy read or pictorial formats.

Staff had improved the bookings and pre-clinic administration process. This involved asking patients at an earlier stage about any additional support needs, such as if they needed a wheelchair to use on arrival.

The outpatients team maintained a quiet room on each shift and offered this for patients who needed a calm space to wait, such as those who were distressed or experienced a sensory disorder. Staff maintained a faith box in the room containing items for religious practice and patients could use this on request.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The provider followed the guidance of the Accessible Information Standard to ensure communication tools were clear and accessible.

Good

Outpatients

Staff had access to communication aids to help patients become partners in their care and treatment. This included pictorial and digital communication tools, such as those issued by specialist organisations.

Physiotherapists worked with other professionals involved with each patient's care as needed. For example, patients could choose to leave independent care, in which case staff referred them to NHS services. Similarly, if a patient was unable to fund on-going independent care, physiotherapists referred them to their registered NHS GP in order to secure continuing care.

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. There were no waiting lists for outpatient services at the time of our inspection. The hospital provided services to NHS patients as part of a national strategy to reduce waiting lists. There were 208 patients on an NHS waiting list for orthopaedic services, which reflected the high demand on the specialty and restricted clinical availability. Staff monitored patients on the waiting list and prioritised their care if their condition became urgent.

Staff had adapted the service to provide remote consultations during COVID-19 restrictions. At the time of our inspection staff had reverted most care to an in-person model, including 95% of physiotherapist sessions.

Staff had adapted opening hours based on patient feedback and demand. Clinics could operate between the department opening hours of 7.30am and 9pm Monday to Friday and between 8am and 2pm on Saturdays.

Staff worked to make sure that they started discharge planning as early as possible. Consultants, nurses, and physiotherapists considered discharge options during each patient's first consultation. The team worked closely with surgical colleagues, who were often responsible for early stage discharge planning. During a physiotherapy session we observed the therapist review the original discharge plan, check the patient's actual and perceived progress, and review of any new symptoms that might impact a safe discharge.

Staff told us their main challenge and frustration were clinic delays and cancellations. Patient feedback indicated this was a theme amongst complaints. We were not assured the senior team had appropriate processes in place to minimise short notice cancellations by consultants.

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 concerns. The service clearly displayed information about how to raise a concern in patient areas. This information was displayed in a range of languages spoken in the local area and staff could provide this in Braille.

Good

Outpatients

Staff understood the policy on complaints and knew how to manage them. Staff told us most complaints they dealt with directly with patients in the department involved late running clinics. During our inspection we observed three patients complain to the receptionist about the time they had waited to be seen.

Another theme of complaints related to a 2% clinic cancellation rate. The provider was aware of the issue and included a note in the most recent consultant newsletter to remind individuals of clinical cancellation processes. In the previous six months, one patient had been booked into a clinic with a consultant who did not work in the hospital and another made a complaint when they felt staff did not show empathy when cancelling their appointment. We were not assured the provider had embedded changes to reduce future occurrences.

In the previous 12 months, outpatients received seven formal complaints. In each case staff had investigated the situation and provided patients with an explanation.

Are Outpatients well-led?

Good

We have not previously rated outpatients as a single service We rated well led as good.

Leadership

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

An interim outpatients manager led the main department and a new manager was due to start imminently. A physiotherapy manager led outpatients physiotherapy.

Staff spoke positively of leadership across the hospital. For example, a new member of staff said they had met each member of the senior leadership team during their induction. They said this stood out as a good memory and made them feel welcomed into the organisation. We observed positive, supportive communication and relationships during our inspection. However, in the staff survey only 69% of staff said they felt supported by the leadership team with regards to their wellness and wellbeing during the pandemic. This was 12% worse than the provider's national outpatient average. After our inspection the provider demonstrated how they acted on these results, such as through training mental health first aiders and implementation of a national wellbeing hub.

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 provider promoted values at three levels: national, hospital-wide, and departmental. In all cases, values focused on a caring, effective service that met people's needs. The provider embedded core values from the point of recruitment to

ensure staff based their practice on them. For example, the hospital director ensured consultants who worked under practising privileges delivered care within the hospital's values. The provider asked staff about corporate values in the annual survey. In 2021, 73% of respondents said they felt the provider's overarching priority was high quality patient care. This was 10% worse than the national average in outpatients.

The provider established a vision and strategy that applied across all sites and departments. The outpatients team understood how they contributed to the overarching vision, such as by driving good patient survey results and maintaining consistently safe standards of practice. The senior team planned to work with staff to establish a vision specific to the department later in 2022.

Staff told us they felt the organisation and leadership team were forward thinking and supported them with future plans. For example, a physiotherapist was working with senior colleagues to scope an increase in sports medicine services.

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 described a positive culture. A new member of staff said, "It feels like everyone is aiming for excellence." They noted other hospitals in the provider's network proactively contacted them to offer training and development opportunities and encourage them to take part. Staff said they felt treated with respect by colleagues.

The provider carried out an annual staff survey. Outpatients demonstrated a high completion rate, with 99% of staff taking part. Respondents reported variable experiences working in the service. For example, 95% of respondents said they felt proud to work for the provider, which was significantly higher than comparable staff groups nationally. In addition, 94% said they had trust and confidence in local leadership, which was 13% better than the provider's national outpatient average. However, only 48% of respondents said they were excited about the future of the provider, which was 23% worse than the national average.

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.

Nineteen consultants and senior hospital clinicians formed the Medical Advisory Committee (MAC), each representing their clinical specialty. The MAC monitored areas of clinical performance, such as unplanned transfers, adverse events, and complaints. The committee also monitored consultant performance and ensured doctors maintained the conditions required under their practising privileges.

In December 2021, the MAC reviewed patient safety and quality in outpatients. The group reviewed hospital-wide processes that would impact on outpatients, such as the implementation of consent processes that met National Institute for Health and Care Excellence (NICE) guidance as part of a best interests group. Senior outpatients staff reported incidents of late running consultant-led clinics to the MAC for discussion with consultants.

Good

Outpatients

The outpatients manager and physiotherapy manager joined monthly clinical governance meetings. Meeting minutes reflected a comprehensive, whole-view process that included all aspects of care and delivery in the hospital. It was evident staff worked collaboratively and maintained a good standard of oversight of clinical measures, risks, and feedback.

Management of risk, 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.

Staff used a daily safety briefing to plan each shift. The briefing reviewed planned and actual staffing levels as well as levels of clinical activity that required specific nurse or HCA input. Briefings included details of recent incident reports and complaints, which enabled staff to implement changes and improvements in real time.

The senior outpatients team monitored risks on an ongoing basis in line with the provider policy and the outpatients manager contributed to the corporate risk register. At the time of our inspection the department had three key risks. These related to blood sample labelling errors, staff recruitment, and the risk of infection from contamination of nasoendoscopes. Risk mitigation plans were comprehensive. The provider used a staff development programme that aimed to improve retention and support staff to develop in their specialties to reduce the risk of vacancies.

Information Management

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.

All staff were required to complete information governance training and 100% were up to date with this.

The service reported one personal data incident in the previous 12 months, which occurred when completed consent forms were not securely stored. The senior team had reinforced the policy with staff and implemented new checks on clinical rooms.

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.

The senior team had a clear drive to improve and maintain engagement with consultants. This reflected the nature of the workforce and challenges in ensuring consistent two-way communication.

The physiotherapy team worked in a system of continual reflection and feedback. The physiotherapy lead carried out two patient observations with new members of the team and provided them with feedback and the opportunity to reflect on their initial experiences in the service.

While participating in the staff survey indicated a high level of engagement, we were not assured senior staff acted on outcomes. For example, only 31% of respondents noted they felt the provider had acted following the last survey. This was the lowest-scoring outcome in the survey and was 27% worse than the provider's national outpatient results. The senior team had prepared a response action plan, which focused on a new leadership team and a drive for greater staff engagement as strategies to improve experiences for staff.

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 provider had introduced quality improvement training for all staff as part of their work with staff to be involved in service delivery and development. At the time of our inspection 88% of staff had completed this. This was less than the 95% target and the senior department team were working with staff to support them to complete this before the end of year target in March 2022.

The service was working towards future sustainability with a new university partnership apprentice programme. The first student was in post and the senior team planned to improve future staffing stability as a result of such initiatives. The breast clinic had engaged in succession planning with the expansion of the service from one specialist nurse to three. Such examples showed us methods staff used to help the service continue to meet demand.

Good

Services for children & young people

Safe	Good
Effective	Requires Improvement
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Good

Are Services for children & young people safe?

Good

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

Mandatory training

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

Nursing and medical staff received and kept up to date with their mandatory training. Data showed staff compliance with mandatory training was 100% for all modules except one. Staff used an electronic system to complete and monitor mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training was comprehensive and aimed to equip staff to meet the needs of children and young people. Staff completed mandatory training in modules including but not limited to, safeguarding, manual handling, fire safety and information governance. For staff working with children and young people, additional training was completed in paediatric immediate life support in addition to adult immediate life support training. Staff received yearly life support refresher training and resuscitation simulation training every ninety days.

The service was working to improve training for clinical staff to meet the needs of children and young people with mental health needs, learning disabilities and autism. The children's lead nurse told us there were plans for staff to complete an e-learning course in learning disabilities and autism.

Safeguarding

Staff understood how to protect children, young people and their families 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. However, children were not always cared for in an optimal environment as the recovery area for children was just separated by screens so noises from adult recovery had the potential to disturb children.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. 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.

Good

Services for children & young people

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The children's lead nurse attended local safeguarding board meetings every month to keep up to date with current safeguarding issues and build relationships with local agencies.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The adult named safeguarding lead the children's named safeguarding lead for the hospital were both trained to level 4 in safeguarding adults and children. All other staff working with children and young people were trained to level three safeguarding children and adults. Data we reviewed confirmed this.

Managers monitored the numbers of children and young people who were not brought to medical appointments by their parents or carers. Managers reported how these had been investigated and the outcomes in the monthly governance report.

Staff followed safe procedures for children visiting the service. Staff were aware of procedures for arranging chaperones and posters were displayed throughout the hospital about requesting a chaperone.

Children were treated in an area separate from adults for overnight stays. An incident was reported in November 2021 governance meeting minutes that an adult had stayed for two hours on the children's unit while awaiting day surgery. While this was not in line with the provider's policy, the provider ensured all patients and children were happy with the temporary arrangement.

Children seen in outpatients did not have access to an area separated from adults, but staff ensured children and young people were never left alone without an adult.

Cleanliness, infection control and hygiene

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

All areas where children and young people were seen were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audit records showed the children's unit scored 100% for the monthly hospital infection control audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to PPE such as aprons and gloves and always wore surgical masks. All staff completed infection prevention and control training as part of mandatory training. The children and young people's service dashboard for 2021 showed there was one surgical site infection in the year January to December 2021.

Environment and equipment

The design and use of facilities, premises and equipment did not always keep people safe as safe as possible. However, staff managed clinical waste well.

The design of the environment was not always in line with national guidance for separate waiting rooms and recovery areas for children and young people. The service did not have a separate waiting room for children and young people in

outpatients. Children and young people were cared for in a recovery area that was separated by screens in the same area as adult recovery. Children and young people could potentially overhear distressing noises from adults in the adjacent recovery area. Children's nurses encouraged a parent or guardian the of child or young person to be when they woke up from the anaesthetic.

The provider had completed a general risk assessment in relation to children and young people interfacing with adults, visitors and staff in the hospital in December 2021. However, this risk assessment stated the mitigations were that children under 16 years old were always accompanied by an adult. This did not address the risk of children hearing and seeing inappropriate conversations and actions from other patients visitors and staff. Mitigations relating to adapting the environment were not included in the risk assessment. This had not improved since the last inspection in 2016 when we noted that the service did not have separate areas for children in outpatients and recovery.

The children's unit was on the fourth floor of the hospital and the door to the unit was kept locked shut. Staff and visitors could only access to children's unit through a door-bell entry system. However, the children's unit was not fully secure. There was no Closed-Circuit Television around the entrance of the children's unit, so it was not possible for staff to monitor who was entering or leaving the unit effectively. There was no signage to remind visitors not to allow people to tailgate when entering the unit.

The children's ward did not have access to a sluice. All patients had an en-suite bathroom and staff told us they rarely needed to access the sluice as it was only needed when doing urine samples. Staff had access to a sluice that was located outside the children's ward. Staff told us this was recorded as a risk on the risk register and had been reviewed by the infection control team.

Staff carried out daily safety checks of specialist equipment. We reviewed the emergency equipment on the unit and found checks were completed daily in the past three months.

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.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration. However, venous thromboembolism (VTE) risk assessments were not always completed in line with national guidance.

The service had a standard operating procedure that set out the safe and agreed admission criteria for children being treated at the hospital. The service accepted children three years or older for admissions and considered patients children until their 16th birthday. There was a risk-based approach to nurse staffing and treatment for young people aged 16 to 18 years. Pre-admission assessments identified whether the young person was appropriate to follow the adult pathway where they would be cared for by adult nurses. This process included considering the wishes of the young person.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. However, venous thromboembolism (blood clot) (VTE) risk assessments were not completed in line with guidance for two out of the five patient notes we reviewed. We discussed the VTE assessments with the children's lead nurse and they agreed a VTE assessment should have been completed for these two patients as they were either post-pubescent children or weighing over 40kg. While staff may have taken action to

mitigate risks such as giving the patient compression stockings, this was not recorded on the VTE risk assessment. The VTE risk assessment used in the records we reviewed was a photocopy of a standard pre-operative assessment version 5 issued January 2018 and due for review January 2020. As this paperwork was overdue for review, the hospital could not be assured staff were following up to date guidance.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The service used the paediatric early warning score (PEWS). We reviewed five patient records and found PEWS was used and escalated in all records.

All clinics were consultant-led. All outpatient staff were trained in paediatric life support, basic or intermediate level. The resident medical officer was always available on site. Staff practised resuscitation simulations within the hospital. Staff had access to adult and child simulation training and completed scenarios on the resuscitation simulators every 90 days.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. The service had a transfer agreement with the local NHS trust which outlined the process to safely and effectively manage children and young people who had deteriorated and needed critical care. All staff were aware of this and were able to detail how they would transfer a critically ill patient, by ambulance to the nearest NHS emergency department.

Nurse staffing

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

The service had enough nursing and support staff to keep children and young people safe. The hospital had a lead children's nurse, two permanent children's nurses and five bank paediatric nurses.

The hospital employed a children and young people's lead nurse who was accountable for all the children's services at the hospital, including outpatient services. This met the Royal College of Nursing guidance on defining staffing levels for children and young people's services.

Managers accurately calculated and reviewed the number and grade of nurses needed for each shift, in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of children and young people. There were always two children's nurses working on the inpatient unit at all times, in line with the admission criteria, and the unit had five beds.

All services at the hospital were planned rather than emergency procedures so the service could plan staffing for the procedures and outpatient appointments being carried out every day. During surgery, a children and young people nurse was always at the hospital. The children's lead nurse reviewed staffing rotas every week at the resource meeting where theatre lists were planned to ensure there was always a children's nurse available when children were at the hospital.

The service had no vacancies, low turnover rates and low sickness rates. The service used bank staff to enable flexibility in the service as the level of activity in children's services fluctuated. The lead children's nurse ensured bank nurses were familiar with the service and had completed all mandatory training, had a full induction and understood the service.

Good

Services for children & young people

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed five records and found all notes were legible and signed in line with national guidance. Records were stored securely. When children and young people transferred to a new team, there were no delays in staff accessing their records.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date. Staff stored and managed all medicines and prescribing documents safely.

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.

Staff knew what incidents to report and how to report them.

We reviewed the last two monthly governance reports for children and young people's services and found a summary of incidents in the past month was recorded but there was no evidence of discussion or sharing of learning. We were unable to determine that learning was shared following clinical incidents due to low levels of activity in the service. Most incidents reported were non-clinical incidents relating to cancellations of surgery due to patients testing positive for surgery.

There was no discussion recorded of why an adult had stayed in the children's unit for two hours before surgery in the children's unit in the governance presentation or how the impact on children and young people had been minimised or considered.

Are Services for children & young people effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. The service had systems for managers to check staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All clinical staff were sent a safety bulletin every month with details of updates to corporate and clinical policies.

Good

Services for children & young people

The Spire children and young people's policy was based on relevant NHS England, Royal College of Nursing, Royal College of Surgeons and NICE guidance.

Staff completed local clinical audits including but not limited to: theatre starve times, completion of paediatric early warning scores, recording of patient temperatures during surgery. Outcomes of local audits were reported quarterly on the children & young people dashboard. Surgical site infections, unplanned returned to theatres and readmissions within 31 days were also monitored on this dashboard.

Nutrition and hydration

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

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

The Spire Healthcare corporate children and young people in hospital policy stated that children and young people should be placed at the beginning of the theatre list to ensure minimal fasting times and maximum recovery time whilst the anaesthetist and consultant were on site. The children's lead nurse confirmed theatre lists were planned at the weekly resource meeting to ensure children's fasting times were minimised.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition.

Pain relief

Staff assessed and monitored children and young people 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 children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw in the five records we reviewed patient's pain was assessed using an appropriate tool regularly and recorded on the NEWS chart.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

The service did not collect enough data to monitor the effectiveness of care and treatment in terms of the outcomes achieved for children and young people. There was no evidence of audit and outcomes data being used to make improvements and achieved good outcomes for children and young people.

The service did not provide us with any relevant national clinical audit data to show outcomes for children and young people were consistent and met expectations, such as national standards. The only patient outcomes data provided was the children and young people's service dashboard for 2021 that showed there were no unplanned returns to theatre and one readmission within 31 days of discharge in the year January to December 2021.

Good

Services for children & young people

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 children, young people and their families.

Managers gave all new staff a full induction tailored to their role before they started work. The children's lead nurse was responsible for ensuring both permanent and bank children's nursing staff had a full induction.

Managers supported staff to develop through yearly, constructive appraisals of their work. Permanent staff had a full appraisal and bank staff completed a streamlined version. The provider's appraisal year ran from 1st March 2021 to 28th February 2022. Data showed for the three-permanent staff in children and young people's services all three staff had competed their mid-year review and one out of three staff had completed their yearly review.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with were positive about the support for development they received.

Managers made sure staff received any specialist training for their role. For example, the children's services lead was arranging for staff to complete training in supporting children with learning disabilities and autistic people.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.

Seven-day services

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

The hospital held outpatient clinics and admitted patients for procedures Monday to Saturday. The RMO was on site 24 hours seven days a week and so was available at night and at weekends. Staff could call for support from doctors and other disciplines.

Children and young people staying overnight in hospital were reviewed by consultants depending on the care pathway every day whilst they were in hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. However, recording of consent in relation to refusal of blood products was not always consistent

Good

Services for children & young people

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. The hospital had a children and young people policy which contained guidance on consent to ensure that assessment, care and treatment were carried out in line with legal and professional requirements relating to consent. This was in date and due a review in 2023.

Staff made sure children, young people and their families consented to treatment based on all the information available. The service had child-friendly information available for a range of common procedures. For example, we reviewed the information leaflets for children explaining magnetic resonance imaging (MRI) and computed tomography (CT). However, child-friendly information to inform consent for paediatric gynaecology services was not available at the time of inspection.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance most of the time. We raised concerns following the inspection about the quality of a consent record for refusal of blood products as this form was completed on paperwork from the local NHS trust and had been signed by the parent of the child but not the consultant. The provider responded that the paperwork for refusal of blood products from the local NHS trust was used as the national Spire policy Consent to Investigation or Treatment had been temporarily withdrawn while it was being updated.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment most of the time. This is a legal ruling whereby clinicians may accept consent from a child under 16 years of age, who has been assessed as competent to understand the implications of consent and who cannot be persuaded to involve their parents in care and treatment decisions. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not to others.

Are Services for children & young people caring?

Insufficient evidence to rate

We did not have sufficient evidence to rate caring at this inspection due to low levels of activity. Our rating of caring stayed the same as the last inspection when it was rated as good.

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 told us they took time to interact with children, young people and their families in a respectful and considerate way. Feedback present to the patient experience committee in April 2021 with feedback from children and young people from January to March 2021 was consistently positive. Children and young people found staff friendly, helpful and helped them to feel relaxed. All twenty patients in the survey said they would recommend the children and young people's service.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress.

Staff we spoke with understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's wellbeing.

Good

Services for children & young people

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.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The service used an online feedback survey to gather views. Data showed patients and families consistently rated the service very good or good between June 2021 and January 2022. In January 2022 the service performed better than the average score for all other Spire hospital locations for 'everything was straightforward', 'the family understood our family's needs', 'I felt that our child was in safe hands' and 'the staff were attentive.' The service scored lower than the Spire average for 65% for the metric 'I felt fully informed throughout the process' with a score of 33%.

Are Services for children & young people responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. Managers worked with the local NHS trust to support delivery of services and reduce waiting times for ear nose and throat procedures, for example.

The children's lead nurse was aware that the level of mental health needs of children who attended outpatients and for overnight stays was increasing. However, at the time of inspection, the service had not taken any action to meet the additional needs of these children.

Managers monitored and took action to minimise missed appointments. Managers ensured that children, young people and their families who did not attend appointments were contacted. Safeguarding leads monitored data and ensured outpatients staff understood why it was important.

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 children, young people and their families access services. They coordinated care with other services and providers.

Children and young people attended the hospital for planned surgical procedures, outpatient appointments, X-ray services and physiotherapy. Following national guidance, inpatient surgical services and outpatient services were only offered to children aged three and above.

Good

Services for children & young people

Wards were designed to meet the needs of children, young people and their families. All rooms were en-suite and decorated in a child-friendly way. At the time of inspection, the playroom was not in use due to COVID-19 infection control precautions. Staff encouraged children and young people to bring in their own favourite toys from home and children and young people had access to the internet during their stay.

Staff supported children and young people living with complex health care needs by using documents such as hospital passports for children with learning disabilities. The children's lead nurse gave an example of how they had supported a family to complete a hospital passport for their child as they had not yet completed one.

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 children and young people were in line with national standards.

Managers monitored the number of inpatient admissions and outpatient activity for children and young people and reported the data to the hospital-wide governance meeting every month. Services for children and young people were a small proportion of the hospital's overall activity. For example, in December 2021 the hospital had 18 inpatient admissions of children aged three to 16 years old and five inpatient admissions of young people 16 to 18 years old. Outpatient activity was 301 face to face appointments in December 2021.

The service provided planned surgical procedures and outpatients only and did not provide emergency care. All surgical procedures were planned so children and young people did not go to theatre after 17:00 so they were treated during standard working hours when most clinical staff were available on site.

Managers worked to keep the number of cancelled appointments to a minimum. When children and young people had their appointments cancelled, managers made sure they were rearranged as soon as possible and within national targets and guidance. The children and young people's service dashboard for 2021 showed there were no avoidable cancellations in the year January to December 2021.

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. However, complaints were not always responded to in a timely way.

Children, young people and their families knew how to complain or raise concerns. The children and young people's service dashboard for 2021 showed the service received two formal complaints in the year January to December 2021.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. For example, we reviewed the response to two complaints relating to children and young people's services and found all concerns were investigated and responded to appropriately with an apology and explanation. However, both the complaint responses were delayed and included an apology about the delay in responding to the complaint.

We did not see evidence of managers sharing feedback from complaints with staff and learning was used to improve the service.

Good

Services for children & young people

Are Services for children & young people well-led?

Good

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

For culture, information management, engagement, learning and continuous improvement please see the Surgery report.

Leadership

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

The children and young people (CYP) service was run by the CYP lead nurse who had accountability for all the children's services at the hospital, including outpatient services. The CYP lead held overall responsibility for quality, safety and safeguarding children and young people within the hospital.

Vision and Strategy

The service was in the process of updating its vision for what it wanted to achieve and a strategy to turn it into action.

The overall hospital strategy was being updated at the time of inspection.

The service had a commitment to "ensure a safe and consistent level of quality is provided to all children and young people, parent and carers." The children and young people's service were working to provide innovative services to children and young people. For example, innovative surgeries for children with cerebral palsy.

Governance

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

We reviewed the last two governance reports that the children's and young people's services lead presented at the hospital wide monthly governance meeting and found data was shared on the levels of activity, incidents reported and safeguarding.

New policies and protocols were reviewed at the hospital monthly governance meeting. For example, at the January 2022 governance meeting the children and young people's major haemorrhage protocol was reported as being finalised.

We reviewed the children and young people service dashboard for 2021. The dashboard monitored compliance with audits such as theatre starve times, consent, safeguarding risk assessment and consultant daily patient records. There was a section on the dashboard to record positive achievement and work to improve care, which included information on monitoring of fluid balance charts and paediatric early warning scores.

Good

Services for children & young people

There was a lead paediatrician and a lead paediatric anaesthetist who represented the CYP service on the medical advisory committee (MAC).

Management of risk, 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.

The organisation had assurance systems and performance issues were escalated through structures and processes.

Leaders did not always identify and mitigate all risks effectively. We identified that while the service had risk assessed the lack of dedicated environments for children in outpatients and recovery, they had not taken meaningful action to mitigate these risks effectively.

Managers did not always have comprehensive and effective oversight of consultant's competency where consultants were carrying out innovative or uncommon procedures. Managers told us they relied on the fact that consultants practice mirrored that conducted in practice carried on outside of Spire Hospitals. However, there was no system that enabled managers to ask about or obtain evidence to demonstrate children and young people got the same, or better or worse outcomes when consultants carried out surgeries in the Spire hospital compared to work in other hospitals.

Requires Improvement

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Nursing and clinical staff received and kept up to date with their mandatory training. We were provided with mandatory training data for ward, theatre and pre-operative assessment staff as of 21 February 2021. We noted that, at the time of the inspection, compliance ranged from 86% in competition law to 97% in anti-bribery training, equality and diversity training, and fire safety training. The deadline for all outstanding training was the end of March 2022, where the target for completion was 95%.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Nursing staff and the Resident Medical Officers (RMO) received training specific for their role on how to recognise and report abuse. 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. We saw details on the ward of how to report an allegation to the local authority.

The hospital had recently introduced safeguarding training modules. At the time of our inspection, hospital-wide compliance with mandatory training for safeguarding children (level 2) was 90% and safeguarding adults (level 2) was 92%. Managers were supporting staff with time to complete any outstanding training before the deadline of 31 March 2022, by when the target was 95% compliance. The adult named safeguarding lead was trained to level 4 in safeguarding adults. 21 staff were trained to level 3 safeguarding adults

Requires Improvement

Surgery

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.

Staff followed infection control principles including the use of personal protection equipment (PPE). We observed staff wearing PPE to safeguard patients and themselves from possible cross infection.

Staff worked effectively to prevent, identify and treat surgical site infections. The infection prevention and control (IPC) lead would investigate all possible surgical site infections. In the last 12 months the hospital had no UK Health Security Agency (UKHSA) reportable surgical site infections.

We saw IPC risk assessment documents which were completed at the preadmission clinic appointment. We were told if risks were identified they would be reviewed by clinical staff.

We reviewed IPC practice in theatres during the pre-operative, peri-operative and post-operative phases, which were in line with NICE guidance (CG 74) and the prevention of surgical site infections.

Staff on the wards and in the preadmission clinic decontaminated their hands in line with the World Health Organizations five moments for hand hygiene and NICE guidance (QS 61 statement three). This standard states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. All the patients that we spoke with told us that they saw staff wash their hands before and after patient contact.

A range of infection control clinical audits were undertaken, and results shared at the IPC committee meetings. Results from the October to December 2021 were all scored between 90-100% compliance.

The committee also had an ongoing action plan and risk register, both of which were reviewed at every meeting.

The areas we inspected were all visibly clean and free from dust.

Environment and equipment

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

The design, maintenance and use of the facilities helped to keep patients safe. All patient rooms were single occupancy to prevent any risks of cross infection.

Patients could reach call bells and we saw staff responded quickly when called. Patients told us they did not wait long for staff to answer their call bell.

The service had enough suitable equipment to help them to safely care for patients. The resuscitation equipment by the ward was shared with the day case unit and medical care. Staff carried out daily safety checks of specialist equipment. There was oxygen and emergency equipment available. We found the resuscitation equipment in theatres and on wards to be in date.

The hospital had its own team of engineers for all daily maintenance tasks. The chief engineer oversaw all the equipment compliance checks. Equipment in theatres and the ward areas had stickers to indicate recent electrical testing and servicing.

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

A new patient risk assessment process had been introduced and staff told us this had improved the amount of information collected and the information shared with patients about their journey from coming into hospital, to what to expect when discharged. The system allowed 'red flags' to be added to patients electronic record which would alert all relevant staff to any additional requirements or patient conditions, such as patients living with dementia, or complex medical conditions.

Pre-operative assessments were carried out to make sure patients were fit to have their surgery. Due to Covid-19, and the introduction of electronic patient led questionnaires, most patients had telephone pre-assessments. However, staff could request patients attend for a face to face assessment if they had complex needs, any concerns were highlighted, or this was the patients or consultant's preference, for example for further tests. A full medical history was undertaken with a list of medication. Pre-operative assessment staff were able to refer patients to the anaesthetist if they had any concerns. Patients were also able to see a physiotherapist and pharmacist if required at this appointment.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them as necessary. The hospital had clear systems and processes to assess and respond to patient risk. The hospital used the national early warning scoring system (NEWS2). This tool allows clinicians to use the observation of patients' vital signs to identify and escalate concerns about the deterioration in a patient's condition, escalating concerns. We checked six patient observation charts. All were fully completed and accurately scored, and we saw the documented escalation of two patients. We saw sepsis boxes were stored in the corridors on the ward and staff were aware of these and how to use them if they suspected a patient had sepsis.

Patients seen at the pre-admission clinic and identified as a potential risk, such as an increased risk of falling, or risks associated with bariatric patients, allergies, such as latex, or anaesthetic risks, were discussed at a weekly resource meeting. At this meeting, staff assessed risks prior to the patient's admission and plans could be prepared to help ensure patient safety.

We attended the surgical safety briefings that took place prior to the day's theatre lists. The daily meetings were attended by operating department practitioners, scrub nurses, radiographers and porters. The team discussed the day's list and patient's specific requirements. Staff discussed the day's case load, x-ray requirements, who was holding the bleep, and any relevant issues that had occurred the previous day.

At the ward's daily safety briefing, staff discussed patients NEWS scores, patients at risk of falls, patient allergies, or with any dementia, anxiety or learning disabilities. We also saw that any recent incidents were discussed, as well as infection control issues. Staff were also given the opportunities to raise any issues they wanted to discuss. Conversations with staff confirmed they felt empowered to speak up.

Staff knew about and managed specific risk issues. For example, reporting sepsis, venous thromboembolism (VTE) risk of developing a blood clot, falls and pressure ulcers.

Requires Improvement

Surgery

We observed four cases in theatres and witnessed the full completion of the WHO surgical safety checklist. The WHO checklist was audited for observation compliance and documentation compliance quarterly. The latest patient safety quality scorecard showed the surgical safety checklist had been completed before every theatre list.

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.

The service had enough nursing and support staff to keep patients safe. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with the number and needs of patients.

There was sufficient staffing to meet patients' needs. There were occasions where there had been shortages of healthcare assistants, but more registered nurses had been rostered onto shifts, therefore meeting safe staffing requirements.

The ward managers could adjust staffing levels daily according to the needs of patients. We saw that, because of an issue with the remote electronic system for monitoring of cardiac patients, managers had increased the number of registered nurses on each shift to keep patients safe. We were told that pressures on staffing had increased because of the complexity of patients, but this was generally well managed, and wards were safely staffed.

Medical staffing

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

The service had enough medical staff to keep patients safe.

A resident medical officer (RMO) was employed directly by the hospital, which provided continuity and improved accountability. They were supported by other RMOs who covered evenings and weekends. The RMOs had access to the consultants if needed in an emergency.

Surgery was consultant delivered and led for both private and NHS patients.

All staff we spoke with knew how to contact surgeons out of hours for both NHS patients and privately funded patients. Staff told us they felt comfortable to phone consultants out of hours.

The hospital had processes which were aligned to the corporate policy, to monitor and maintain the practicing privileges of consultants who worked at the service. We reviewed a sample of consultant records and all documents relating to practice privileges were accurate and up to date. There was evidence that they ensured there was information and details of references, evidence of professional registration, Disclosure and Barring Service (DBS) check, and documentary evidence of qualifications relevant to the duties for which practising privileges was issued.

Requires Improvement

Surgery

There was evidence that staff employed under practising privileges received support, training and professional development. Where a clinician worked across both the NHS and private sector, there was evidence of cross-recognition, which included assurance that the service had sight of the medical practitioner's continuing professional development/ good standing certificate each year. There was evidence that appraisals took place annually. We found evidence that there were procedures for granting, refusing, renewing, suspending and restricting the practising privileges agreement.

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, and all staff could access them easily. We reviewed six patient notes and records, which we found to be were up to date and signed by the member of staff completing the entry. In all care records we looked at we saw a diagnosis and management plan, VTE risk assessments, evidence of daily ward rounds, consent forms signed, as well as assessments of pressure areas and nutritional status.

When patients transferred to a new team, there were no delays in staff accessing their records.

Patients' records were stored securely and out of sight of patients and visitors at the nurse's station.

Discharge summaries were communicated to the patients GPs. We saw records of discharge information sent to the patients GPs on their discharge.

The hospital provided us with high level analysis of ward and theatre documentation audit results from December 2012 to February 2022 (three months). They audited clinical risk assessments, consent to treatment, documentation, accompanying notes, and the single patient record. Compliance ranged from 95 to 100%.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff were aware of how to access medicines advice and supplies during the pharmacy opening hours and there were arrangements for out of hours support.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers. A member of the pharmacy department was available to speak to patients about their medicines and provide advice and support to the staff on the ward.

Staff told us there was a new pharmacy lead and the team were excellent at providing support when it was needed. They were involved in a lot of preparatory work and took part in daily rounds to make sure people were ready to go home. However, the team worked until 5pm. There was a formal out of hours service outside of standard opening times, but not all staff we spoke with were aware of this.

Staff completed medicines records accurately and kept them up to date. We reviewed four prescription charts, which were completed in full and all doses of medication administered were signed for. We also noted that allergies were documented, and antibiotics prescribed within guidelines.

Requires Improvement

Surgery

Staff stored and managed all medicines and prescribing documents safely. Each patient had a locked facility for storing their medicines in their room. Patients were assessed and could choose to take their own medications. Staff confirmed that post-surgery they would ensure patients would take their medicines on time. The medicines room and trolley were all secured, and only authorised staff could access medicines stored in these areas.

The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Departments we visited had suitable cupboards to store controlled drugs. The hospital pharmacy team audited controlled drug processes. We saw actions identified from the audits, which helped to keep processes safe.

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 and they raised concerns and reported incidents and near misses in line with the hospital's policy. There was a positive culture of incident reporting. The staff we spoke with on the ward, in the preadmission clinic and theatres were aware of their responsibility and felt supported to report incidents.

Staff used an electronic incident reporting system. We reviewed some of the risks reported and saw clear evidence of actions taken and lessons learnt. Staff received feedback from investigation of incidents. The computer system used, automatically sent feedback to the member of staff who reported the incident once it had been investigated.

There was evidence that changes had been made as a result of incidents.

Staff reported serious incidents and never events to the hospital director, the director of clinical services, national lead, and the clinical commissioning group (CCG), in line with the Spire group policy. Senior teams cascaded all learning from serious incidents and never events to staff at all levels. We saw documentation at ward and theatre meetings, as well as at the medical advisory committee (MAC).

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Are Surgery effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

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.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to the hospital's policies and procedures via their computer system.

Requires Improvement

Surgery

The wards used care bundles in line with NICE guidance and the institute for healthcare improvement. A bundle is a structured way of improving the processes of care and patient outcomes with small, straightforward sets of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcome.

The hospital undertook quarterly audits of venous thromboembolism (VTE), a term referring to blood clots in the veins. The audits checked that patients had been risk assessments for VTE. The results showed improvements in 2021, from 76% in January to March 2021, to 97% in October to December 2021.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

The hospital used the malnutrition universal screening tool (MUST). This is a five- step-screening tool to identify possible risks of malnutrition. Staff assessed patients' nutritional status daily.

Patients waiting to have surgery were not left nil by mouth for long periods. The pre-admission staff discussed the length of time a patient needed to fast prior to their operation and ensured patients were fully aware of their 'nil by mouth' regime for fluids and food. Staff encouraged patients to maintain drinking water until two hours before surgery to reduce dehydration and any possible side effects of this.

Following surgery patients had effective management of nausea and vomiting. Patients were prescribed anti-emetic (anti-sickness) medication to enable them to drink and eat.

Staff told us the hospital was able to cater for patients religious and cultural needs. This information would be shared with the catering staff following the preadmission assessment.

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.

Staff assessed post-operative pain on the ward in a comprehensive and consistent manner, in line with the Faculty of Pain Medicine's core standards. Patients who reported pain had analgesia offered, explained and administered in a timely and efficient manner. Patients received pain relief soon after requesting it. Patients we spoke with confirmed they did not have to wait long for their pain relief.

Staff prescribed, administered and recorded pain relief accurately. We saw this was recorded on the patient's prescription charts.

Discussions with patients regarding effective pain control and analgesia commenced at pre-admission appointments. Staff informed patients about what pain and what analgesia to expect post-operatively.

The hospital used a pain trigger to action tool to assess patients' level of pain and requirements for analgesia. We saw that performance was at 81% in September 2021, and the hospital held pain study days in October 2021. By November 2021, performance had improved to 100%.

Patient outcomes

The service did not collect enough data to monitor the effectiveness of care and treatment in terms of the outcomes achieved for patients. There was no evidence of clinical audit and outcomes data being used to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in some relevant national clinical audits. For example, Patient Reported Outcome Measure (PROMs). This is a measure of health gain in patients undergoing hip replacement and knee replacement surgery. This is done using questionnaires before and after surgery.

The hospital also submitted data regarding patient reported outcome measures (PROMs). PROMs measure health gain in patients undergoing hip replacement and knee replacement in England, based on responses to questionnaires before and after surgery. The number of responses was extremely low (April 2020 to March 2021), which covered the start of the pandemic. Patients who responded were asked before and after their procedure to score their health status. Over this time 13 people responded regarding their hip replacement, 12 patients stated their score improved, one had worsened. Of the six people who responded following a knee replacement, all stated their scores improved. However, it should be noted this relates to a very small cohort of patients.

The hospital sent data to the National Joint Registry (NJR) which records, monitors, analyses and reports on performance outcomes in joint replacement surgery. By doing so they could compare themselves against national data which showed favourable performance.

The hospital submitted data to the National Institute for Cardiovascular Outcomes Research (NICOR). Hospitals use the data to improve quality of care by checking that the care received by heart disease patients meets good practice standards. For electrophysiological/ablation procedures the hospital showed compliance with national guidance. However, the audit of cardiac rhythm management showed numbers of procedures undertaken were too few to comply with the recommendations, and therefore it was not possible to benchmark cardiac surgery performance.

We asked the service to provide us with further patient clinical outcome data, and how these were monitored to improve outcomes for patients. Managers told us they complied with National Institute for Health and Care Excellence (NICE) guidelines, such as the "Five steps to safer surgery" but did not monitor outcome measures. We were also told that the service did not monitor Association of Anaesthetists of Great Britain and Ireland (AAGBI) outcome data.

Managers and staff did not use the results of either local audits or the national audits above to improve patients' clinical outcomes. We were not provided with any information or minutes of meetings to show that patient clinical outcomes were discussed or how they could be improved. We requested audit data and only received local audits relating to the environment rather than clinical audits relating to the effectiveness of care.

At the time of the inspection the hospital did not provide data to support the targeted improvements of outcomes for patients. Following the inspection, we were told the hospital had a quality improvement (QI) programme, which started in

Requires Improvement

Surgery

January 2022, focused on reducing the average length of stay for patients undergoing hip and knee surgery from five days to two days. This QI programme was designed to drive a number of improvements in patient outcomes including reducing their risks of infection, reducing their immobility and venous thromboembolism events. It was also designed to achieve enhanced recovery benefits such as reducing the need for analgesia, more rapid return of bowel function, and patient experience. It will be reported in July to September 2022. Until the data is available, there is no evidence that outcomes for patients have improved.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff were given an induction guide, providing useful information to supplement their induction. This also included a skills checklist, including signing off that mandatory training had been completed, plus other role specific training.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge at their appraisals. The resident medical officer (RMO) had a recent appraisal and told us the process worked well.

Nursing staff told us that the ward mangers provided training 'on the job' and were available and approachable to ask questions at any time. The ward managers had an open-door policy and we saw staff regularly approaching them for advice and support.

Training in the identification and treatment of sepsis was included in the intermediate life support training and the 'deteriorating patient' study day. The staff we spoke with described the 'Sepsis Six' pathway for identifying and treating sepsis, in line with NICE guidance (NG 51). We saw clear guidance displayed at the nurses' station and in corridors on wards. There was a sepsis trolley on one ward, and staff told us this contained all the information they needed should it be required.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Requires Improvement

Surgery

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was effective multidisciplinary (MDT) working between all staff groups. Staff and teams worked together in a coordinated way to provide care to patients.

Staff we spoke with reported they had a good working relationship with the pharmacy department who had a visible presence on the ward. Visits were frequent throughout the day and staff were always able to help when advice was required.

We witnessed effective MDT working across all departments at the weekly resource meeting. The meeting was attended by the director of clinical services and representatives of departments, such as physiotherapy the booking team, catering, outpatients and the pre-admission clinic. The MDT discussed any issues or risks identified at the pre-admission clinic and allocated the appropriate resources.

Effective MDT working could also be seen at the pre-admission clinic, where physiotherapists for those patients undergoing joint replacements started preparing patients for what to expect post-operatively and when they got home.

Seven-day services

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

Consultants visited their patients every day, including weekends whilst they were admitted. Each patient had a named consultant throughout their pathway who completed these visits.

Most services were provided seven-days a week across the hospital. The hospital carried out elective operations between Monday and Saturday with out of hour's provision for emergency returns to theatre. Physiotherapists offered services from Monday to Saturday and there was always access to consultants, in and out of hours. The hospital provided a pharmacy dispensing service six days a week. There was a formal arrangement for out of hours advice.

The hospital also had access to radiology support remotely out of hours. However, not all staff who may need to access this service were aware of it or how to access it.

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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We reviewed six sets of patient notes and saw that consent had been requested in each case.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. All staff we spoke with had awareness of the MHA. Staff told us that they were seeing an increasing number of patients with dementia and as a result, they had been given additional training, and had regular discussions with colleagues and managers about supporting patients with mental health requirements.

Requires Improvement

Surgery

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) as part of their safeguarding adults training. Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. The RMO told us they had annual training on MCA and DoLS, plus additional training which had provided good preparation in light of increasing complexity of some patients, such as those living with dementia.

Are Surgery 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.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. One patient told us 'all the staff have been amazing they are when I need them, and have been very caring'.

Patients said staff treated them well and with kindness. All the feedback we received during the inspection was very positive about the conduct of staff and their kindness to the patients. We saw all staff introduce themselves when they entered patient rooms, and patients confirmed that they knew the names of the nursing staff and the housekeeping staff.

Staff followed policy to keep patient care and treatment confidential. We saw staff closing doors to patients' rooms when they were having private conversations

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

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. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. One patient told us how involved they had felt in every part of their patient journey. They told us they had concerns about managing pain, and they had been listened to at the reassessment appointment. They told us they had not had to repeat this at any stage, but that all members of staff had ensured their pain was managed well. They told us 'I feel like part of the team here.

Another patient told us that, despite being in a single room, staff had regularly checked in on them, and left the door open at their request. They told us that, as visitors were not allowed at the time of the inspection, this made them feel less lonely.

Requires Improvement

Surgery

Although visitors were not allowed because of Covid-19, staff did allow relatives of carers or patients with learning difficulties, dementia or mental health concerns to visit. This was to reduce the level of anxiety for these patients, and to enable them to be more settled.

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. At the time of the inspection bad weather was closing local roads, and we spoke with a patient who was concerned about being discharged the following day. They told us staff had liaised with them about being flexible with their discharge time and that this had reduced their anxiety.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff we spoke with told us this was more challenging with families and carers not being able to visit most patients, but if they had any concerns, they would call family members to discuss any ongoing needs patients may have on discharge.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The patients we spoke with told us they would speak up if they felt they had any concerns.

Patients gave positive feedback about the service. All patients we spoke with gave positive feedback, and this was supported by patient feedback collated by the hospital. The hospital used the Friends and Family Test to collect patient information and the latest data showed that 97% of patients' satisfaction was rated as good or very good. 87% of patients said their needs had been met. However, only 59% were satisfied with their discharge.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. At the time of this inspection Spire Bristol was accepting NHS Orthopaedic patients through 'Choose and Book' and also taking waiting list transfers from a local NHS trust. They were also taking cardiology and cardiac surgery waiting list transfers from another local NHS trust. Around 85% of the hospital's patients waiting over 52 weeks were transfers from the NHS. 100% of the patients waiting over 104 weeks were transfers from the NHS trust, transferred at the point where these patients were already breached. The hospitals had an action plan to prioritise surgeries for these patients.

Facilities and premises were suitable for the services being delivered.

Requires Improvement

Surgery

Meeting people's individual needs

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

Staff made sure patients living with dementia, received the necessary care to meet all their needs. A box had been devised to hold equipment to help patients living with dementia.

All rooms were single occupancy, and each had en-suite facility of a toilet and shower. Height adjustable beds and other equipment were provided to meet the needs of patients. Patients could reach call bells and staff responded quickly when called.

The service had information leaflets available in languages spoken by patients and the local community. Managers made sure staff, and patients could get help from interpreters or signers when needed.

Staff had access to communication aids to help patients become partners in their care and treatment. The hospital offered access to translation services for patients where English was not their first language. The hospital had also signed up to the Accessible Information Standard, which aimed to make sure that people who had a disability, impairment or sensory loss could be given information they could easily read or understand.

The multidisciplinary team weekly resource meeting discussed any patients identified in the pre-admission clinic with specific or complex needs, and these needs were also discussed at the weekly resource meetings. This resource meeting allowed staff to assess and plan the care the patient may require in advance of their admission.

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression.

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. Not all patients received treatment within agreed timeframes and national targets. At the time of this inspection Spire Bristol was accepting NHS Orthopaedic patients through 'Choose and Book' and also taking waiting list transfers from a local NHS trust. They were also taking cardiology and cardiac surgery waiting list transfers from another local NHS trust. Around 85% of the hospital's patients waiting over 52 weeks were transfers from the NHS. 100% of the patients waiting over 104 weeks were transfers from the NHS trust, transferred at the point where these patients were already breached. The hospitals had an action plan to prioritise surgeries for these patients.

Managers and staff worked to make sure that they started discharge planning as early as possible. We saw that discharge was a core part of the pre-operative assessment, which included any physiotherapy needs as well as any equipment or community support requirements. Patients we spoke with confirmed they were aware of what they would need when they were at home, and this had been confirmed with them at their preoperative assessment.

Requires Improvement

Surgery

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 concerns. Patient who had received NHS funded care were able to complain via the local NHS trust or Clinical Commissioning Group.

Staff told us about the policy on complaints and knew how to manage them. Managers investigated complaints and identified themes. They shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of learning from complaints.

We noted that all complaints received by the hospital in the last 12 months had been closed within the 20-day deadline.

The hospital was a member of the Independent Sector Complaints Adjudication Service (ISCAS) which provides independent adjudication on complaints for ISCAS subscribers. ISCAS is a voluntary subscriber scheme for the vast majority of independent healthcare providers.

Are Surgery well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service, although there were some gaps in the evidence for some senior members of staff. 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.

Leaders had the skills, knowledge and experience to run the service. The hospital was led by a hospital director and director of clinical services. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them.

There was clear and visible leadership at the hospital. All the staff we spoke to regarded the senior and local management teams as approachable and very visible around the hospital. Senior staff clearly operated an open-door policy. During interviews with managers on wards and in theatres, it was clear there were no barriers to communicating with the matron and hospital director.

Staff we spoke with were extremely complimentary regarding the theatre manager. We saw they had made a difference to the culture within the team. They had encouraged a culture where staff could speak up about concerns they had.

However, not all requirements in relation to recruitment were available for the hospital director – references and occupational health records were not available. We asked the service if this meant these records were not available within the wider organisation and it was confirmed they weren't. Furthermore, there was an absence of some recruitment

records for other senior staff at the hospital. Whilst risk assessments had been carried out in regard to these, it was not clear how these mitigated the risks created by a lack of information about the recruitment of these individuals. Therefore there were people working in the hospital without the documents as set out in the requirements of employment, which outlines the information required to be kept by providers about persons employed.

In relation to the issuing of practicing privileges, there was evidence the service ensured there was information and details of references, evidence of professional registration, Disclosure and Barring Service (DBS) check, and documentary evidence qualifications relevant to the duties for which practising privileges was issued.

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.

We saw that both wards and theatres had strategies which linked to the hospital's overall strategy. In theatres the mission was to "bring together the best people who are dedicated to developing excellent clinical environments in order to deliver the highest quality of outstanding personalised care". The purpose was to "make a positive difference to patients' lives through outstanding personalised care". There was also a list of theatre values. On ward, the mission was to "bring together the best people, dedicated to developing excellent clinical environments and delivering the highest quality patient care". And also, "to continue to invest in people and facilities to ensure patients receive high standards of care".

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. During the pandemic, the service had provided NHS support treating admitted patients, outpatients and diagnostic imaging. Senior leaders told us that collaborative working would continue.

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.

All staff we spoke with told us they were proud to work at Spire Bristol. We were told managers were approachable, staff were supportive, and they felt valued. Staff had been promoted to more senior roles, the hospital encouraged each location to 'grow their own' to aid retention and increase morale.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff were encouraged to report all incidents as they were a learning opportunity. Staff confirmed they could raise any issues with their line manager or other senior staff on site.

The hospital had a Freedom to Speak Up (FTSU) service in the hospital which was well resourced. Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken. The hospital had two FTSU guardians, supported by 11 ambassadors. Staff we spoke with were all aware of this service. We were told that the culture of speaking up had improved within the hospital, and this was encouraged from the senior management team.

Requires Improvement

Surgery

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.

There were governance structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The hospital held monthly clinical governance meetings, and the standing agenda included: incidents; risk register updates; changes to guidance; complaints; and departmental updates.

However, when we requested the current governance strategy, this was not provided to us, as the hospital was in the process of updating it.

We saw evidence of the environmental audits and minutes of monthly or quarterly meetings where staff discussed these and other topics. The majority of these audits demonstrated high compliance.

The hospital medical advisory committee (MAC) was an integral part of the governance structure. The purpose of the MAC is to advise the hospital director, the director of clinical services and any other relevant Spire employees on any matter relating to the proper, safe, efficient and ethical medical use of the hospital site where members of the Medical Society were undertaking or supervising the delivery of healthcare services. The MAC consisted of the senior staff of the hospital such as the hospital director, matron and representatives from various specialist consultant groups. The MAC met four times a year to consider and provide advice on maintaining high clinical standards, assessment of the risks involved and ensuring continuous improvement in the quality of clinical care.

The MAC reviewed incidents and root cause analyses, mortality and morbidity, complaints and patient satisfaction. However, we could not identify where results of clinical audits were discussed and monitoring and improving patient outcomes.

The hospital wards held monthly departmental team briefs and clinical governance meetings to discuss safety issues, such as learning from incident reports, and root cause analyses, complaints and incidents and safeguarding. They also covered incident and compliance training, updates on national policies and guidelines, quality scorecard, staff survey action plans, and risk management.

Management of risk, issues and performance

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

The hospital risk register had ten risks, and these were either hospital-wide or by department. We saw up to date action plans.

We saw key risks were identified and promoted throughout the hospital. The hospitals had identified controls for all of these risks to minimise impact on patients. These risks also matched concerns of staff we spoke with.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. A hospital-wide safety briefing meeting was held every day with a representative from each department in attendance. This offered the opportunity for all departments to raise concerns and share information.

Requires Improvement

Surgery

There were processes to suspend or remove a consultant's practising privileges where there were concerns about their practice. The hospital provided evidence, which demonstrated a clear transparent approach within the governance processes and procedures of the hospital.

Information Management

The service collected reliable data but did not analyse all of it 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 was used to measure performance but not always make improvements (see 'Patient Outcomes' above). Quality and sustainability both received coverage in relevant meetings at all levels.

Staff had sufficient access to information and challenged it when necessary. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

There were arrangements to ensure data or notifications were submitted to external bodies as required.

Data systems were secured and monitored. Staff told us they had a secure log in for each computer and these timed out if they were not used in a set time. Staff told us they logged out or locked the computer when they need to leave the desks.

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.

The hospital displayed 'you said we did' posters in patient areas. Patients had identified there was a variation in how much water they could drink pre-surgery, and staff had set up boards in patient rooms to write down when patients should cease to drink water, and at what time they should stop eating.

The hospital held patient experience committee meetings four times a year. We saw this gave staff an opportunity to assess patient feedback and learn from feedback and act. For example, we saw that information provided by a patient at their pre-operative assessment regarding a previous adverse reaction to medication had not been clearly noted. It was noted there had been a miscommunication between the pre-operative assessment service and the catheterisation laboratory. An updated was issued to ensure relevant information was shared with the wider multi-disciplinary team to help ensure this would not happen again.

Learning, continuous improvement and innovation

Staff told us about, and demonstrated they acknowledged the value of engaging with service improvement initiatives.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Results of local and national audits must be assessed to identify potential improvements to patients' outcomes in surgery. Regulation 17 (2) (a) • The service must assess, monitor and improve the children and young people's service to monitor patient clinical outcomes. Regulations 17 (2) (a) • The service must maintain securely an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided. Care and treatment provided in the critical care unit was not clearly documented in patients notes and the service did not carry out any audits for assurance of the quality of record keeping. Regulation 17 (2) (c)

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed • Information must be available in relation to each such person employed. Recruitment information was not available in relation to some senior staff at the service, including – but not limited to - the hospital director. Regulation 19 (3) (a,b).