

Spire Healthcare Limited

# Spire Regency Hospital

## Inspection report

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29 November 2021  
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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?		Good	
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 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 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 good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The 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. Most 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.

However:

In Surgery;

- The surgical services did not achieve national standards for waiting times from referral to treatment. However, they had undertaken actions to improve this.
- The service had suspended some quality monitoring and audit activities due to COVID-19 pressures.
- The environment across the surgical wards and theatre areas was not always dementia friendly.

In Medical Care;

- The service had not installed a double sink for the process of endoscope decontamination. Although this was a temporary measure it was not in line with their own endoscopy policy.
- The new endoscopy pathway recording booklet was completed inconsistently.
- Chemical substances were not always stored in a lockable storage cupboard or sink in the decontamination room.

In Outpatients;

- The process for monitoring maintenance of equipment was not embedded and one of the fridges was not included in daily routine checks. The service level agreement for the ophthalmic laser was past the date for review, at time of inspection, however; renewed when highlighted.

## Summary of findings

- The service did not capture re-booking information following a cancellation or when a patient did not attend (DNA).The service had not embedded care for all patients with a protected characteristic such as a mental health need.

# Summary of findings

## Our judgements about each of the main services

### Service

### Rating

### Summary of each main service

#### Diagnostic imaging

Good



Diagnostic imaging is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for diagnostic imaging.

#### Medical care (Including older people's care)

Insufficient evidence to rate



Medical care services were a small proportion of hospital activity. This included endoscopy. The main service provided by this hospital was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Due to the nature of the service provided and the limited activity at the time of our inspection we did not have enough evidence to rate medical care at the hospital.

#### Surgery

Good



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

We rated this service as good because it was safe, effective, caring, responsive and well-led.

#### Outpatients

Good



Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for outpatients.

# Summary of findings

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# Summary of this inspection

## Background to Spire Regency Hospital

Spire Regency Hospital is operated by Spire Healthcare Limited and located in Macclesfield, Cheshire. The hospital provides a range of elective inpatient and day case surgical procedures for NHS and private fee paying adult patients, including general surgery, orthopaedic surgery, ophthalmology, ear, nose and throat (ENT) surgery and some spinal and vascular surgery.

The hospital has two operating theatres that operate three theatre sessions per theatre, six days per week. The Byron suite (inpatient ward) has capacity to accommodate 18 patients in ensuite single rooms and is open 24 hours per day, seven days week. The Coleridge ward has capacity to accommodate six patients in individual rooms and is mainly used for day case patients.

The hospital provides a range of outpatient services for adults. Patients under 16 years of age can attend outpatient consultation appointments only. If these patients require any further care or treatment, they are referred to another of the provider's hospitals.

The hospital provides day case endoscopy services and is in the process of building a new endoscopy and minor operations (EMO) suite. This is expected to be in place by the end of January 2022. Whilst the refurbishment work is completed, all endoscopy procedures have been carried out in the main theatres by the existing theatre staff. Endoscopy procedures are undertaken typically four days per week.

The diagnostic imaging department at the hospital provides a comprehensive range of diagnostic services for patients including general X-ray, computerized tomography (CT) scans, magnetic resonance imaging (MRI), bone density (DEXA) scanning, ultrasound and mammography.

Spire Regency Hospital has been registered since July 2016. The hospital was previously registered with CQC under a different provider since October 2010.

The hospital director has been the registered manager for the service since August 2018.

The service is registered to provide the following regulated activities:

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

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.

We previously inspected Spire Regency Hospital during October 2016. The report was published February 2017. We rated the hospital as good overall, with an overall rating of good for surgery and the outpatient and diagnostic services. We inspected but did not rate medical care services as part of the inspection. There were no regulatory breaches identified during the inspection.

# Summary of this inspection

## How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. The inspection was unannounced. We carried out the on-site inspection on 23 to 24 November 2021 and carried out staff interviews remotely on 29 November 2021.

During the inspection visit, the inspection team:

- Inspected the main ward and theatre areas, the sterile services department, the endoscopy decontamination room, the outpatients department and the diagnostic imaging department.
- Spoke with 45 staff, including a housekeeper, the director of clinical services, the governance manager, the ward manager, theatre manager, ward nurses, theatre nurses, outpatient nurses, healthcare assistants, the theatre administrator, physiotherapists, occupational therapists, receptionists, administrative staff, bookings staff, the diagnostic imaging lead, the outpatients lead, the lead decontamination healthcare assistant, the preoperative assessment lead, the sterile services manager, the engineering manager, the support services assistant, the bed manager, consultants, consultant anaesthetists, pharmacists, the national clinical information lead, human resources advisors, the hospital director and the chair of the medical advisory committee.
- Looked at the training and recruitment files for 12 staff.
- Spoke with 16 patients and relatives.
- Looked at 28 patient records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## Outstanding practice

We did not identify any areas of outstanding practice as part of this inspection.

## Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action the service **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 **SHOULD** take to improve:

#### For Surgery:

- The service should ensure appropriate actions are taken to improve performance for patient waiting times from referral to treatment. Regulation 12(1).
- The service should consider implementing improvements in the ward and theatre areas in order to make the environment more dementia-friendly.

#### For Medical Care:

# Summary of this inspection

- The provider should ensure that chemical substances hazardous to health, are stored in a lockable storage cupboard or sink in the decontamination room. Regulation 12(2)(d)
- The provider should ensure that a double sink for the process of endoscope decontamination is installed in line with their own endoscope policy. Regulation 12(2)(e)
- The provider should consider following the pathway recording booklet that has been introduced or indicate which part of the booklet is not in use.

## **For Outpatients:**

- The provider should ensure that all fridge temperatures are monitored. Regulation 12 (2)(f).
- The provider should ensure locking the dirty utility door or moving the cleaning fluids stored. Regulation 12 (2)(h).
- The provider should ensure that oversight of all equipment maintenance is embedded. Regulation 17 (1).
- The provider should ensure that there is oversight of service level agreements including the laser protection adviser. Regulation 17(1).
- The provider should consider reviewing the way data is collected for patient outcomes to show departmental results.
- The provider should consider capturing re-booking information following a cancellation or if did not attend (DNA).
- The provider should consider having a process to refer patients to mental health services.








# Our findings

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Medical care (Including older people's care)	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

## Diagnostic imaging

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

### Are Diagnostic imaging safe?

Good 

This is the first time we have inspected diagnostic imaging at this hospital as a separate 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. Staff received and kept up-to-date with their mandatory training. At the time of the inspection, compliance for mandatory training was 86% for diagnostic staff. The services completion target for mandatory training was 95% by the end of March 2022. The remaining staff had until the end of March 2022 to complete outstanding modules in line with the provider's training calendar.

The online mandatory training was comprehensive and met the needs of patients and staff. The mandatory training included courses covering basic life support, infection control, duty of candour, safeguarding children and adults level two and three, the Mental Capacity Act and Liberty Protection Safeguards, health and safety, manual handling and medication safety.

Radiologists completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training to the hospital in line with the practising privileges policy. Records provided by the service showed consultants were up-to-date with mandatory training.

All staff including agency staff had an induction programme which included mandatory training.

The clinical manager monitored mandatory training and alerted staff when they needed to update their training. The department manager received a monthly update regarding training and raised noncompliance with individual staff if they had not completed it.

### 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.**

# Diagnostic imaging

Radiologists received training specific for their role on how to recognise and report abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could name the hospital lead for safeguarding adults and children and they were able to clearly articulate the process and would escalate any concerns to them if necessary. Adult safeguarding training at level three had a staff completion rate of 100% and child safeguarding training at level two had a staff completion rate of 100%. The department manager had level four safeguarding adults and children training. This was in line with hospital policy.

There was safeguarding referral flowcharts displayed on the diagnostic noticeboard which directed staff on how to make a safeguarding referral and local key contacts. There had been no safeguarding referrals in the 12 months prior to inspection.

Staff knew how to recognise adults and children at risk of suffering harm and were aware of safe procedures to follow for children visiting the department.

Patients we spoke with told us they felt safe and were always treated respectfully by staff.

## 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.**

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had responded well to the COVID-19 pandemic. The department provided staff with personal protective equipment (PPE) such as gloves, aprons, masks and/or face visors. We observed all staff wore PPE where necessary.

Imaging appointment times had been adjusted to reduce the number of patients waiting to be seen to help maintain social distancing. There were social distancing measures in place in the main waiting area.

The service completed monthly hand hygiene audits. The current audit showed that compliance with hand hygiene was 100%.

The diagnostic department had not reported any MRSA, *Clostridioides difficile* (C. difficile) or *Escherichia coli* between November 2020 and November 2021.

The waiting areas, examination room, diagnostic areas and changing rooms were all visibly clean. We saw completed cleaning rotas for both rooms and diagnostic equipment.

Radiographers completed hand hygiene before seeing a patient, wore suitable personal protective equipment and cleaned diagnostic equipment after each use. Radiographers used sanitising wipes and placed paper sheets on the scanning couch, these were disposed of after each patient.

Each clinical area had a foot operated clinical waste bin, sharps bins were present which were clean, not over filled and secure.

There were disposable privacy curtains that had date for change on them, these were clean and were replaced every two months.

# Diagnostic imaging

Ultrasound probes were cleaned in line with best practice, the cleaning process was documented and audited.

Staff were observed to adhere to the department's hand hygiene and 'arms bare below the elbows' policies. There was a hand wash sink in each clinical area which had instructions on the correct hand washing technique; "5 Moments of Hand Hygiene".

There was both wall mounted and bottles of hand sanitizer throughout the department, staff were observed using this both before and after patient contact.

In the ultrasound room there was a cleaning and disinfection guide which had been signed and completed.

## 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.**

Patients and staff entered the main entrance. Patients were asked about their COVID-19 status and were directed to the diagnostic waiting area. The waiting area was spacious and had adequate seating, there was priority seating for patients who had recently had surgery. The waiting area and diagnostic department was spacious enough to be accessible to wheelchair users.

Patients accessed the radiology department from the open plan outpatients waiting area into the diagnostic reception area.

Patients could reach call bells and staff had access to alarms in the event of an emergency.

The diagnostic department was on the ground floor, this included an ultrasound scanning room, a mammography scanning room, a plain x-ray and combined fluoroscopy suite and a DEXA scanner.

Equipment in the department was clean and well maintained and servicing contracts were in place. There were maintenance arrangements in place to ensure equipment was serviced and maintained as needed, there was evidence of future planned maintenance checks.

There were secure lockers for patients to store their belonging during their scan.

Lead aprons were used when staff were carrying out fluoroscopy scans, these aprons were used to protect against radiation exposure. Staff used body and thyroid shield lead aprons. The aprons we inspected were well maintained and in good condition. Staff told us the aprons were scanned yearly to check quality and ensure they offered protection.

Local rules for radiation were displayed throughout the department and had been signed by the appropriate members of staff.

There were clear signs and warning lights outside controlled areas where radiation was being used, which told both staff and patients not to enter when the sign was illuminated. These signs were in working order.

# Diagnostic imaging

There was pause and check signs in the control areas of each diagnostic room which reminded staff to check patient identity, correct area for scan, radiation dose and clinical justification. On inspection we observed staff checking the identity of the patient by asking full name, date of birth, address, and the areas to be scanned. Radiographers also asked patients if they knew why they were having a scan and if they knew what an x-ray was.

Emergency resuscitation equipment was available for the service on the ground floor. The diagnostic department shared a resuscitation trolley with the outpatient's department. The resuscitation trolley was clean, and contents were secured with a tag. There was an oxygen cylinder on the trolley which was secure and full. The trolley was checked daily, during our inspection the trolley was checked with the ward manager and two pieces of equipment were found to be missing, a full check of the trolley was then carried out and the items were replenished.

## 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**

We observed reception staff confirming patient identity when they arrived at the department, this was then checked again by radiographers before patients were scanned.

The service had two radiation protection supervisors in the department. The service had a service level agreement with an external company for a radiation protection advisor.

The department carried out scenario-based training which included basic life support and patient collapse scenarios. All staff were required to complete basic life support as part of their mandatory training.

Safety questionnaires were completed prior to imaging procedures taking place and patient allergies were noted on their electronic record.

The department had a deteriorating patient policy, staff were able to explain what they would do in the event of this happening, this included calling the resident medical officer (RMO), beginning observations and getting the resuscitation trolley. The RMO would then decide to manage the patient at the hospital or authorise emergency transfer to a local NHS trust.

There was a World Health Organisation (WHO) checklist in place in ultrasound and a WHO surgical safety checklist for non-general anaesthetic procedures.

Posters were located in the department reminding staff and patients about the need to discuss their pregnancy or risks associated with the possibility of pregnancy.

The service had a risk register that included the risks for radiology. The manager could tell us the top five risks for the service. Risks were reviewed weekly and were displayed for the staff to have access to.

Staff told us how they dealt with any specific risks, for example if the radiographer noted any unexpected or significant findings from image reports these would be escalated to the treating consultant. Staff would contact the referrer by telephone and follow this up with an urgent report.

# Diagnostic imaging

## Staffing

**The service had enough staff 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 staff to keep patients safe. The service included radiographers, healthcare assistants and non-clinical administration staff. The service had four whole time equivalent (WTE) radiographers. The manager adjusted staffing levels daily according to the number of clinics running and the number of patients attending. Bank staff were used to cover additional shifts if required.

Managers made sure bank and agency staff had a full induction and understood the service before starting their shift. The induction programme included training on how to use the diagnostic imaging equipment. Any agency staff were used on a long-term contract so that they became familiar with the service.

The service had a low turnover of staff and had recently recruited to a vacancy with a radiographer who was registered with the Health and Care Professions Council.

The service had enough medical staff to keep patients safe. There were six radiologists supporting the service who were employed under practising privileges. The radiologists provided reporting services as self-employed consultants under practising privileges. We saw evidence that the hospital checked all medical staff had valid professional registrations, medical indemnity insurance, completed mandatory training and appraisals.

Photographs of the staff were displayed in the waiting area so patients could be familiar with the staff and their roles.

## 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. Patient notes were in the forms of electronic and paper. Paper notes were securely locked away in areas which could only be accessed by staff.

We reviewed 10 patient records, all were clearly recorded with the required information for example, radiation doses, personal details, consent and confirmation that results were shared with GP, referring consultant and the patient.

Radiologists reported on images on shared electronic systems and results were securely sent to referring clinicians.

The department used electronic systems such as picture archiving communication services (PACS) and radiology information software (RIS) for the storage and transfer of images. Images could be sent securely to other hospital sites if the radiologist responsible for the patients' care needed to review the image.

The electronic imaging systems used were password protected and all radiographic staff and radiologists had personal log in details.

## Medicines

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

# Diagnostic imaging

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines used were local anaesthetic, contrast agents, cleansing agents and barium. The department did not use any controlled drugs. Staff followed current national guidance to check patients had the correct medicines.

Medicines were stored, managed and prescribed in line with the hospital's policy. All medicines were stored safely in locked cupboards.

We found the fridge for medicines was in good working order and there was a system in place to record the room and fridge temperatures which were adhered to.

Contrast medium was given by patient specific directives (PSDs). A PSD is a written instruction, signed by a prescriber for medicines to be supplied and or administered to a named patient after the prescriber has assessed the patient on an individual basis.

In the event of an emergency, the department had an adult anaphylaxis box which was in date, it was secured with a number tag by the pharmacy.

## 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 knew what incidents to report and how to report them. Staff reported incidents via and electronic systems. Staff shared examples of incidents reported.

There had been no never events and no serious incidents reported in the previous 12 months. Staff were aware of how to raise concerns, report incidents and near misses in line with the hospital policy.

We reviewed an incident that was investigated, which included clear lessons learned, actions taken to prevent a recurrence and resulted in updated and clearer guidelines. Learning was shared and had been communicated with staff.

Staff understood the term duty of candour, which was covered in a mandatory training module for staff to complete. There was a duty of candour policy in place and staff were able to tell us what their responsibility was when something had gone wrong,

The service outlined the process of reporting a radiation incident in their radiation local rules.

Learning from incidents was shared in team meeting and displayed on the department board. Staff informed us there was a monthly update of the hospitals incidents and lessons that had been learnt.

The last non radiation incident involved an incorrect referral, however this was highlighted at the patient identity check, this led to a time delay for the patient, but the correct examination was done.

# Diagnostic imaging

## Are Diagnostic imaging effective?

Inspected but not rated 

We inspect but do not rate effective in diagnostic imaging services.

### 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.

Guidance from the Royal College of Radiologists the College of Radiographers and the National Institute of Health and Care Excellence were available to staff via the intranet.

The service provided care and treatment based on national guidance including the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Policies were aligned with and referenced the Ionising Radiation Regulations 2017. The Ionising Radiation Regulations 2017 are regulations concerned with the protection against exposure to ionising radiation as a result of work activities. The radiation safety policy and local rules for radiation safety were up to date and were available to staff both as a paper copy or electronically.

We observed that all local rules were signed and dated by staff as being understood, within the twelve months prior to our inspection. Imaging risk assessments were completed, and we saw that pathways were in place for certain conditions such as; the breast 'one stop clinic'. Local rules were in each diagnostic room and had been signed by each member of staff. Managers checked that staff followed these.

The diagnostic department used World Health Organisation (WHO) surgical safety checklist when carrying out invasive procedures.

The corporate provider Spire Healthcare held a national steering group for radiographers, which allowed for best practice to be shared across the provider and gave an opportunity to make recommendations on new guidance.

The corporate provider Spire Healthcare had a national lead for diagnostics who provided radiographic clinical leadership. The national lead ran the patient safety quality review inspection program. The lead had undertaken two inspections in the last 18 months and highlighted areas for improvement such as displaying dose levels in rooms, ensuring all members complete clinical competencies and ensure pause and check was being done before each scan. We saw evidence that these actions had been addressed.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs.**

Hot and cold beverages were available to patients and staff told us that food could be provided to patients if they had been in the department for a long period of time.



# Diagnostic imaging

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**

We observed patients being scanned who had recently had orthopaedic surgery. On each occasion staff assessed patients' pain and asked if they were happy to continue with their scan. Staff told us that pain was managed well by medical staff. If staff identified a patient was in pain or patients requested pain relief, the doctor would be contacted to assess and prescribe treatment, as appropriate.

## Patient outcomes

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

Refer to surgery section for details.

The diagnostic department used pathways and protocols for procedures that were evidence based and available on the intranet for staff. We saw examples of these for example x-ray imaging. Staff told us that if there needed to be a deviation from protocol then this would need to have to be justified by the patients radiologist.

Mammography screen images were double reported by two consultant radiologists in line with NHS Breast Screening Programme standards.

Managers used information from the audits to improve care and treatment. A diagnostic member of staff had recently been made the audit champion for the department, their role would be to have oversight of audits within the department.

Staff told us the department was working towards the 'Quality Standards for Imaging Accreditation'. This sets best practice to improve patient care and outcomes.

## 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 service made sure staff were competent for their roles. All new staff were required to attend a corporate induction followed by a local induction. Areas covered included health and safety, infection prevention control governance and incident reporting. Staff told us they had received a thorough induction and had then shadowed staff until their competences were completed. Staff told us they felt well supported during their induction. Staff in the radiology also had a role specific induction which covered areas such as clinical policies and procedures, radiation local rules and Ionising Radiation (Medical Exposure) Regulations (IR(MER)). Diagnostic radiographers had a comprehensive training in all diagnostic procedures in the department and there was a competency-based assessment in place.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that they had received an appraisal in the last year and they had highlighted areas for development and improvement with their manager, we saw evidence of this when we reviewed staffs training and development files.

# Diagnostic imaging

A competency framework was in place. This meant staff undertook training and were assessed in practice; the manager then verified that the member of staff was competent. All staff were expected to meet these competencies. Diagnostic staff had both electronic and paper files which included training certificates and competencies they had achieved. Our review of four staff files confirmed these had been completed appropriately.

Staff told us there were opportunities for continual professional development which was a requirement of their registration with the Health and Care Professions Council (HCPC).

One radiographer/mammographer had undertaken bad news training to support them in their role.

The service employed radiologists via practising privileges. There was a robust system in place which ensured clinicians were compliant with regards to their registration and training, any non-compliance resulted in a radiologist losing the right to work at the hospital until rectified.

We looked at the recruitment file for one radiographer working in the diagnostic imaging services and these these showed evidence that appropriate recruitment pre-employment checks had been carried out. This included identification checks, qualifications, Hepatitis B inoculation certificates, at least two employment references, Disclosure and Barring Service (DBS) checks and HCPC registration.

We also looked at the records for one radiologist working in the diagnostic and imaging services. These contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and DBS checks.

Team meetings were held monthly to discuss issues, provide peer support and share learning.

## Multidisciplinary working

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

We observed staff working well together as a team, the department had a positive and respectful atmosphere.

A radiologist told us they believed there was very good lines of communication within the department. Both diagnostic and administrative staff told us radiologists at the department could be contacted if needed and were always happy to answer questions.

## Seven-day services

**Imaging services were available regularly to support timely patient care.**

The imaging department was open Monday to Friday, the service did not routinely open on Saturdays although to assist with the back log of appointments due to COVID-19 there was currently six day working in the department. There was an on-call service out of hours.

## 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.

# Diagnostic imaging

## 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.**

The process for patient consent was detailed in a corporate consent policy. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed staff obtaining verbal consent from patients before carrying out a scan, staff asked patients if they knew why they were having the scan, explained the procedure and confirmed with the patient if they were happy to have the scan.

Staff were aware of the hospital's mental capacity policy and could explain what would happen if a person did not have the capacity to consent to any imaging procedure. They told us they would not continue with the scan but would seek further guidance from the referring doctor.

Staff were aware of how a best interest's decision would be made on behalf of a patient. Staff clearly recorded consent in the patients' records. We reviewed 15 patient notes, these all had consent signed by the patient and were on the correct form.

Staff had received and kept up to date with training in the mental capacity act and liberty protection safeguards.

Staff told us that patients without capacity were usually accompanied by a carer and there were dementia friendly advocates within the hospital.

For patients who could not speak English there was an interpretation service which could be used to help with the consent process.

## Are Diagnostic imaging caring?

This is the first time we have inspected diagnostic imaging at this hospital as a separate core 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. Staff introduced themselves to patients and took time to ask how they were feeling. Staff asked patients how they felt about the imaging procedure and if they had any questions.

Staff asked patients if they fully understood the information given to them and assured that, if they had any questions, to ask a member of staff.

# Diagnostic imaging

Staff clearly explained the diagnostic procedure and the time it would take to the patient. We witnessed staff interacting with patients before and throughout their procedure. Staff gave patients positive feedback during the imaging procedure, where appropriate and continued to ask how the patient was doing. Patients were reminded to tell staff if they wanted the procedure to stop at any time.

The diagnostic department reception was in a separate room to the main waiting area which allowed patients and reception staff to speak without being overheard which allowed for greater privacy and dignity.

Staff maintained privacy and dignity by ensuring blinds and doors were closed when patients entered the room.

Chaperones were available to support patients during procedures if needed. Staff had received training for the role. There was changing rooms in the department which had chaperone policy posters in them, the chaperone policy had been interpreted into eight different languages on the poster. For the one stop breast clinic, a student nurse had undertaken chaperone training to support women during their clinic appointment.

Four patients spoke positively about the care provided by staff, each patient felt staff had been compassionate and caring. One patient told us that the care they had received was excellent. We listened to staff making booking calls where they were kind sensitive, caring, very helpful and reassuring to patients.

## Emotional support

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

Staff maintained constant interaction with patients throughout their scans, they talked patients through the procedure and went at a pace that suited the patient. Patients who may need more time for scans due to complexities such as mobility issues or pain were highlighted during the booking process so that additional time could be added to their appointment.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff asked patients if they felt they would be able to maintain a certain position for the length of time needed while undergoing a scan. For patients who were unable to do this staff offered emotional support and ensured that patients were as comfortable as possible in order to complete the scan.

There was a one stop breast clinic and staff told us how they supported patients who were attending the clinic and awaiting results.

Patients told us that staff were very reassuring. Staff told us the team were very supportive of each other if they were involved with emotionally challenging situations. A member of staff had recently undertaken training in 'breaking bad news'.

For patients with phobias or anxieties about their treatment, they may be given visual techniques by the radiographer to assist them to relax or shown the room prior to the scan to relieve anxieties.

## 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.**

## Diagnostic imaging

Staff made sure patients and those close to them understood their care and treatment. Staff could explain what they would do if they recognised a patient who may need additional support to understand and be involved in their care example of this were translation and interpreter services.

There was a range of imaging and diagnostic information on the services website, which was available to patients, this information explained why you might need an x ray, who will do it and the procedure.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were posters in the waiting area which highlighted to patients how to give feedback.

We observed staff interacting positively with patients. Staff spoke with patients sensitively and appropriately depending on their individual needs. The manager told us, 'they go the extra mile every day to all give the best to patients.'

### Are Diagnostic imaging responsive?

Good 

This is the first time we have inspected diagnostic imaging at this hospital as a separate core 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 department offered a range of diagnostic services to both self-paying and NHS patients.

The carpark was in front of the hospital which had parking spaces for people with disabilities.

Facilities and premises were appropriate for the services being delivered. There was a large waiting area which was close to the diagnostic department. There was priority seating available for patients who had recently had orthopaedic surgery. There were hot and cold beverages available in the waiting area. The waiting area was on the ground floor and accessible to wheelchair users.

The department monitored patients who did not attend for treatment, the levels were low. Patients would be contacted and asked if they wanted to book a new appointment.

The department offered late evening and weekend appointments to accommodate for patients who could not make weekday appointments, for patients who needed an urgent scan the best effort was made to give the patient a scan on the day they were referred.

The mammography one stop breast clinic allowed patients to have a mammogram, ultrasound and biopsies, and these were reviewed by a doctor all on the same day.

# Diagnostic imaging

## 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. Patients with complex needs were provided with increased appointment times to allow staff time to provide additional support.

Staff gave examples of patients with learning disabilities who had attended for diagnostic imaging. Patients had been accompanied by carers for support.

Interpreter and translation services were available. Posters were displayed in languages other than English.

For patients who had a sensory impairment the services had aids in place. For patients who were blind or who had sight issues, information could be requested in braille format. For patients who had hearing aids, the service had a hearing loop available at reception, though the imaging team were not aware this was available.

Posters were displayed in the waiting area and changing rooms which explained what an x-ray was and why they are used.

Access to a hoist was available for bariatric patients or patients who had mobility issues.

The service had a box for patients and visitors which included religious texts, prayer mats, compasses and details of the local place of worship.

The senior mammographer had developed the one-stop breast clinic to assist in getting patients through speedily. They were in the process of developing a patient information leaflet to explain the process from admission can take up to three hours so that patients were informed beforehand.

## Access and flow

**People could access the service when they needed it and received the right care promptly.**

Patient appointments were booked by the administrative team, who assessed patients' individual needs and scheduled an appointment with adequate time.

Managers worked to keep the number of cancelled appointments to a minimum, managers made sure they were rearranged as soon as possible and within national targets and guidance.

In the last 12 months the diagnostic department had to cancel 10 patient appointments. If a patient's appointment was cancelled administrative staff would call the patient on the same day and rebook an alternative appointment as soon as possible.

## 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.**

# Diagnostic imaging

The diagnostic department had one complaint in last 12 months. This complaint was investigated and responded to; it did not need to be reviewed by an independent external adjudicator such as the Independent Sector Complaints Adjudication Service (ISCAS).

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with knew how to raise concerns; all the patients we spoke with told us they had been asked if they were happy with the service they received after their procedure.

The service clearly displayed information about how to raise a concern in patient areas. Posters in the waiting area directed patients on how to make a complaint. It asked patients to raise the complaint to a member of staff firstly and highlighted the process to make a formal complaint.

Managers investigated complaints and identified themes. The diagnostic manager told us that the service took complaints seriously and tried to resolve complaints at the point of care. If a formal complaint was made it was reviewed and the learning and improvements were shared across the service.

## Are Diagnostic imaging well-led?

Good 

This is the first time we have inspected diagnostic imaging at this hospital as a separate core 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.**

See surgery for the main findings.

The service had a clear leadership structure in place, the diagnostic department had a manager who was also the lead for outpatients.

The diagnostic manager told us they felt well supported by senior managers at the hospital. The diagnostic manager was visible in the department, staff told us they were approachable and supportive.

The diagnostic manager had been appointed in the last 12 months and told us about future plans for the department and plans which had begun such as helping staff develop through increased training.

### Vision and Strategy

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

See surgery for the main findings.

# Diagnostic imaging

The service's strategy was displayed throughout the hospital for both patients and staff to see. The service had a 2022 strategy which included developing and building the teams within the hospital to retain talent; to continue to deliver excellent clinical quality and to deliver superb customer experience.

The diagnostic department had a vision to 'accommodate every patient in a timely manner by providing highly skilled radiology professionals; promoting clinical excellence and outstanding patient care.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

See surgery for the main findings.

We observed an open and positive culture during our inspection of the diagnostic department. Staff we spoke with told us they enjoyed working in the hospital and that the team got on well and worked well together to achieve good patient care.

In the diagnostic department we observed a positive team interaction which include radiologists, radiographers and administration staff.

Staff spoke about recent appraisals and areas which they had been supported for future learning and training.

## 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 surgery for the main findings.

There was a clinical governance committee who met regularly, they reviewed policies and procedures, discussed incidents and complaints and highlighted any safety issues in the hospital. The diagnostic department had daily morning huddles and monthly staff meetings.

The radiology services held monthly staff meetings. Meeting minutes from October 2021 showed that discussions took place around incidents, workforce, performance and governance issues and key risks, along with shared learning. Meeting minutes showed action plans were in place and these were followed up at subsequent team meetings.

The service had a medical advisory committee (MAC) which was made up of consultants who worked at the hospital, and included radiologists.

There was a service level agreement in place for a radiation protection advisor from an external organisation to support the diagnostic department.

## 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.**



# Diagnostic imaging

See surgery for the main findings.

The diagnostic department had a risk register in place and there was a nominated radiographer who had oversight of it, risks had been graded and appropriate mitigations put in place. The risk register was reviewed at governance and health and safety meetings.

There were two radiation protection supervisors in the department and an external radiation protection advisor who could advise on risk or issues within the department.

The service was in the process of its annual reject analysis when we inspected. This audit highlighted how many scans had been rejected and why, so to gain learning and improve future practice.

## 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.**

See surgery for the main findings.

There were information boards in the main waiting areas which displayed the hospital results in regards to audits and recent patient satisfaction surveys.

The service stored personal and sensitive information securely and only authorised staff could access this information. Scans could be transferred securely to NHS trusts for radiologists to review.

Information governance was included in the services mandatory training.

## 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 surgery for the main findings.

The service had daily departmental safety huddles where members of the diagnostic department would attend. There was also daily hospital meeting which the diagnostic manager would attend. There was also monthly staff meeting where operational information from both the hospital and organisation would be shared.

The diagnostic manager had recently developed a 'good deed book' in the department, this allowed staff to document when they felt they had provided excellent care. The departments manager spoke about the importance of recognising when staff had provided good care.

The service actively encouraged patients to give feedback, there was patient satisfaction survey in place.

# Diagnostic imaging

## 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.**

See surgery for the main findings.

The diagnostic department had a commitment to continuous improvement. It had recently purchased a new bone density scanner (DEXA) which was due to be installed in 2022. This new machine will expand procedures to include whole body morphometry for muscle and fat analysis for metabolic disorders and sports medicine.

The two radiographers in the department had been trained via the National Osteoporosis Society in DEXA scanning to ensure a high level of competence and understanding. A third member of the radiography staff had just commenced their training.

# Medical care (Including older people's care)

Safe	Insufficient evidence to rate 
Effective	Insufficient evidence to rate 
Caring	Insufficient evidence to rate 
Responsive	Insufficient evidence to rate 
Well-led	Insufficient evidence to rate 

## Are Medical care (Including older people's care) safe?

Insufficient evidence to rate 

We did not rate safe because we did not have sufficient evidence to rate the service.

### Mandatory training

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

Mandatory training was delivered through e-learning modules with some face to face training modules. Managers monitored mandatory training on a monthly basis and alerted staff when they needed to update their training. One endoscopy assistant we spoke to said they were given protected time and encouraged to complete their mandatory training where they had fallen behind.

Staff were given the opportunity to complete mandatory training during work time or in their own time. Where staff completed training in their own time, they were offered overtime pay. The staff we spoke with told us mandatory training was accessible and they were given sufficient time and support to complete their mandatory training.

For our detailed findings, see the surgery report.

### 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.**

We spoke with the lead decontamination healthcare assistant who said that they undertook safeguarding training and knew how to escalate any concerns.

For our detailed findings, see the surgery report.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, the endoscopes decontamination unit did not use a double sink in line with practice guidelines.**

## Medical care (Including older people's care)

All endoscopy procedures were carried out in the main theatres by the existing theatre staff. All endoscopy patients were admitted into the surgical ward on the day of their procedure and received care and treatment by the existing surgical ward staff.

Data audits for cleanliness showed that surgery including endoscopy was consistently over 94% from June to November 2021 and 100% compliant for the same period for hand hygiene.

The service had defined roles, responsibilities and a designated area for decontamination of endoscopic equipment. The designated endoscopy room was no longer in use and procedures were being undertaken in the surgical theatre. This was because a new facility was being built that would create better flow for undertaking endoscopy procedures and decontamination. Three surgical health care assistants were trained and responsible for the endoscope decontamination process. They were accountable to the theatre manager.

The endoscopy room was visibly clean and clutter free. Due to a recent temporary change and building alterations there was only one sink to hand wash endoscopes which was not in line with the service endoscopy cleaning policy which recommends a double sink for manual cleaning. However, staff could describe how they managed this to ensure the equipment went through the required cleaning process using water changes. Plans seen for the new facility showed that a double sink would be installed and this work was due for completion in January 2022.

Clean endoscopes were stored in the steriliser until required in theatre. They were bagged and placed in a clean tray with a green lid ready for use. The cleaning ticket stayed with the clean endoscope for traceability. Their sterilisation had an expiry date on the tickets and if not used within that time frame had to be reprocessed before use.

The bedside endoscope clean was said to take place immediately after the completion of the endoscopic procedure which was clearly described by staff. Used endoscopes were sealed with red lids and placed in a trolley ready for removal to the decontamination room. This was followed by the manual clean of the endoscope in the designated area and reprocessed in a washer disinfectant following best practice guidance.

We reviewed several cleaning records for equipment in the decontamination room which were completed, up-to-date and demonstrated that all areas were cleaned as per the required daily and weekly cleaning schedules. We checked cleaning chemicals compatibility and staff could explain the correct concentration.

Water samples were taken weekly from washer chambers and water reservoirs which were sent to an external laboratory for testing to ensure no microorganisms were present. We reviewed one report for a six-monthly period that showed compliance with testing.

Staff followed infection control principles including the use of enhanced personal protective equipment (PPE) for the decontamination of endoscopy equipment.

Application of risk management to medical devices was overseen by the maintenance engineer.

For our detailed findings, see the surgery report.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, we found that chemicals were not in a locked cupboard.**

## Medical care (Including older people's care)

The maintenance and use of equipment kept people safe. Maintenance contracts with manufacturers of the equipment were in place for annual testing and three services a year. Weekly testing was done by the designated staff for endoscopy decontamination equipment. Checks for endoscopy wear and tear was carried out during the hand washing process which was clearly described by staff undertaking this role.

There were processes in place for the validation of test reports for endoscopy equipment which was validated by an independent authorising engineer in decontamination (AED). This was reviewed by the service's decontamination lead and maintenance engineer to consider any issues raised before it was signed off as completed.

The design of the endoscopy environment followed national guidance in the surgical theatres. Plans viewed for the new endoscopy facility showed a clear flow for procedures and decontamination.

The service had enough suitable endoscopy equipment to safely care for patients and allow for effective decontamination processes.

There was a robust tracking and tracing system that recorded each stage of the decontamination process for each endoscope, the persons involved, storage and subsequent patient.

Each endoscope and relevant staff had bar codes which were scanned, and tickets produced showing when they were last used, and which clinician used them before entering the washer disinfectant and followed the scope to the end process and drying cabinet. The traceability and cleaning compliance tickets stayed with the endoscopes so that they could be checked prior to use. Staff used latex free gloves when handling the endoscopes to protect patients who may be latex sensitive.

There was a clear flow of dirty to clean instrumentation within the single decontamination room and systems were in place to minimise cross contamination and prevent the release of endoscopes not decontaminated appropriately.

The service undertook assessments and reviews of their activities under the control of Substances Hazardous to Health Regulations 2002 (COSHH). Documentation and manuals were accessible to staff electronically and relevant hard copies kept with substances. Staff we spoke with knew where to find, and actively used them. However, it was noted that hazardous substances stored under the sink were not in a lockable cabinet. This was pointed out to staff who were aware that the temporary sink was not lockable. It was confirmed and seen that the decontamination room was kept locked with only designated staff allowed access. The endoscopy procedures took place in theatre.

For our detailed findings, see the surgery report.

### 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 used a nationally recognised tool to identify deteriorating patients which was evidenced in four patients' records reviewed.

There were clear pre-assessment processes for patient suitability to undergo an endoscopy at the hospital. Screening for allergies, COVID-19 and MRSA were undertaken in advance of coming into hospital. Patients who met certain criteria following completion of a medical questionnaire did not require further pre-operative risk assessments or being seen before their endoscopy procedure. The criteria included being under 50 and with no additional comorbidities.'

# Medical care (Including older people's care)

Patients were given a 15-minute telephone appointment if a medical questionnaire was not completed or any further discussion was needed. Where increased risk was identified this was escalated to the consultant to determine risk and management.

A full pre-operative assessment was required for patients with identified risks such as, those taking blood thinning medications, to ensure suitability for treatment and management. Options were available to book patients in for a longer face to face appointment if necessary.

Medications were not routinely stopped for day case patients undergoing endoscopy under sedation for example, patients living with diabetes, with support from their specialist, were said to manage their own medication in most cases. The pre assessment team said they did not have specific guidance for managing this as all patients seen for endoscopy were able to manage their own conditions and medications.

For our detailed findings, see the surgery report.

## 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 staff a full induction.**

Information received from the provider showed there were seven consultant general surgeons and endoscopists, seven Spire staff trained and involved in endoscopy procedures and three staff trained in decontamination.

For our detailed findings, see the surgery report.

## Records

**Staff kept detailed records of patients' care and treatment. Records were up to date, stored securely and easily available to all staff providing care. However, there were inconsistencies where information was recorded.**

Patient notes were comprehensive, and all staff could access them easily. However, a new endoscopy pathway booklet had been introduced and of the four records reviewed completion of the booklet was inconsistent with only one booklet being fully completed. However, the required information could be found in the records elsewhere.

Both electronic and paper records were stored securely with secure passwords for online systems and locked cabinets for paper records.

We reviewed four patient records which showed that records were dated, signed and up to date.

For our detailed findings, see the surgery report.

## Medicines

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

Medicines used for endoscopy services were managed by the surgical ward and theatre teams.

For our detailed findings, see the surgery report.

# Medical care (Including older people's care)

## 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 knew what incidents to report and how to report them. There had been no reported incidents in the last 12 months related to endoscopy procedures.

Staff received feedback from investigation of incidents, both internal and external to the service and staff met to discuss the feedback and look at improvements. There was evidence that changes had been made as a result of feedback. For example, when two abnormal test results came back from the external laboratory for infection control of the endoscopy washers, action was taken to identify the cause. Human error of recording the test was identified and this was shared with staff involved in the testing of water samples. In addition, as a precaution the machine was put through a robust cleaning process and the infection prevention and control lead reviewed the external reports from the testing laboratory.

Clear pre-assessment processes were in place to identify any high-risk patients for endoscopy procedures. The preoperative assessment team spoke to patients by phone and assessed if they were suitable to undergo the procedure at the hospital.

The service used a surgical safety checklist for endoscopy. Combined data for surgery and endoscopy was reviewed from the provider and showed 100% compliance. The provider told us that the majority of audit activity was paused following quarter two in order to alleviate resource pressures across clinical services during the pandemic. Therefore, the data presented was representative of compliance in quarter one and two of this year.

For our detailed findings, see the surgery report.

## Are Medical care (Including older people's care) effective?

Insufficient evidence to rate 

We did not rate effective because we did not have sufficient evidence to rate the service.

## 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.**

For our detailed findings, see the surgery report.

## Nutrition and hydration

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

# Medical care (Including older people's care)

For our detailed findings, see the surgery report.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain.**

Pain comfort scores were based on the Gloucester comfort scale with zero representing no pain to four indicating severe pain. Pain comfort scores were recorded in three out of four patient's endoscopy records reviewed.

For our detailed findings, see the surgery report.

## Patient outcomes

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

Patient outcomes were not available for endoscopy as information received from the provider was for endoscopy and surgery combined.

The service was not joint advisory group (JAG) accredited for endoscopy but was going to work towards JAG accreditation for gastro intestinal endoscopy once the new facility was in operation. The service did not participate in relevant national clinical audits for endoscopy.

For our detailed findings, see the surgery report.

## Competent staff

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

Managers made sure staff received any specialist training for their role which was evidenced in six staff files and additional data received from the provider. All decontamination staff (including staff who undertake any part of the decontamination or handling of endoscopes) were trained and had demonstratable competencies for their roles. We saw in staff records appropriate training was undertaken and staff signed off as competent. In addition, a member of staff had received additional training and certification to train other members of staff as required in decontamination of endoscopy equipment.

The service had recently appointed an endoscopy lead who was due to start in post in January 2022. The theatre manager was the responsible lead until the post was filled.

There was evidence of Control of Substances Hazardous to Health (COSHH) training for all decontamination staff in the competency files we reviewed.

For our detailed findings, see the surgery report.

## Multidisciplinary working

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



## Medical care (Including older people's care)

Theatre staff worked well with decontamination staff. Patients were admitted to the ward and staff worked well together.

For our detailed findings, see the surgery report.

### Seven-day services

**Key services were not available seven days a week.**

The endoscopy service was not provided seven days a week. Endoscopy sessions were being undertaken one day a week with additional clinics once every two weeks in the main surgical theatre.

For our detailed findings, see the surgery report.

### Health promotion

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

For our detailed findings, see the surgery report.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.**

Staff recorded consent in the patients' records which was evidenced in all four records we reviewed.

For our detailed findings, see the surgery report.

## Are Medical care (Including older people's care) caring?

We did not rate caring because we did not have sufficient evidence to rate the service.

### Compassionate care

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

The Friends and Family Test is a survey that measures patients' satisfaction with the healthcare they have received. The test data between October 2020 and October 2021 showed the average monthly responses for patients reporting a good or very good experience across the surgical services, including endoscopy, ranged between 94% and 100%. This indicated the majority of patients were positive about their experience and recommending the hospital's surgical services to friends and family. The average monthly response rate ranged between 46 and 68 patients per month during this period.

For our detailed findings, see the surgery report.

## Medical care (Including older people's care)

### Emotional support

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

Patients or their relatives could be referred for access to counselling and psychological support if required.

For our detailed findings, see the surgery report.

### Understanding and involvement of patients and those close to them

For our detailed findings, see the surgery report.

## Are Medical care (Including older people's care) responsive?

Insufficient evidence to rate 

We did not rate responsive because we did not have sufficient evidence to rate the service.

### Service planning and delivery to meet the needs of the local people

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

The endoscopy services were provided in the surgical ward and theatre areas.

For our detailed findings, see the surgery report.

### Meeting people's individual needs

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

For our detailed findings, see the surgery report.

### Access and flow

**People could access the service when they needed it and received the right care promptly. Patient length of stay and discharge processes were effectively planned and organised.**

The provider did not have specific data for endoscopy waiting times against national requirements as they were included in the surgical wait times.

The registered manager said they managed patient waiting times to treatment, including endoscopy, by prioritising clinically first, and then chronologically, based on wait times. The provider has supported local trusts with higher priority patients. This was to ensure equity of access to treatment across the area, an approach agreed with the regional National Health Service England team (NHSE) and the local clinical commissioning group (CCG).

## Medical care (Including older people's care)

Cancelled endoscopy appointments were rebooked within 28 days. When appointments were cancelled a process was in place to call the patient the same day to rebook an alternative appointment.

Endoscopy inpatient procedure wait times were performed within a 60-minute wait prior to the procedure according to data provided.

The registered manager told us they had recruited new general surgeons to help reduce treatment wait times. With the opening of the new endoscopy unit in January 2022 the service will have increased capacity to reduce the waiting times, and support priority cases for local hospitals.

For our detailed findings, see the surgery report.

### Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. Patients, relatives and carers knew how to complain or raise concerns.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning.

For our detailed findings, see the surgery report.

## Are Medical care (Including older people's care) well-led?

We did not rate well-led because we did not have sufficient evidence to rate the service.

### 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.**

The service did not have an endoscopy lead, but a new lead had been appointed to start in January 2022. The theatre manager oversaw the endoscopy procedures.

The staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

For our detailed findings, see the surgery report.

# Medical care (Including older people's care)

## Vision and Strategy

**The provider had a vision for what it wanted to achieve for the new endoscopy unit and a strategy to turn it into action.**

We were shown plans for the purpose-built unit and the procurement of a new track and trace decontamination system to further improve traceability of endoscopes.

For our detailed findings, see the surgery report.

## Culture

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

The staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical and endoscopy services. They told us there was a friendly and open culture and that departmental and senior site managers were visible and approachable.

For our detailed findings, see the surgery report.

## Governance

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

For our detailed findings, see the surgery report.

## 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 service had suspended some quality monitoring and audit activities due to Covid-19 pressures.**

For our detailed findings, see the surgery report.

## 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.**

For our detailed findings, see the surgery report.

## Engagement

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

# Medical care (Including older people's care)

For our detailed findings, see the surgery report.






## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The service was in the process of upgrading the existing endoscopy unit to a new endoscopy and minor operations (EMO) suite. This was expected to be in place by the end of January 2022 and provide improvement to the endoscopy environment and decontamination facilities. The service was working towards joint advisory group accreditation once the new unit was operational.

For our detailed findings, see the surgery report.

# Surgery

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

## 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.**

Mandatory training was delivered through e-learning modules with some face to face training modules. Managers monitored mandatory training on a monthly basis and alerted staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training covered key topics such as health and safety, compassion in practice, fire safety, information governance, data protection, infection prevention and control, equality and diversity, manual handling and adult and children's safeguarding training.

The mandatory training was completed on a rolling monthly basis and the hospital's annual target for the current training year was to achieve at least 95% training compliance for all staff by the end of March 2022.

The hospital reported they had achieved above the 95% compliance target for all mandatory training modules at the end of the previous training year (2020/2021).

Mandatory training compliance for the current year for individual training modules across the surgical ward and theatre teams ranged between 74% and 97% at the time of our inspection. This showed most staff across the surgical services had completed mandatory training but the hospital's training completion target of 95% had not yet been achieved for all training modules. The remaining staff had until the end of March 2022 to complete outstanding modules in line with the provider's training calendar. The end of year target of 95% compliance had already achieved for some training modules (such as anti-bribery training and equality and diversity training).

The ward and theatre managers told us training compliance had been impacted by the COVID-19 pandemic. The services planned for staff to complete any outstanding training during a planned shutdown of the hospital between 24 December 2021 and 4 January 2022. The ward and theatre staff also completed additional role-specific training in addition to the core mandatory training. This included topics such as duty of candour, food safety, controlled medicines, mental capacity

# Surgery

act, medical gases and blood transfusion (sampling, collection and administration). The hospital reported compliance in additional role-specific training at 89% for theatre staff and 87% for ward staff, which demonstrated most staff had completed the additional role-specific training. The remaining staff had until the end of March 2022 to complete outstanding modules in line with the provider's training calendar.

Staff were given the opportunity to complete mandatory training during work time or in their own time. Where staff completed training in their own time, they were offered overtime pay. The staff we spoke with told us mandatory training was accessible and they were given sufficient time and support to complete their mandatory 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. The hospital reported overall staff compliance of 97.5% for safeguarding children's training and 98% compliance for safeguarding adult's training at the end of the previous training year (2020/2021) and the training target of 95% had been achieved.

Records for the current training year showed 81% of theatre staff and 88% of ward staff had completed adult safeguarding (level three) training and 74% of theatre staff and 88% of ward staff had completed safeguarding children (level three) training. This showed most staff across the surgical services had completed safeguarding training but the hospital's training completion target of 95% had not yet been achieved. The remaining staff had until the end of March 2022 to complete outstanding modules in line with the provider's training calendar.

The safeguarding training also included female genital mutilation and prevent (counter-terrorism strategy) training.

The director of clinical services was the safeguarding lead for the service and had completed adult and children's safeguarding (level four) training. The director of clinical services told us 19 staff across the hospital had also completed the level four training, including the majority of safeguarding specialist link nurses. There were 11 specialist safeguarding link nurses across the hospital and staff were aware of how they could seek advice and support from them.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had safeguarding policies available to support staff and these could be accessed on the hospital's intranet.

Safeguarding incidents were reviewed by the managers and the director of clinical services and also by the hospital's safeguarding committee, which held meetings every three months. The service reported one safeguarding incident during the past 12 months in relation to the surgical services. The incident was reported in May 2021. Appropriate actions had been taken to protect the patient, including referral to the local authority and the patient's general practitioner (GP).

## 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 received mandatory training in infection prevention and control and there were infection prevention and control policies and procedures in place which provided further guidance for staff.

# Surgery

The hospital had not reported any healthcare-acquired infections or outbreaks during the past 12 months. Patients underwent MRSA screening and pre-admission checks for other infection risks, such as *Clostridioides difficile* (*C. difficile*), prior to admission for surgery. We saw evidence of this in the four patient records we reviewed during the inspection.

Staff followed national guidance around managing COVID-19 risks. Any patients and visitors attending the hospital were required to wear personal protective equipment, such as masks. The hospital maintained separate access and flow pathways with colour-coded zones (such as green pathway for patients who had confirmed negative COVID-19 tests). We saw there were appropriate measures in place for segregation and social distancing to minimise the risk of spread of infection.

Surgical patients attending the hospital were also required to carry out a COVID-19 lateral flow test if they had been vaccinated or COVID-19 *polymerase chain reaction* (PCR) test if they had not been vaccinated. We saw evidence of staff collecting this information in the patient records we looked at.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital reported surgical site infection (SSI) rates were consistently low (0.6%) during the past 12 months. The UK Health Security Agency surgical site infections surveillance reports showed there had been no reported surgical site infections following hip replacement and knee replacement surgery reported by the surgical services between October 2020 and June 2021.

The ward and theatre areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning schedules and daily checklists were in place and up to date, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Staff used alcohol wipes and chlorine-based disinfectant to clean and decontaminate surfaces and equipment and applied green labels to individual items to indicate they were clean and ready for use.

The hospital had an on-site sterile services department (SSD) for the decontamination and sterilisation of reusable medical equipment and devices. The SSD was accredited to the ISO 13485:2016 and EC 93/42/EEC standards and accreditation certificates were displayed in the department. The most recent ISO 13485 standards accreditation was achieved during September 2020 and was valid for three years. The accreditation report identified five minor recommendations for improvement, such as undertaking a formal annual management review for the department and we saw an action plan was in place for implementing the recommendations.

The department was managed by the sterile services manager, who was supported by two additional staff. The sterile services department provided support for the theatre teams and operated from 8am to 8:30pm from Monday to Saturday.

The housekeepers were responsible for cleaning bed spaces in between patients, cleaning the general environment and replenishing hand gels and personal protective equipment stocks. There was a programme in place to routinely flush all water outlets to minimise the risk of *Legionella* and we saw checklists were completed to document flushing activities. The theatres underwent periodic deep cleaning every six months and additionally if there had been any contamination (such as after patients with infection risks).

There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance appropriately. Visitors were encouraged to wash their hands.



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All the staff we observed wore suitable personal protective equipment, such as gloves, aprons and visors while delivering care. Gowning procedures were adhered to in the theatre areas. Clean linen was appropriately stored and segregated in dedicated cabinets. Patients identified with an infection could be isolated in single rooms in the ward areas. Staff used appropriate signage to protect staff and patients if there was a patient had been isolated.

Infection control audits took place on a weekly and monthly basis across the wards and theatre areas. These included checks of the cleanliness of the general environment and equipment and hand hygiene compliance.

The service generally performed well for cleanliness. Audit results between May 2021 and November 2021 showed the surgical ward and theatre areas achieved compliance scores between 90% and 100%. The audits showed there had been a continually improving trend in compliance scores, from 90% compliance in May 2021 to 100% compliance during November 2021. Where cleanliness issues were identified, remedial actions were put in place and these were followed up to minimise the risk of spread of infection. The hospital reported there were no outstanding audit actions following the most recent audit in November 2021.

Hand hygiene audits showed staff in the surgical services achieved 100% compliance between May 2021 and November 2021. Where hand hygiene issues were identified, managers told us this was discussed with individual staff members to improve compliance.

The hospital had appointed an infection prevention and control (IPC) lead who oversaw infection control processes and provided support for staff. The service also had a number of infection control link nurses in place to provide support and guidance for staff. The IPC lead reported on infection control processes, incidents (such as outbreaks), audits, training and changes to policies and national guidance to the senior management team every three months.

The IPC lead also had a weekly update with the director of clinical services to ensure rapid response to any concerns and actions and reported new concerns at the daily hospital huddle.

There was a hospital-wide infection prevention and control committee, which held meetings every three months to review infection control processes. The committee included representatives from all departments across the hospital, as well as estates and pharmacist involvement. The committee was also attended by a consultant microbiologist, who remained on hand for any day to day concerns or queries to support the hospital team.

## Environment and equipment

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

The surgical ward and theatre areas we visited were well maintained and provided a suitable environment for treating patients.

There was an on-going refurbishment plan, which included planned upgrades to the ward and theatre areas. The refurbishment plan for the ward areas was planned for completion by the end of January 2022 and included the refurbishment of the clean utility, the installation of four additional hand wash sinks in the main ward corridor and the removal of the carpeted areas in the main ward corridor. As part of the refurbishment plan, most inpatient rooms and bathrooms had been upgraded with four outstanding room upgrades planned for completion during January 2022.

# Surgery

The refurbishment plan for the theatre areas included upgrades to doors and the installation of new key-coded locking systems to improve security and access to the theatre areas. Plans also included new clinical hand wash basins, new scrub sinks and a refurbished anaesthetic room with interlocking doors to the scrub room in line with latest infection prevention and control best practice.

The service had a planned shutdown between 24 December 2021 and 4 January 2022 to complete refurbishment activities in the clinical areas. The service was also in the process of building a new endoscopy and minor operations (EMO) suite. This was expected to be in place by the end of January 2022.

The theatres had effective systems for the storage and management of surgical implants and surgical procedure packs. However, we found the storage areas in the ward and theatre areas were cluttered. Staff told us they felt they did not have sufficient storage facilities and we saw equipment such as trolleys, hoists and monitoring equipment stored in the corridors.

Access to the surgical wards was secure and the theatre rooms were locked when in use. The doors to the theatre area were controlled by a keypad entry and closed at all times with an automatic mechanism. The general environment and equipment in the ward and theatre areas was well maintained but we found the storage areas were cluttered. Staff reported there was a shortage of storage space; however, there was a suitable system in place for safe storage and management of consumables and surgical implants. The hospital had procured a new porta-cabin building to relocate some of the existing office areas with a plan to use the existing office rooms for ward and theatre equipment storage. The installation of the porta-cabin was pending local authority planning approval at the time of the inspection and the hospital director told us the work would be undertaken promptly after planning approval had been granted.

All the patient rooms in the ward areas were either single or double rooms, each with ensuite walk-in shower and toilet facilities. Each patient room had call bells and auxiliary outputs (such as oxygen and medical gases). Patients could reach call bells and we saw that staff responded quickly when called.

All the equipment we saw (such as hoists and blood pressure monitoring machines) were clean, well maintained and had service stickers displayed showing they were within the service, calibration and electrical safety test due dates. Equipment such as trolleys and stands were visibly clean and staff used disinfectant wipes to clean and decontaminate equipment.

There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing was overseen by the engineering manager. Equipment servicing was carried out by external contractors and this was overseen by the engineering manager.

The engineering manager told us approximately 80% of equipment across the hospital was serviced and maintained through an external contractor. The engineering manager told us they sourced other contractors (such as the equipment manufacturers) for the servicing of the remaining equipment that could not be serviced by the main contractor. The engineering manager was currently in the process of identifying and applying asset identification labels to all equipment not covered by the main servicing contractor.

The service had enough suitable equipment to help them safely care for patients. Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly.

# Surgery

Single-use, sterile instruments and consumable items were stored appropriately and were within their expiry dates. Staff disposed of clinical waste safely. There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Staff used sticker labels to place on clinical waste bags, indicating the area and date the label was applied.

Staff carried out daily safety checks of specialist equipment. Emergency resuscitation equipment for adults and children was available in all the areas we inspected and this was checked by staff. We saw that daily and weekly equipment check logs were complete and up to date in the areas we inspected. All the emergency resuscitation trolleys we saw were tagged to minimise the risk that items could be tampered with. Resuscitation trolley audits over the past three months showed resuscitation trolley compliance was 96% in the ward and 100% for theatres, indicating high staff compliance in maintaining resuscitation 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 completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

On admission to the surgical ward and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks. Staff told us they screened patients for suspected sepsis and utilised the sepsis six care bundle if required.

Ward staff used a red, amber, green (RAG) rated system for managing patients identified at risk of falls and patient rooms had signage to indicate the level of falls risk to inform staff of the level of care and support required for that patient, such as enhanced observations and physiotherapist support.

Staff knew about and dealt with any specific risk issues. Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care. Staff carried out 'intentional rounding' observations at least every four hours so any changes to the patient's medical condition could be promptly identified. We looked at four patient records and these showed that patients were reviewed regularly and escalated appropriately when required.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.

There was a NEWS champion in place, who carried out informal patient record checks on the ward at least two days per week. There was also a specialist point of care testing nurse, that carried out patient tests (such as blood glucose level tests) on the wards a number of times in the week.

A monthly early warning score audit was completed across the surgical services to assess compliance against the hospital's policies and National Institute for Health and Care Excellence (NICE) standard CG50 (Acutely ill adults in hospital: recognising and responding to deterioration). The audit results for May 2021 to November 2021 showed monthly compliance ranged between 95% and 100%.

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Shift changes and handovers included all necessary key information to keep patients safe. Staff used the SBAR (situation, background, assessment, recommendation) tool during handovers and handover discussions included any patient safety risks.

The service had an inclusion and exclusion criteria that identified patients who could or could not be admitted for treatment. The inclusion criteria excluded certain patients, such as patients with an American Society of Anaesthesiologists (ASA) classification level three or four (complex health needs) or patients with a body mass index (BMI) greater than 40 were not admitted to the surgical services and were referred either to NHS acute hospitals or to one of the provider's other hospitals that could accommodate these patients.

Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify if there had been any changes to their medical condition since their initial consultation and a decision was made whether treatment could commence.

We observed two theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.

Theatre staff carried out safety huddles prior to commencing surgical procedures and also conducted a de-brief at the end of theatre list. We looked at the records for six patients who had undergone surgery and these showed surgical safety checklists were completed correctly.

There was a routine audit at least every three months to check staff compliance against the safer surgery checklist across the theatre areas. This included an observational audit to observe staff practice. Audit results showed staff compliance was high and ranged between 97.5% and 100% between January 2021 and June 2021.

The surgical services had arrangements with local NHS trusts to allow patients whose health deteriorated during or after surgery to be promptly transferred to a local acute trust if needed. Where a patient's health deteriorated, staff were supported with medical input to stabilise patients prior to transfer and patients were accompanied by a member of staff during their ambulance transfer.

There had been five transfers of surgical patients during the past 12 months. In each case, the patients were appropriately stabilised by the medical staff or the theatre recovery teams and transferred in accordance with the hospital's policies.

The consultants and anaesthetists were trained in life support training at a level relevant to their role. The resident medical officer (RMO) was trained in advanced life support and was on site at all times. The theatre manager told us three theatre staff had also completed advanced life support (ALS) training. The remaining ward and theatre staff had completed either immediate life support (ILS) or basic life support (BLS) training in line with the provider's policy. There was at least one person in theatres with advanced life support training at all times, in line with Resuscitation Council UK guidelines.

There was a hospital-wide resuscitation team that was made of alternating multidisciplinary staff with ILS and ALS training. The resuscitation team carried bleeps and responded to emergencies. The hospital carried out a daily simulation exercise to test the team's responsive times.

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## 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. The ward and theatre areas we inspected had sufficient numbers of trained nursing and support staff with an appropriate skill mix.

Nurse staffing levels were based on the 'safer staffing' acuity tool. The ward manager could adjust staffing levels daily according to the needs of patients. The ward manager told us they only carried out planned elective surgery and this allowed the ward and theatre teams to plan staffing requirements and staff rotas in advance and allocate additional staff for patients with higher dependency needs.

The theatre teams were suitably staffed in line with national guidelines, such as the association of perioperative practice (AfPP) guidelines for safer staffing. There were at least two recovery nurses in place at all times theatre activities were undertaken.

The theatre manager told us they had recently recruited international nurses to fill vacant theatre nurse posts. We spoke with two international nurses who confirmed they worked supernumerary until they had received their Nursing and Midwifery Council (NMC) registration pins. The theatre teams currently only had vacancies for two operating department practitioners (ODPs).

The ward manager told us they currently had 2.2 whole time equivalent nursing staff vacancies and 1.6 whole time equivalent healthcare assistant staff vacancies and recruitment for these was on-going.

Staffing levels in the ward and theatre areas were maintained through the use of bank staff, agency staff or existing staff working additional hours. Managers limited their use of bank and agency staff and requested staff familiar with the service. Where bank or agency staff were used, managers made sure all bank and agency staff had a full induction and understood the service.

The overall agency staff usage across the hospital was 5%, which was in line with the hospital's standard of 5%. The hospital director told us agency staff usage was kept to a minimum but had been required due to increased staff absence resulting from the COVID-19 pandemic.

Staff across the surgical services received daily support from a team of eight housekeepers and 12 physiotherapists (including four bank physiotherapy staff) who worked a variety of shift patterns. There were two housekeeping staff vacancies due to recent leavers and recruitment for the vacant posts was on-going at the time of the inspection. The ward staff were also supported by four administrative staff, who reported to the bed manager.

The ward and theatre managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave as part of the daily hospital-wide and departmental huddles. Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues.

Staff also used a red flag system to escalate unsafe staffing levels. There had been no red flag staffing incidents reported by the surgical services during the past 12 months.

# Surgery

## 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. Surgical procedures were carried out by a team of consultant surgeons and anaesthetists over a broad range of specialties, such as orthopaedic surgery, ophthalmology, vascular and general surgery.

There were 128 consultants working under practicing privileges across the hospital, including 47 consultant surgeons and 40 consultant anaesthetists. The majority of consultant surgeons worked across both the surgery and outpatient services at the hospital.

The consultants and anaesthetists were responsible for their individual patients during their hospital stay and were required to provide on-call support during evenings and weekends. Patients were reviewed by a consultant on a daily basis. Audit records showed the hospital achieved 100% compliance for daily consultant patient reviews between January and June 2021.

Medical cover on the wards was provided by resident medical officers (RMO) who worked alternate shifts for one week. The RMO's were provided by an external agency and rotated across a number of the provider's other hospitals. During their shift, the RMO was based at the hospital 24 hours per day for that week. The RMO was resident on site and was available on-call during out-of-hours.

During their shift, the RMO was responsible for providing medical cover on the ward. Their duties included the monitoring of patients in the ward areas, prescribing medicines and other duties, such as taking blood samples if needed.

The RMO told us they received induction training and were provided with policies and procedures applicable to their role, such as for patient discharge or patient transfer. The RMO also told us they received good support from the ward staff and could contact the on-call consultant or anaesthetist responsible for a particular patient if further advice or support was needed.

Ward staff told us that the RMO cover was sufficient to meet patient needs because the majority of patients were deemed low risk and did not have complex medical needs. The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.

## 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 stored securely. Staff used paper-based patient records for recording risk assessments, consent, discharges, care plans, patient assessments and for medical and nursing notes. When patients transferred to a new team, there were no delays in staff accessing their records.

Staff used paper-based records for standardised nursing activities, such as for daily 'intentional rounding' observations and nutritional care. We saw that observations were well recorded, and the observation times were completed at least every two hours or more frequently depending on the level of care needed by the patient.

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We looked at the records for four patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis. We found that patient's care plans were person-centred and were completed to a good standard. Multidisciplinary staff interventions were recorded in daily notes and these were up to date.

A patient record audit was carried out every three months, based on a sample of 30 patient records across the hospital for the full patient pathway. Audit results showed compliance ranged between 94.7% and 100% between April 2021 and November 2021, indicating high levels of compliance for accuracy and completeness of patient records.

## Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed all medicines and prescribing documents safely and securely, in line with the provider's medicines management policies.

Staff carried out daily checks on controlled drugs and routine medicine stocks (including fluid bags) to ensure that medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly. The hospital director was the controlled drugs accountable officer for the service.

We saw that medicines that required storage at temperatures between 2°C and 8°C were appropriately stored in medicine fridges. Fridge temperature logs showed that these were checked daily and the medicines we checked were stored at the correct temperatures. Log sheets also showed that staff monitored the temperature of the clinic rooms in the surgical wards and theatres on a daily basis.

There was a system in place for staff to notify the maintenance or pharmacy teams where medicine fridge or treatment room temperatures exceeded the maximum temperature range.

The hospital used paper-based prescribing and medicines administration records. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff completed medicines records accurately and kept them up-to-date. We looked at the medicine administration records and discharge medicine records for four patients and saw these were complete and up to date. Information such as patient allergy status was documented.

Medical gases were appropriately and securely stored in each area we inspected. The medicine records also showed patients who required oxygen treatment had oxygen prescribed and this was appropriately documented.

The hospital had an on-site pharmacy dispensary that operated during normal hours on weekdays and limited hours on Saturday. The pharmacy team consisted of a pharmacy manager (also a pharmacy technician), a pharmacy dispenser and two pharmacists. The pharmacy team provided on-call cover for the ward and theatre staff during weekends and out of hours service. The ward and theatre managers could also access the dispensary during out of hours if emergency medicines were required.





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Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. A pharmacist was present on the ward daily and reviewed all medical prescriptions, including antimicrobial prescriptions and to take home discharge medicines, to identify and minimise the incidence of prescribing errors. A pharmacist also attended the safety huddles at the start of each day.

The pharmacy team were responsible for maintaining and replenishing controlled drugs, routine medicines and fluid bags and carried out routine checks for stock levels and expiry dates. All the medicines we saw were kept safely in locked cabinets and were within their expiry dates.

The pharmacy team carried out a range of medicines management audits that were reported on a monthly and three-monthly basis. The audits were reported mostly at hospital-level with some specific to a department or team (such as controlled drug register audits in theatres). The audits undertaken included antimicrobial stewardship in the last 31 days, medicines reconciliation, discharge medicines turnaround times, safe and secure medicines storage, medicines prescribing and documentation of missed doses.

We looked at the results for these audits during the period between July 2020 and June 2021 and found overall compliance ranged between 94% and 100%, indicating high levels of staff compliance with medicines management processes. The hospital reported there were currently no outstanding actions as all the audits undertaken in the most recent three months (April to June 2021) had achieved 100% compliance.

## Incidents

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

Staff knew what incidents to report and how to report them. The service had policies and guidance in place for staff on how to identify, categorise by level of harm and report incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. All incidents, accidents and near misses were logged on an electronic incident reporting system. Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the ward or theatre managers.

New incidents were discussed at daily hospital-wide huddles at the start of each day. The hospital director, director of clinical services and governance manager reviewed all new incidents on a daily basis to identify any serious incidents that required immediate actions, such as escalation to the corporate provider or external reporting to organisations such as the Care Quality Commission or NHS service commissioners.

All serious incidents and potential never events were escalated to the corporate provider's serious incident panel, who determined the level of investigation required for serious incidents and confirmed if incidents would be declared as never events.

There had been no 'never events' reported in relation to the surgical services during the past 12 months. The last reported never event was in July 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.



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The surgical services reported 19 serious incidents requiring investigation between October 2020 and October 2021. None of the incidents related to serious patient injuries during procedure or to serious patient harm. There was one incident relating to patient consent, two incidents where a patient acquired deep vein thrombosis (DVT) post-operatively and four instances where patients had complications following surgery and required transfer to an NHS acute hospital for a higher level of care.

We looked at a sample of three root cause analysis investigation reports and saw these were completed appropriately and showed remedial actions had been put in place to minimise the risk of reoccurrence. The investigation reports included information such as chronology of events, details of treatment undertaken, root cause leading to incident, duty of candour details, action plans and details of any good staff practice to aid learning.

There had been a total of 312 incidents reported by the ward staff and 100 incidents reported by the theatre teams between October 2020 and October 2021. The most frequent incident categories reported documentation / patient information, unplanned inpatient admission following day case and cancellations.

The director of clinical services reported that incidents reported for unplanned inpatient admissions following day case were not as a result of patient safety concerns but mainly related to commissioning arrangements where patients listed for some procedures (such as hernias) were admitted as day cases, there were instances where some of these patients were required to stay overnight, particularly those whose surgery was performed later on the list. The incidents were reported to ensure the hospital could track the overnight stays, and check for any trends. This did not affect patient safety as patients requiring overnight stay were informed in advance of their admission to the hospital.

Staff told us they received feedback about incidents reported and that this was used to improve practice and the service to patients. Learning from incidents was shared through hospital-wide flash alerts, posters on notice boards, bulletins and newsletters and this included learning from incidents that had occurred at the provider's other hospitals. Meeting minutes showed that incidents were also discussed during routine senior management team, medical advisory committee, clinical governance and departmental meetings so shared learning could take place.

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. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The hospital reported 100% compliance in relation to undertaking formal duty of candour following incidents and complaints during the past 12 months.

There had been no patient deaths reported by the hospital during the past 12 months. There was a process in place for patient deaths to be reviewed and investigated through the hospital's medical advisory committee. The provider also had a central process for an independent review of all patient deaths, including a review by a medical examiner.

There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.

## Safety Thermometer

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

Information relating to patient safety, such as patient falls, pressure ulcers and infections was displayed on notice boards in the ward and theatre areas we inspected.

# Surgery

Patient safety incidents were monitored and reviewed as part of monthly departmental and hospital-wide meetings.

There had been no pressure ulcers reported by the service in the past 12 months and there was a low incidence rate for patient falls (0.12%) and venous thrombo-embolism (0.05%).

## Are Surgery 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.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, such as from The National Institute for Health and Care Excellence (*NICE*) and the Royal Colleges' standards.

The national early warning system (NEWS) was used to assess and respond to any change in a patient's condition, in-line with NICE guidance CG50. All patients were risk assessed on admission for their risk of venous thromboembolism (VTE – blood clots), in line with the NICE guidance QS201. The theatre teams also used the 'five steps to safer surgery' checklists, based on World Health Organisation guidance. Staff also used modified safety checklists for certain surgical procedures, such as for ophthalmology.

The hospital used care pathways that had been developed to meet best practice guidelines which staff followed to ensure patients received safe care and treatment. Care pathways were in place for all treatments provided. We reviewed care pathways for a number of surgical procedures, including general surgery, knee replacement and hip surgery and found these were based on best practice guidance.

The services also used a number of enhanced care and recovery pathways in areas such as for hip and knee surgery. Enhanced recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery.

Changes to clinical practice, national guidance and policies were reviewed and developed centrally by the corporate provider and cascaded to the hospital and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. We saw evidence through corporate key learning summaries and through departmental ward and theatre team meetings that changes in practice and guidance updates were routinely discussed.

Staff told us policies and procedures reflected current guidelines and were easily accessible through the provider's intranet. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines.

# Surgery

## 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 used a nationally recognised screening tool to monitor patients at risk of malnutrition. We looked at four patient records which showed staff carried out an assessment of patients' nutritional requirements and used the *Malnutrition Universal Screening Tool (MUST)*. Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff carried out an audit every three months to measure whether patients had a MUST assessment completed prior to surgery. Audit results for the period between January 2021 and September 2021 showed compliance ranged between 96.6% and 100%, demonstrating high levels of staff compliance.

Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff. Staff told us they could contact specialist nurses for support and patients could also be referred for dietitian or speech and language therapist support if needed.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Patients ordered their meals and drinks through the support services assistant a number of times during the day. The hospital had separate menus for inpatient and day case patients, with options available for patients with specific requirements, such as vegetarian, halal and kosher meals. We observed patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Patients were given advice on starve times for certain procedures as part of their pre-operative assessments. The patients we spoke with told us they were given clear advice on starve times prior to admission and were offered drinks and snacks as soon as their procedure was completed. Staff carried out an audit every three months to monitor compliance against theatre starve times. The audit results showed there had been significant improvement in compliance, from 67% compliance (between January to March 2021) to 83% (between July to September 2021).

There had been a number of actions taken to improve compliance, including ward staff contacting patients by phone the day prior to admission to discuss starve times, the introduction of 'hydration' champions to support staff on the ward and the introduction of discussions around starve times at every theatre pre-operative huddle, where anaesthetists confirmed patient hydration instructions should the patient have to wait.

The service also planned to further improve compliance through the introduction of weekly spot-check audits and monthly hydration meetings as well as a pre-op lead review of documentation and patient information around starve times.

## 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.**

# Surgery

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used pain assessment tools to monitor pain symptoms at regular intervals. Acute pain symptoms were managed by the surgical consultants.

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort. The patients we spoke with told us they received good support from staff and their pain relief medicines were given to them as and when needed. Patients were also given information on how to manage pain symptoms and prescribed pain relief medicines following their discharge from the hospital.

A monthly 'pain to trigger' audit to monitor the timeliness of pain relief for patients was introduced in 2021. Audit results across the hospital initially showed poor staff compliance during January 2021 (43%) and February 2021 (73%). However, the audit results for March 2021 (100%), April 2021 (82%), May 2021 (100%) and June 2021 (100%) showed there had been significant improvements made and demonstrated high levels of staff compliance.

The ward manager told us audit findings had shown that staff routinely administered pain relief and reassessed pain symptoms but did always document this accurately in the patient records. The ward manager told us compliance was monitored and staff were routinely encouraged to maintain accurate documentation.

## Patient outcomes

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

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards.

The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data did not identify any concerns and showed the service performed in line with national averages.

Performance reported outcomes measures (PROMs) data for 2020 reported to PHIN showed 100% of patients reported they had improved since their hip replacement and knee replacement surgery and the hospital performed better than the England average.

The national joint registry (NJR) data for 2020/21 showed that patient outcomes, revision rates and mortality rates for hip, knee and shoulder surgery at the hospital were within the national averages.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Audit findings were reviewed as part of routine departmental staff meetings and as part of the clinical governance meeting and medical advisory committee meetings, held every three months.

## 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.**



# Surgery

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Bank and locum staff also had inductions before starting work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received an annual appraisal including a mid-year review. The hospital's appraisal completion target was to complete mid-year and full year appraisals for all staff by the end of February 2022 and managers told us they were on target to achieve this. The hospital reported that 100% of the ward and theatre staff had completed their mid-year appraisals for the current year.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their substantive employer (such as the NHS trusts) and this was reviewed as part of the practicing privileges processes. Where consultants did not have substantive employment within the NHS, the provider arranged for their appraisal to be completed by a designated responsible officer.

The clinical educators supported the learning and development needs of staff. There was one clinical educator in place, who mainly provided training and support for the theatre teams. The ward manager, theatre manager and director of clinical services also provided training support for staff. The director of clinical services told us they had arranged a number of training workshops and refresher courses for staff to participate in during the planned service lockdown in December 2021. Staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Ward staff received competency based training and assessments covering a range of topics, such as chaperoning, use of equipment, taking bloods, administering medicines, cannulation and line insertion, caring for children or patients living with dementia, managing deteriorating patients and prevention of patient falls and pressure ulcers.

We looked at the training records for four staff from the ward and theatre areas and these showed they had undertaken competency-based training that had been assessed by a trainer or line manager. The surgical staff we spoke with told us they routinely completed and updated their competency-based training within their specialty area and felt confident to do their role.

The theatre manager told us the three appointed surgical first assistants had completed or were currently undertaking formal university qualifications as surgical first assistants. The hospital also had specific competencies in place for surgical first assistants.

## Multidisciplinary working

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

There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis in the ward and theatres to ensure all staff had up-to-date information about risks and concerns.

The ward staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between the theatre teams. Ward staff told us they had a good relationship with consultants and the resident medical officer (RMO). The RMO, pharmacist and physiotherapy staff attended daily safety huddle meetings.

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Staff worked across health care disciplines and with other agencies when required to care for patients. There was routine multidisciplinary working between consultants and external NHS hospital staff and general practitioners (GP's) to discuss the patient's care and treatment. Ward staff also liaised with a number of different services when co-ordinating a patient's discharge. This included hospitals, community services, and social services depending on the area the patient was from.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals. The ward and theatre staff told us they received good support from pharmacists, dietitians, physiotherapists as well as diagnostic support such as for x-rays and scans.

The hospital had commissioning contracts in place and primarily provided surgical procedures for NHS patients from two local NHS acute trusts. The hospital also had service level agreements in place for a number of services such as pathology, equipment maintenance and waste disposal.

## Seven-day services

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

Patients were reviewed by consultants daily depending on the care pathway. The resident medical officer (RMO) was on site seven days per week and available on-call during out of hours service. The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.

Routine surgery was performed in the theatres during weekdays (8am-8pm) and on Saturdays (8am-5pm). The theatres did not routinely operate on Sundays.

The Byron ward (inpatient ward) accommodated overnight patients seven days per week and staffing levels were suitably maintained during out-of-hours and weekends. The Coleridge ward was mainly used for day case patients and operated during normal weekday hours and did not routinely open overnight or at weekends. However, the ward could be used at weekends during busy periods if needed.

There was an on-call rota for key staff groups, including senior managers, pharmacy, physiotherapy and imaging (such as X-rays). Physiotherapy support was available on site during normal hours on weekdays with on-call cover during out of hours and weekends.

The pharmacy was also open for a limited number of hours on Saturdays and Sundays. Ward staff had access to the pharmacy dispensary so they could access emergency medicines during out of hours if required. A pharmacist was also available on-call outside of normal working hours and at weekends.

## Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the surgical wards. The wards had a range of information leaflets to provide support and advice for patients around healthier living.



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Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff told us they routinely discussed health promotion and lifestyle choices with patients as these could impact on their ability to receive treatment at the hospital. For example, patients identified as being overweight, patients at high risk due to high alcohol consumption or patients that were smokers were given advice and support, including on how to refer or gain access to external NHS services.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Staff clearly recorded consent in the patients' records. We looked at four patient records which showed that patient consent had been obtained and planned care was delivered with their agreement.

Staff made sure patients consented to treatment based on all the information available. The consent forms we looked at showed the risks and benefits of the specified surgical procedure were documented and explained to the patient.

The hospital-wide consent audit was carried out every three months. The audit results up to June 2021 showed compliance was 98.8%, which demonstrated high levels of staff compliance. The compliance score was also better than the average across other Spire hospitals nationally. The ward manager and theatre manager told us poor compliance was mainly due to illegible signatures. Staff reported one instance where a consent form was illegible and the patient's surgical procedure was rescheduled.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training was incorporated into the adult safeguarding (level 3) training. The hospital reported there had not been any instances in the past 12 months where a Deprivation of Liberty Safeguards application had been made.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The medical staff were trained to carry out mental capacity assessments, in order to determine if a patient had the capacity to make their own decisions. We saw evidence of capacity assessments undertaken in one patient record and the assessments were complete and up to date.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. If a patient lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf. We saw evidence of this in one patient record where the patient had been assessed as lacking capacity to make their own decisions and an independent mental capacity advocate (IMCA) had been appointed to make decisions on the patient's behalf.

There was a hospital-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

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The hospital only provided a limited number of services for children and young people but the staff we spoke with had a clear understanding on how to gain consent from patients under 18 years of age. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The consent policy stated where a child is not Gillick competent, consent can be given by someone on their behalf who has parental responsibility.

The fees charged for treatments offered to privately funded patients were clearly stated prior to patients undertaking any care and treatment.

The hospital director told us they had suspended providing cosmetic surgery procedures since the beginning of the COVID-19 pandemic (March 2020) to increase support for NHS waiting list patients and did not have any plans to restart cosmetic surgery procedures in the near future.

## 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 and those close to them in a respectful and considerate way. We saw that patients were treated with dignity, compassion and empathy. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff followed policy to keep patient care and treatment confidential. All patients in the ward area were admitted to individual rooms so their privacy could be maintained. We observed staff asking patients if they wanted to leave their room door open or closed. We saw nursing and surgical staff spoke with patients in private to maintain confidentiality.

Patients transferred between the ward and theatre areas were given dressing gowns and their dignity was maintained. 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.

Patients said staff treated them well and with kindness. We spoke with six patients during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: “staff are excellent, attentive, very pleased with how my operation went”, “they looked after me well, couldn’t ask for more”, “the staff here are excellent” and “staff are very caring, very nice”.



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The Friends and Family Test is a survey that measures patients' satisfaction with the healthcare they have received. The test data between October 2020 and October 2021 showed the average monthly responses for patients reporting a good or very good experience across the surgical services ranged between 94% and 100%. This indicated the majority of patients were positive about their experience and recommending the hospital's surgical services to friends and family. The average monthly response rate ranged between 46 and 68 patients per month during this period.

## 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 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 staff providing reassurance and comfort to patients.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. The comments received included: "the anaesthetist was very kind and reassuring" and "I was nervous but received good reassurance from all the staff, the anaesthetist was friendly and really helpful".

Patients or their relatives could be referred for access to counselling and psychological support if required.

## 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 staff speaking with patients clearly in a way they could understand.

Staff supported patients to make informed decisions about their care. Patients told us the nursing and medical staff fully explained the care and treatment options to them and allowed them to make informed decisions. Patient comments included; "the consultant clearly explained everything", and "staff clearly explained risks and benefits of procedure".

The hospital had restricted visiting due to the COVID-19 pandemic; however, staff told us they allowed patients' relatives or carers to accompany patients if this was seen to be in their best interest or there were exceptional circumstances, such as if the patient was living with dementia or learning disabilities. The theatre staff gave an example of allowing a patient's carer to accompany them in the anaesthetic room to provide support.

## Are Surgery responsive?

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.**

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The service planned and provided services in a way that met the needs of local people. The hospital provided a range of elective inpatient and day case surgical procedures, including general surgery, orthopaedic surgery, ophthalmology, ear, nose and throat (ENT) surgery and some spinal and vascular surgery.

Facilities and premises were appropriate for the services being delivered. The hospital had two theatres that operated three theatre sessions per theatre, six days per week. The Byron suite (inpatient ward) had capacity to accommodate 18 patients in individual rooms and accommodated patients 24 hours per day, seven days week. The Coleridge ward had capacity to accommodate six patients in individual rooms and was mainly used for day case patients. The Coleridge ward could also be used to accommodate patients from the inpatient ward if additional bed capacity was required.

The surgical services were mainly available for NHS and private fee-paying or insured patients over 18 years of age. The service did not routinely provide treatment for patients under 18 years of age and these patients were referred to another of the provider's hospitals for treatment. However, the hospital reported there had been four instances where 16 to 18-year-old patients received surgical treatment at the hospital. These were all privately funded patients and their care and treatment had been assessed by paediatric-trained staff and each patient deemed as suitable and Gillick competent to be treated on an adult pathway and adult ward. Staff told us they were able to segregate these patients in individual rooms.

Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance, so they did not experience delays in their treatment when admitted to the hospital.

The service had an inclusion and exclusion criteria and patients admitted for treatment were generally healthy or suffered from mild systemic disease and considered to have a low risk of developing complications during treatment.

Managers planned and organised services, so they met the needs of the local population. There were daily safety huddles and bed management meetings so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients. The bed manager reviewed patient admissions on a daily basis and allocated patients to the ward beds up to three weeks in advance, using an electronic patient management system. The ward and theatre staff carried out twice weekly theatre scheduling meetings.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Patients were cared for in individual rooms and there had been no same-sex accommodation breaches reported during the past 12 months.

The hospital director told us they had suspended providing cosmetic surgery procedures since the beginning of the COVID-19 pandemic (March 2020) to increase support for NHS waiting list patients and did not have any plans to restart cosmetic surgery procedures in the near future.

The service was also in the process of upgrading the existing endoscopy unit to a new endoscopy and minor operations (EMO) suite. Endoscopy patients were admitted to the surgical ward and underwent treatment in theatres whilst the refurbishment work was being undertaken.



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## 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. However, the environment across the surgical wards and theatre areas was not always dementia friendly.**

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets in different languages or other formats (such as braille, large print or 'easy read' format) were also available or could be printed upon request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed and staff knew how to access them.

Patients with certain conditions were excluded from undergoing treatment at the hospital. For example, patients with complex pre-existing medical conditions or a body mass index (BMI) of greater than 40 required an additional risk assessment to ensure their surgery was safe to proceed at the hospital without higher level care facilities. This was outlined in the provider's elective admissions policy.

The hospital did not provide services to treat obesity (bariatric surgery). These patients were offered services at another of the provider's hospitals.

The service had an equality and diversity policy in place that outlined the processes for equal opportunities including how they ensured they did not discriminate, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff also received equality and diversity training as part of their mandatory training

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff completed role-specific training in the Mental Capacity Act and completed competencies in caring for patients living with dementia. The surgical services also had dementia link nurses in place to provide support and advice if needed.

The initial consultations and pre-operative assessments identified patients living with dementia or a learning disability and this allowed the staff to decide whether they could treat these patients and put plans in place to provide safe care and treatment. The ward and theatre teams were also able to review patient needs and preferences as part of daily safety huddles prior to and on the day of surgery.

Staff told us patients living with dementia or a learning disability would normally be accompanied by a carer and the hospital had facilities to accommodate patients' relatives or carers overnight.

The Byron suite (inpatient ward) had a dedicated room to accommodate patients living with dementia or a learning disability. This was a larger room that had capacity to accommodate the patient's carers or relatives. However, we observed during our inspection that the environment across the surgical wards and theatre areas was not always dementia friendly. For example, there were no visual aids or dementia-friendly signage in place to facilitate patients living with dementia

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Staff we spoke with were able to give examples of reasonable adjustments made when carrying out procedures for patients with specific needs, such as adjusting theatre lists to accommodate patients' needs or preferences. Staff gave examples of how they recently implemented adjustments for a patient with autism and liaised with relatives and a social worker to allow for safe patient discharge.

The services were accessible for patients with a wheelchair and other facilities were available for patients living with a disability (such as hearing loops).

## Access and flow

**People could access the service when they needed it and received the right care promptly. Patient length of stay and discharge processes were effectively planned and organised. The surgical services did not achieve national standards for waiting times from referral to treatment. However, they had undertaken actions to improve this.**

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

Patients undergoing private treatment did not experience significant delays or waiting times for their treatment. The hospital provided elective surgery across a number of elective surgical specialties for NHS patients on the referral to treatment waiting lists, under commissioning arrangements with two local NHS acute trusts.

There was a total of 1,713 NHS patients across all surgical specialties on the referral to treatment (RTT) pathway in October 2021. This included 1,281 patients on pathway waiting less than 18 weeks (74.8%), 432 patients waiting greater than 18 weeks (25.2%), including 41 patients waiting between 40 and 51 weeks (2%) and 70 patients waiting longer than 52 weeks.

The proportion of patients waiting longer than 18 weeks from referral to treatment was below the incomplete pathway national standard for at least 92% of patients waiting less than 18 weeks from referral to commencing treatment. There is no national comparative data for referral to treatment performance for acute independent hospitals, however the incomplete pathway RTT performance at this hospital was better than the England average for NHS acute trusts during October 2021 (65.6).

The hospital director told us they carried out daily monitoring of RTT performance for new and existing NHS patients who had been referred to the hospital for surgical treatment. To maintain patient safety, available capacity was allocated based on clinical need and patients were managed in order of clinical priority, in line with the Royal College of Surgeons clinical prioritisation guidance. The services supported local NHS trusts with higher priority patients, by scheduling those patients for surgery at this hospital. Patients on the waiting list had been reviewed by a clinician to identify any changes to their clinical needs and were prioritised for surgery if required.

The hospital reported that the support provided for NHS trust patients requiring urgent care had extended the wait time for patients awaiting non-urgent treatment. This approach had been endorsed by the clinical commissioning group (CCG) and NHS England (NHSE), with weekly meetings in place to support the backlogs in NHS Trusts. At the time of our inspection, the hospital was continuing to support the urgent cases from NHS trusts, and waiting times for patients were reducing. The services had a number of actions in place to improve RTT compliance, including recruiting additional

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general surgery consultants and ear, nose and throat (ENT) surgeons to allow for the provision of additional theatre lists. The hospital reported that the launch of the new endoscopy and minor operations (EMO) suite by the end of January 2022 would also create additional theatre capacity from transferring endoscopy lists to the suite and the minor operations suite would create new capacity to support minor procedures currently undertaken in the theatres (such as ENT surgery).

Managers and staff worked to make sure patients did not stay longer than they needed to. The majority of patients attended the hospital for day case surgery. Patients undergoing orthopaedic or general surgery procedures could remain in hospital for up to three days. The hospital reported 75% of patients received treatment as day case procedures during 2020.

During the inspection, we did not observe any significant concerns relating to patient access and flow. The environment in the wards and theatres appeared calm and relaxed and we found a number of beds were empty during the days of the inspection. Patient admissions were staggered throughout the day so that patients did not have to wait for a long period of time once admitted to the ward. The patients we spoke with told us they had not experienced any delays on the day of surgery and had been promptly admitted to the ward and theatres on the day of surgery.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.

The shift nurse in charge on the ward was responsible for carrying out all patient discharges and liaised with the resident medical officer and pharmacists so that patients were discharged in a prompt and timely manner. All discharged patient received a follow up call within 24 hours of the discharge and post-operative care and treatment was provided through outpatient appointments.

Patient records showed staff had completed a discharge checklist that covered areas such as discharge medicines prescribed and communication to the patient and other healthcare professionals, such as GP's, to ensure patients were discharged in a planned and organised manner.

Managers worked to keep the number of cancelled operations to a minimum. There had been 61 surgical procedures cancelled on the day of surgery between January 2021 and October 2021 (equivalent to 1.7% of total procedures undertaken during this period). The main reason for cancellations on the day of surgery were patient choice and COVID-19 cases and self-isolation requirements.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. The hospital reported 53 of the 61 cancelled patients were given an appointment within 28 days of the cancellation and eight patients (13%) were not rebooked within 28 days, of these five were due to patient choice and three due to other reasons.

There had been 18 instances where patients did not attend their appointment between November 2020 and October 2021. The main reason for patient not attending their appointment was related to COVID-19 cases and self-isolation requirements. Where patients did not attend their appointment, staff contacted them to determine the reason they did not attend and to reschedule a new appointment date.

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## Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

The hospital's complaints policy stated that complaints would be acknowledged within three working days and responded to within 20 working days for routine formal complaints. Where this was not possible (such as for complex complaint investigations), staff were required to send a letter explaining the reason for the delay to the complainant after every 20 working days.

Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns within the organisation (to the corporate provider) or to external organisations such as the Parliamentary and Health Service Ombudsman (for NHS patients) and the Independent Sector Complaints Adjudication Service (ISCAS) for private funded patients.

From December 2020 to November 2021 there were a total of 39 complaints across the hospital, including five complaints relating to the ward and one complaint about the theatres. The most frequent reason for complaints was in relation to consultants (19 complaints). The hospital reported 78% of complaints had been responded to and closed within 20 days during this period.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning.

Staff could give examples of how they used patient feedback to improve daily practice. Staff learning from complaints included raising awareness of good patient care among the surgical teams, consultants, booking teams and medical secretaries. The ward had created a form to document and confirm staff had listened to answerphone messages and none were missed.

## Are Surgery well-led?

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

## Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

# Surgery

The overall lead for the hospital was the hospital director, who was supported by the director of clinical services, the financial and commercial manager and the business development manager.

The hospital also had a governance manager, an engineering manager, an infection prevention and control lead, a bed manager and a health and safety and risk lead in place. The medical staff were overseen by the chair of the medical advisory committee (MAC).

The ward manager and the theatre manager were responsible for the day to day management of the ward and theatre areas. There was a senior nurse in charge on each shift on the ward, who acted as a coordinator and oversaw patient discharges. The consultant surgeons and anaesthetists had clinical responsibility for the patients they treated.

The ward and theatre managers had the relevant skills and abilities to manage the surgical services effectively. They understood the risks to the services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring.

A daily safety and business huddle took place at the start of each day. This was led by the hospital director and involved the senior management team and heads of department. There were regular safety huddles and team briefings in the ward and theatre areas so that staff received all relevant information.

The nursing, support and medical staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and said they provided good support.

## Vision and Strategy

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

The hospital's purpose was 'making a positive difference to our patient's lives through outstanding personalised care' and the hospital's mission statement was 'To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'.

The hospital had an overarching clinical strategy for 2021, which included five strategic objectives; to develop and engage staff, to develop excellent clinical quality, to deliver superb customer experience, to achieve an excellent CQC rating and to deliver to business performance targets.

The strategic objectives were underpinned by key performance goals and measurable targets, including for clinical quality, patient safety and medical and clinical governance. Progress against key objectives was monitored and reported as part of routine senior management meetings and medical advisory committee meetings.

The clinical strategy 2021 had been developed by the director of clinical services, with involvement from departmental leads and team leaders. The senior management team was in the process of developing the clinical strategy for 2022.

The vision, values and strategic objectives were clearly displayed on notice boards across the ward and theatre areas. They had been cascaded to staff across the services and the staff we spoke with had a good understanding of these. Objectives were incorporated into individual staff appraisals.

# Surgery

The ward, theatre and sterile services teams had also developed their own departmental vision and values that were based on the hospital's strategy and objectives and we saw these were clearly displayed in the areas we inspected.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

The staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical services. They told us there was a friendly and open culture and that departmental and senior site managers were visible and approachable.

The ward staff, theatre staff and consultants we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers.

Staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. The director of clinical services was the Caldicott guardian for the service. The governance manager was the freedom to speak up guardian for the service and told us they were in the process of appointing a number of freedom to speak up ambassadors across the hospital.

All the staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed. There had not been any significant whistle blower concerns raised by the service or received by the Care Quality Commission during the past 12 months.

## 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 clear governance structures in place that provided assurance of oversight and performance against safety measures. There were a number of groups and committees (such as the health and safety and risk committee, infection prevention and control committee, medical advisory committee, clinical governance committee) in place that held meetings either monthly or every three months and reported to the senior management team.

The medical advisory committee (MAC) held meetings every three months led by the MAC chair. The MAC meetings were attended by the senior management team and surgical specialty lead consultants. Meeting minutes for October 2021 showed the MAC undertook reviews of new and updated guidance, consultants' performance, practicing privileges reviews as well as a review of governance and key risks.

The clinical governance meetings were held every three months and were attended by the senior managers and departmental leads. Meeting minutes for November 2021 showed discussions took place around performance and quality, governance, incidents, complaints and audit performance.

The senior management team (SMT) held meetings on a monthly basis. Meeting minutes for November 2021 showed discussions took place around governance, risks and performance. The SMT meetings also reviewed minutes and reports from the various committee meetings held across the hospital.



# Surgery

Meeting minutes also showed governance and quality reports with detailed information and data around incidents, complaints, audit results, staffing information, governance and risks were produced to inform the clinical governance, MAC and SMT meetings.

The hospital director and senior managers held daily and weekly informal meetings to discuss day to day issues. There were daily huddles held in the ward and theatre areas and a hospital-wide huddle held daily to manage patient risks and cascade governance information to staff.

The ward and theatre teams held monthly clinical staff meetings. Meeting minutes from September to November 2021 showed that discussions took place around incidents, workforce, performance and governance issues and key risks, along with shared learning.

Meeting minutes showed action plans were in place and these were followed up at subsequent meetings.

There was regular communication and oversight from the corporate provider. The senior management team and departmental leads routinely reported governance, performance and risks to the corporate provider and the senior managers and departmental managers participated in regular peer meetings to share learning and benchmarking with the provider's other hospitals across the region and nationally.

Practising privileges were routinely reviewed and authorised by the hospital director, director of clinical services and the MAC chair and were also reviewed at the medical advisory committee.

The hospital reported there were no outstanding queries relating to practising privileges. We looked at the records for two consultants who worked across both the surgical and outpatient services. These contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks.

We spoke with two surgical consultants and the MAC chair, who told us practising privileges were reviewed every two years and they were required to submit updated appraisals, GMC registration information and indemnity insurance information to the hospital on an annual basis. The hospital director told us any individuals working under practising privileges received reminders to submit required documentation annually and individuals who did not submit the required information within required timelines would have their practising privileges removed or suspended. Practising privileges were also removed if individuals had not undertaken any clinical activity for over 12 months, unless there was a valid reason why these should be maintained.

We also looked at staff recruitment files for an operating department practitioner, two theatre nurses, a ward nurse and a healthcare assistant. These showed evidence that appropriate recruitment and pre-employment checks had been carried out. This included identification checks, qualifications, Hepatitis B inoculation certificates, at least two employment references, Disclosure and Barring Service (DBS) checks and Nursing and Midwifery Council registrations and revalidations.

## 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 service had suspended some quality monitoring and audit activities due to COVID-19 pressures.**

# Surgery

The key risks relating to the surgical services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member (such as the ward manager or director of clinical services) responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the hospital risk register.

Staff were supported by the hospital health and safety and risk lead to review open risks and identify mitigations / controls to reduce or eliminate risks. Key risks and risk register entries were reviewed at monthly departmental meetings as well as clinical governance, medical advisory committee and senior management team meetings.

Routine staff meetings took place to discuss day-to-day issues and to share information on complaints, incidents and audit results.

We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as infection control, patient records and medicines management. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters.

The hospital used an electronic audit and quality monitoring system to record the majority of audits undertaken by staff. Staff used electronic hand-held devices and tablet computers to record audit information and audit reports were collated and produced centrally. Audit findings were reviewed at routine departmental and hospital-wide meetings and monitored centrally by the corporate provider.

The hospital director told us the corporate provider had suspended the requirements for some audit reporting from July 2021 onwards due to staffing pressures resulting from the COVID-19 pandemic. The hospital had recommenced the full audit programme in November 2021.

This did not have a significant impact on the hospital's quality monitoring processes as we found that audit and monitoring of key processes, such as infection control, patient records and staff recruitment, training and appraisal was still taking place and routinely monitored at departmental and hospital level meetings. However, this information was reported to the corporate provider which meant clinical dashboards displaying key performance and audit results only included performance data up to June 2021.

## 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.**

Performance information was collected and analysed by the surgical services and was used to develop and support the delivery of services. Staff used electronic systems for the real-time planning and monitoring patient flow and theatre utilisation and cancellations. The surgical services had performance dashboards in place that were updated monthly and provided a detailed overview of patient safety, performance and staffing indicators. The clinical dashboards included comparative data over time and comparative data from the provider's other hospitals nationally.

# Surgery

Staff completed data protection training and information governance training as part of their mandatory training. Training compliance across the surgical ward and theatre teams ranged between 81% and 88%. This showed most staff across the surgical services had completed this training.

We did not identify any concerns in relation to the security of patient records during the inspection. The majority of patient records were paper based and we saw that patient records and patient bed side notes were kept securely. Staff competency and training files were paper based and stored securely. Records such as staff recruitment records, audit records and staff rotas were held electronically.

The governance manager was the General Data Protection Regulation (GDPR) lead for the service. The hospital reported there had been no data breaches that were reportable to the *Information Commissioner's Office (ICO)* in the past 12 months.

Computers were available across the wards and theatre areas and staff access was password protected. Staff we spoke with did not identify any concerns relating to accessing IT systems or any connectivity issues.

The ward and theatre areas had a number of notice boards that displayed information such as audit and survey results, safety bulletins, meeting minutes, quality and performance dashboards, patient safety and infection control information.

Staff could access policies, procedures and clinical guidelines through the provider's intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

## Engagement

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

Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings and took part in daily huddles across the areas we inspected. The service also engaged with staff through newsletters, briefs and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The service carried out an annual staff survey to gain feedback from staff about their experiences. The hospital-wide staff survey (2021) had a response rate of 75% and showed 77% of staff were proud to work for the service, 77% have the opportunity to do what they do best every day and 87% of staff would be happy with the standard of care if a friend or family member needed treatment.

The staff survey achieved low scores in a number of areas, including opportunities to learn and grow (70%), treating people as equals regardless of differences (66%) and for being given the opportunity to talk about their progress in the past six months (61%). The hospital had developed an action plan in response to the staff survey. This included actions such as investing in facilities and equipment, investing in staff training and apprenticeships and improving staff engagement, communication and involvement in planning services.

The hospital continued to provide on-going support for staff in relation to the COVID-19 pandemic. This included clinical supervision and debrief support and occupational health support available for staff in relation to emotional health and well-being.

# Surgery

Staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the Friends and Family surveys, which indicated most patients were positive about the care and treatment they received.

A patient satisfaction survey was also carried out in real time to seek feedback from patients in relation to the quality of care, patient experience and the quality of premises and staff and reports were issued to the hospital from the central team monthly. The most recent report (covering the period between July 2021 and September 2021) showed most patients responded positively and the service scored above 90% for most of the survey questions. The findings of the survey had been reviewed and improvements had been implemented in areas where patient response scores were lower than expected. The survey achieved a score of 79% for the quality of food. The hospital reported this was due to restrictions on kitchen working during the COVID-19 pandemic that had led to limited choices and they planned to improve this through a new and more extensive patient food menu. The survey also scored 85% for availability of car park spaces and 90% for hospital facilities. The hospital had recently extended the car park to provide more provision and had an ongoing refurbishment programme to improve facilities in order to improve patient experience.

The hospital director told us public engagement within the local area to promote services had been impacted due to the COVID-19 pandemic and they planned to carry out further public engagement once the COVID-19 pandemic was over.

We saw evidence there was routine formal and informal engagement with stakeholders, commissioners, other healthcare providers which the hospital worked with under service level agreements and routine engagement with the corporate provider and the provider's other hospitals.

## 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 culture across the services was based on innovation, continual learning and quality improvement. There were a number of quality improvement projects under way and the services planned to roll out quality improvement training for additional staff across the service.

The service had implemented a pain management quality improvement project during 2021. The project aimed to improve staff compliance and patient experience in relation to pain management.






A number of improvements had been implemented or were planned as part of the project, including additional training and education for staff, introduction of a pain referral to anaesthetic clinic, involvement of pharmacists in anaesthetic clinics and for multidisciplinary team (MDT) meetings to include pain management plans to be delivered by ward and recovery staff.

The improvement measures undertaken had resulted in a significant improvement in staff compliance in the 'pain to trigger' audit.

We saw examples of innovative good practice, such as the use of clinical waste bag sticker labels in the theatre areas.

Staff were encouraged to identify ways in which the services could improve. We saw examples of staff being acknowledged for exemplar working through staff awards and excellence reports. The theatre staff also received a national joint registry (NJR) award during 2019/20 for being a quality data provider.

# Outpatients

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

## Are Outpatients safe?

Good 

This is the first time we have inspected outpatients at this hospital as a separate 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.**

Mandatory training was delivered either face to face or via eLearning dependent on the module. During the COVID-19 pandemic this had mainly been electronic, however; plans were in place to increase the number of face to face sessions.

A clinical educator monitored compliance and supported staff to complete mandatory and optional training modules.

The mandatory training was comprehensive and met the needs of patients and staff.

Compliance for mandatory training was between 92% and 100% for each module at the time of our inspection across the outpatient services. The remaining training was expected to be completed by March 2022 at the end of the current training year. There was a planned reduction in hospital activity where staff would have increased capacity to complete.

### 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.**

There were no safeguarding referrals in the 12 months prior to inspection.

All staff, including healthcare assistants, received adult and children's safeguarding training levels one and two. Trained staff were trained to level three.

For adult safeguarding, there was 96% compliance in outpatients and 92% in physiotherapy. There was 96% compliance for children's safeguarding and 100% in physiotherapy.

# Outpatients

A dedicated children's team had been established and these three staff had received training to level four. Any children that were seen were funded independently. For 16 and 17 year old patients, a specialist paediatric nurse risk assessment was carried out by another Spire location to determine Gillick competence before an appointment was made with a consultant with skills to provide care and treatment to young people.

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

Safeguarding leads were available locally, regionally and nationally for support for adults and children and young people.

Flow charts were available that highlighted the safeguarding process including key contacts.

Posters that indicated chaperones were available to attend appointments were displayed throughout the department in consulting rooms and public corridor areas.

## 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.**

There was one main entrance and exit to the hospital that was accessed by patients and staff. This led directly to the outpatient department.

Anyone entering was met by a member of staff who controlled access. Instructions for hand sanitising were advised and a change of face mask to a clean clinical mask. Patients and visitors were directed to sign in and indicate if using the car park.

Earlier in the pandemic, patients were contacted, prior to their appointment to complete a screening questionnaire and had temperature checks on arrival. This activity had stopped, at the time of inspection, with the area designated a red zone.

Social distancing was advised and signage was in place to support it. Screens were in place at reception desks and chairs were spaced out. There was adequate seating to accommodate patients, or relatives waiting. Patients were encouraged to attend on their own but relatives could be accommodated if needed.

Personal protective equipment (PPE) was available in all areas including gloves, aprons and masks. There were clinical sinks in all consulting rooms and treatment rooms. These included hand-washing instructions, soaps and hand sanitisers. All staff, we observed wore PPE appropriately and were bare below the elbows in clinical areas.

Consulting rooms and treatment rooms included disposable privacy curtains that were all dated to indicate when they were last changed with appropriate time frames of change.

We were told that if a patient had a known infection, they would be seen at the end of the clinic prior to a deep clean.

The hospital was undergoing refurbishments and these included the outpatients department. These were being completed in phases. The consultant rooms had been painted, wallpaper removed and carpets removed. There were plans to remove carpets in most of the waiting areas. Where carpets had been removed, the flooring was washable. Chairs in the waiting areas were being replaced, although, currently could be wiped clean.

# Outpatients

Corridor areas, in the physiotherapy department were carpeted but there were plans to remove it.

There were appointments, that were booked as face to face, had been converted to virtual appointments where possible to minimise the number of patients in the hospital. This included the therapy service that included physiotherapy and occupational therapy.

For face to face appointments, gaps between them had increased to allow for the extra cleaning requirements. The department looked visibly clean with a resident housekeeper available.

Staff were required to complete COVID-19 lateral flow tests twice weekly.

We observed that equipment included 'I am clean' tags to indicate cleaning. Sharps bins were available in all rooms, were dated and not overfilled.

Bins were colour coded to indicate whether domestic, clinical or soiled waste and were pedal controlled.

Minor procedures were carried out in designated rooms in the department where specialist equipment was available. In the ear, nose and throat (ENT), room, patients could undergo procedures where doctors used flexible endoscopes. A clinical process was in place for cleaning the endoscopes, after each procedure using a specialised wipe system. All staff supporting this procedure had received e-learning and a guideline was available to review. Face to face training had been arranged but yet to be undertaken. The room was cleaned between patients as per guidance. There were plans to increase the number of scope kits available so that they could be cleaned in the hospital's sterile supplies unit (SSU) after each patient use.

In areas where risk of infection had been assessed as high, the equipment for scopes completed in the outpatient's department (OPD), including hysteroscopy, was single-use and taken to SSU for cleaning with a green and red tray system.

The service carried out infection prevention and control audits, however; some activity was paused due to clinical pressures. Cleanliness audits, for January, April and July 2021, in outpatients were 100% compliant. Hand hygiene audits for April, July, August, September and October 2021 were all 100% compliant.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.**

As part of the hospital's refurbishment programme, the outpatient department had expanded into two areas with separate reception areas. Patients and visitors accessed the department by the main entrance and exit door. This was automatic and accessible for individuals with reduced mobility. There were eight consulting rooms and two treatment rooms all located on the ground floor.

There were a variety of chairs, for patient use, although these were being replaced.

All areas were free from clutter with designated store cupboards for equipment not in use. As part of the refurbishments, one of the store cupboards would need to be relocated but nothing was confirmed at the time of inspection.

There was clear signage including an illuminated no entry sign when ophthalmology laser treatment was in operation.

# Outpatients

Random sampling of sundries indicated that there was stock rotation and stock was within their dates of expiry.

The physiotherapy department was located on the second floor. This was accessed by one of two lifts. The department had a reception area, three consulting rooms, shared by therapists and a gym area.

All consulting and treatment rooms included keypad access to enter, although these were being changed to swipe access. We were told that all staff knew the codes and could access the rooms.

The room designated as sluice / dirty utility was not locked. Housekeepers accessed this room for cleaning products that were obtained from dispensers on the wall.

Each room had a daily checklist that were completed by staff.

The resuscitation equipment was positioned so it could be accessed from all areas of the department. There was an adult resuscitation trolley and a paediatric bag for any children's emergencies. These were tagged with a unique number. A cursory check of the equipment on top of the trolley were checked daily. Full checks were completed monthly and the tags replaced.

The contents of the adult trolley were found to be complete. The paediatric equipment was divided into colour-coded ages for different sizes of children. Two bags were checked, with the ward manager, and two pieces of equipment were found to be missing. This was escalated to the resuscitation team who promptly carried out a complete check and replenished the missing items prior to tagging the bags.

An audit of resuscitation equipment, completed in July 2021, reported 100% compliance in outpatients. Staff we spoke with told us the trolley that was situated in the physiotherapy department was maintained by a third party provider, who shared the area. However, following the inspection we were told that the provider was responsible for the trolley. The audit of that trolley was reported as 78.9%. Actions were completed and awaiting re-audit.

We checked a sample of monitoring equipment and found that not all included a current date for a maintenance check, such as the vital signs monitor and the centrifuge, used to spin blood, in the treatment room. Following the inspection, an urgent maintenance request was submitted and actioned for servicing the centrifuge and other identified equipment. Other machines, seen onsite, included stickers to indicate the date of the last check including the stand-on weighing scales.

Equipment had been identified, prior to inspection, that had probes that were not working correctly. These machines had been removed from patient care areas and placed in storage awaiting repair.

Staff we spoke with told us that there were two main third party contracts, for equipment in the OPD. They were currently identifying all equipment as recorded on the asset register. This register included equipment present, however; did not indicate when equipment was due for maintenance checks. A copy of the service log, for the majority of equipment maintenance was received. This showed that all equipment, in outpatient and physiotherapy areas, had been serviced within the 12 months prior to inspection except three items that were within 14 months. We received a copy of a service level agreement for the maintenance of the endoscope machine, in outpatients, dated 26 November 2021.

## Assessing and responding to patient risk

### Staff identified and quickly acted upon patients at risk of deterioration



# Outpatients

We observed reception staff appropriately confirming the identify of patients on arrival. Patients were signposted to their designated area to await consultation in socially distanced waiting areas.

All clinical staff completed resuscitation training in basic life support (BLS) and paediatric life support (PBLs) as a minimum as part of mandatory training requirements. A number of the team had completed the higher level immediate life support course (ILS).

There was 100% compliance with resuscitation training requirements in outpatients (25 staff in total) and physiotherapy (12 staff in total). In outpatients, 13 staff had completed ILS as well as one member of staff in physiotherapy. There were 12 staff in outpatients who had completed PBLs as well as eight staff in physiotherapy. Eight staff in outpatients had completed paediatric immediate life support (PILS).

The ward manager was scheduled to attend advanced life support (ALS) training for adults and European paediatric life support (EPALS) training for children early in 2022.

Staff completed unannounced emergency scenarios to rehearse skills across the hospital. This meant staff could be prepared for any real emergency.

There were emergency call bells in each consulting room, treatment room and disabled toilet.

A staff member was designated at daily huddles to carry a bleep to support in case of an emergency within the hospital. Emergency bells were tested daily.

The resuscitation equipment was shared between outpatients and diagnostics. In the physiotherapy area, there was an additional resuscitation trolley. This was shared with a third party organisation that adjoined the department.

Any new patient arriving in the department were required to complete a registration form.

For patients who were unwell, during their time in the department, they could be monitored. Staff completed national early warning score (NEWS) charts when needed. Audits of NEWS were completed at hospital level rather than individual departments. Refer to surgery section for details. During clinic times, consultants were in the department and the hospital resident medical officer (RMO) could be called if necessary. If the patient needed to be seen urgently in an NHS hospital an emergency ambulance was called to transport them. Key information would be shared with the provider to continue care and treatment.

The department included ophthalmology consulting and treatment rooms. One room was utilised for yttrium aluminium garnet (YAG) laser treatment for self-funded adult patients. The service also treated self-funded patients with age-related macular degeneration (AMD) throughout the pandemic. This room also contained other equipment such as biometry machines and vision testing.

The laser room had a sign outside the door that illuminated when the laser was in use. A blind covered the window and the mirror was covered when in use. The door was lockable from inside and goggles were available. A fire extinguisher was located close to the room. There were local rules to operate the laser with signed sections for authorised consultants and staff who supported the consultants. However, the local rules, in the room were passed their date of

# Outpatients

review (October 2020). We escalated to the registered nurse who was the designated laser protection supervisor (LPS). The ward manager contacted the laser protection advisor (LPA). We were told that an updated copy was being prepared and would be in place that day. We received a copy of the letter to indicate an extension of the local rules, from the LPA, until 31 December 2021. A further letter reported that the LPA was planning to visit the site on 6 January 2022.

There were anaphylaxis boxes, for adults and children, that were kept in the treatment room. Both had been sealed by the pharmacy department and indicated the earliest expiry dates of the medication. These boxes were checked daily.

At the last inspection it was highlighted that the location should consider using a World Health Organisation (WHO) safety checklist for minor procedures in the outpatient department. Since that inspection, a checklist has been implemented for OPD procedures.

The provider completed audits of WHO and reported between 98%-100% compliance in outpatients throughout 2021.

## 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 staff a full induction.**

Registered nurses and health care assistants were employed in the outpatients department. The physiotherapy department employed therapists including occupational therapists. Both areas were supported by administrative and reception staff in their department areas, bookings and medical records areas.

Staffing in outpatients was planned using the provider's staffing tool. At the time of inspection, there was one part-time vacancy available for a registered nurse. Regular bank nurses were employed to support any shortfalls in nurse staffing.

The team consisted of six registered nurses, one of which was acting in the role of sister, and six healthcare assistants. An additional nurse manager worked supernumerary, although completed one clinical shift per week to support other staff. The manager participated in the on-call rota for the hospital one week in six. The manager was also supporting the diagnostic and therapy teams, at the time of inspection.

Nursing staff attended a daily huddle to discuss any concerns as a team. The manager also participated in the hospital-wide 'ten at ten' where information was shared by each department.

The information displayed on the television, in the waiting area, included the different uniforms for staff at the hospital.

The therapy staff included an advanced practitioner, six physiotherapists and an occupational therapist.

The doctors who worked in the department were all consultants and were employed under a practising privileges process.

## 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 information was recorded in paper records. These were prepared by the medical records team and followed the patient through their care pathway beginning in the outpatients department.

# Outpatients

Appointments were made by the booking team, on site with dedicated staff for NHS and self-funded or insured patients. Bookings were shared with the records team who prepared individual records ahead of clinics. There was a secure record storage area, where records could be kept for three months. After this time, they were couriered securely to a central storage facility for the organisation. Records could be retrieved from this facility within 24 hours. There was an electronic tracking system which meant records could be located at all times. This included if records were retained for quality processes.

Patient records were prepared for planned clinics and stored in secure trolleys, for morning and afternoon clinics, that were accessed by keypads. These trolleys were stored securely in the outpatients department until needed.

Records included referral sheets with information about patients including contact details, any past medical history and allergies as well as the current reason for attending. Any previous attendances, for the organisation, were included in the records.

Each patient record included an outcome sheet that was completed, by the consultant who indicated the next steps for the patient at the completion of appointments.

Following appointments, consultants contacted the patient's GP, or referrer to inform them of the outcome via an electronic summary. Patients received a copy of the correspondence.

Any follow-ups were organised by the bookings team prior to the notes being returned to the medical records team.

For patients attending for therapies, records were stored securely in the physiotherapy department. Once discharged from therapy, records were transferred to the main records area.

The provider audited records, although this was at hospital level for the complete pathway. This meant they were unable to provide a breakdown for outpatients.

Refer to surgery section for details.

## Medicines

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

There were processes in place for the management and storage of medicines in the outpatient department.

There was an on-site pharmacy where medicines could be sourced as per patients on the in-patient ward.

Medicines were stored appropriately in locked cupboards in rooms accessed by keypads.

There were no controlled drugs.

There were no patient group directions (PGD's) in place for medicines.

Most medicines were stored in the treatment room. We reviewed a sample of the medicines and saw they were within their expiry dates.

# Outpatients

Ophthalmology medicines were stored in a locked cupboard in a secure ophthalmology consulting room.

Environmental temperature was monitored, including the minimum and maximum, in both locations and checklists were completed.

Consultants recorded administration of medicines in patient records. Prescription charts were available if patients needed to be admitted.

In the treatment room medicine fridge temperatures were checked daily including recordings of the minimum and maximum temperatures however the specimen fridge was not monitored. We escalated on site. As a result, the provider was planning to introduce same measures as the other fridge.

The storage and security of medicines audit results for the outpatient services achieved 100% compliance during June 2021 and 98.1% compliance during July 2021, indicating high levels of staff compliance.

Refer to surgery section for details.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers shared lessons learned with the whole team and the wider service.**

There were no never events or serious incidents in the outpatient department in the last 12 months. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic barriers are available at a senior level and should have been implemented by all healthcare providers.

There was an electronic system to report incidents and staff we spoke with knew how to report them.

There were 165 incidents, for outpatients in the 12 months prior to inspection; all were classified as either no harm or low harm.

Incidents were discussed at team meetings and shared across the organisation in '48 hour flashes' information.

Staff we spoke with understood the term 'duty of candour.' The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

## Are Outpatients effective?

Inspected but not rated 

We inspect but do not rate effective for outpatients.

## Evidence-based care and treatment

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

# Outpatients

Care and treatment was evidence-based and provided in line with best practice guidance including the National Institute for Health and Care Excellence (NICE). Guidelines were available for staff locally.

Staff could access policies and procedures via the organisation's intranet and computer systems.

Organisational briefings were disseminated across locations monthly. These included any changes and updates to NICE guidance. Changes to policies were made centrally and any changes highlighted to local hospitals.

For changes needed quickly, the organisation cascaded '48 hour flash reports', each week, where information could be shared with staff at daily huddles.

A sample of the organisation's policies were reviewed such as chaperone, children and young person's care, pregnancy testing, infection, prevention and control, medical devices, privacy and dignity and decontamination of naso endoscopes. All policies were within their date of planned review. There were local policies for children and young people, however; these were in the process of being reviewed.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**

Staff we spoke with told us that if a patient required pain relief, in the outpatient department, a prescription could be created and analgesia administered.

Pain audits were completed but reported at hospital level rather than core service.

## Patient Outcomes

**Staff did not always monitor the effectiveness of care and treatment.**

Refer to surgery section for details.

An organisational audit programme was in place. The location submitted to the national quality scorecard.

We requested data for outpatients but only received information for surgery.

## 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.

An induction programme was available for staff new to the role including bank staff.

All staff, in the outpatient department had completed an annual personal development plan. Any training needs were identified and discussed with the manager.

Role specific competencies were completed and a record maintained in individual portfolios.

# Outpatients

There was a hospital clinical educator who supported the learning and development needs of staff.

Staff we spoke with told us that there were opportunities to shadow other more experienced staff if necessary.

There was 100% compliance with appraisals in the outpatient and physiotherapy services.

We looked at staff recruitment files for a nurse and a healthcare assistant working in the outpatient services and these showed evidence that appropriate recruitment pre-employment checks had been carried out. This included identification checks, qualifications, Hepatitis B inoculation certificates, at least two employment references, Disclosure and Barring Service (DBS) checks and Nursing and Midwifery Council registrations.

We also looked at the records for two consultants working in the outpatient services and these contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and DBS checks.

## 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 we spoke with told us that the departments worked well together and supported each other across departments.

Staff, including nurses, administrative, housekeeping and consultants in the outpatient areas worked as a team when providing care and treatment.

The 'ten at ten' meeting occurred each day with representatives attending from each department including outpatients and physiotherapy.

If any clinical multidisciplinary (MDT) meetings were required, for individual patients, these were carried out, and supported by the local NHS trust if needed, such as for patients undergoing cancer treatment

## Seven-day services

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

The outpatient department was open Monday to Saturday to meet the demands for the service from 8am until 9pm with clinics during the day and early evening.

## Health promotion

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

Therapists treated patients to support their recovery to be independent.

Leaflets were available on request as well as online exercise programmes.

## 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.**

# Outpatients

The consent process began in the outpatients department where consent was initially verbal and may be written dependent on the patient pathway.

The organisation had a consent policy to support staff in accessing the necessary consent appropriate to an individual patient's needs.

Mental Capacity Act (2005) was included in safeguarding training as well as specific competencies that included consent processes for different groups of people.

There was an interpreter service that was available for patients whose first language was not English.

For patients who had been assessed as lacking capacity to consent, they would be accompanied by someone close who was able to make an appropriate decision about any care and treatment.

The outpatient department saw children whose care was self-funded. No invasive procedures were carried out for children under the age of 16 years old.

For young people aged 16 and 17 years old, the service was supported by another nearby location for the organisation. Staff at that location contacted the young person to assess if they were Gillick competent to consent to any care or and / or treatment at the service.

The NHS defines Gillick competence as "Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment."

## Are Outpatients caring?

Good 

This is the first time we have inspected outpatients at this hospital as a separate core 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.**

We observed that patients, and their families, were treated with respect and promptly in the waiting area. There were good interactions between staff and patients in all areas. Patients were greeted at the door and directed to the reception desk prior to the appropriate waiting area. Consultants greeted patients and escorted them into consulting rooms.

Privacy and dignity was maintained during consultations. They took place in individual closed rooms. There were privacy curtains in each of the consulting rooms for examination purposes. Chaperone posters were displayed in the consulting rooms and staff could support in this role. If a patient preferred someone close to them, this could be accommodated.

# Outpatients

Patients we spoke with were positive about the care and treatment received in the department from all staff including clinical and administrative staff.

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.

The hospital participated in the NHS Friends and Family Test (FFT).

From October 2020 and September 2021, there were between 92% and 100% of patients, who provided feedback, said that they were likely or extremely likely to recommend the outpatient service. The average monthly response rate ranged between 31 and 97 patients per month during this period.

The provider completed monthly satisfaction surveys. From January 2021 to October 2021, there were between 90% and 100% of patients who were either likely or extremely likely to recommend the outpatient service and for the same time period 88% to 100% of patients in the physiotherapy service.

Patient satisfaction surveys were completed by patients as they attended for their care in real time. A monthly report was produced by each service and department. Refer to surgery section for details.

## 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.

We observed staff recognising when a patient was feeling anxious or worried. Extra time and space was given to patients to help put them at their ease.

Nurses with special interests cared for certain patients and provided emotional support for patients. One of these roles included the breaking of bad news to patients.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

For patients or staff who wished to participate in a spiritual ceremony, this could be accommodated in a quiet area.

## 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.



# Outpatients

Patients could be accompanied by those close to them if preferred. Examples were shared where, despite the restrictions on visitors, as a result of the pandemic, patients were able to attend with support of a carer or multiple carers.

We observed family members both attending appointments with patients and being available in the waiting room.

Staff supported patients to make informed decisions about their care.

Staff talked with patients, families and carers respectfully in a way they could understand.

Posters displayed information for patients and carers. There were no leaflets on display, as part of infection measures, however; they could be sourced if needed.

## Are Outpatients responsive?

Good 

This is the first time we have inspected outpatients at this hospital as a separate core 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.**

The outpatient service included both NHS and self-funded patients with many of the patients referred by their local GP.

The hospital was located close to the town centre with links to local transport networks close by. It was near to the local NHS general hospital although received referrals from other areas of South Manchester and Derbyshire.

A car park that was free of charge was available, however; at the time of inspection, building works had reduced the number of available spaces. There were designated spaces for blue badge holders. Staff were encouraged to park at alternative sites nearby to maximise numbers available.

There was an exclusion criteria at the hospital to ensure all admissions could be safely cared for with the facilities available. This meant that patients may be seen in the department but then could be referred to another of the provider's hospitals with more complex facilities or back to the NHS. Booking staff were available to speak with if needed. There were dedicated teams for NHS and self-funded or insured patients who supported patients through the process and signposted elsewhere if needed.

The outpatient department was open six days a week (Monday to Saturday) from 8am until 9pm to help meet demand for the service. Clinical and reception staff were available when the department was open to support patients including weekend and evening clinics. Virtual clinics using video technology were available to help reduce visits to the hospital.

Patients and visitors could access wi-fi on their personal devices.

# Outpatients

As a result of the pandemic, appointments had been carried out both face to face and virtually depending on the appropriateness both in the outpatient department and in the physiotherapy department.

Local commissioning arrangements meant that patients could self-refer to the physiotherapy department, by-passing their GP. Therapists signposted patients to online exercises that could be completed in their own home; these included instructional videos. Group sessions were being planned for hip and knee physiotherapy for later this year. This would include three patients and a therapist in the departments gym.

There was no facility for referring for emergency mental health support.

## Meeting people's individual needs

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

There was clear signage outside and inside the hospital directing patients appropriately. Patients were escorted to consultations in the outpatient department.

The entrance had automatic doors that were accessible for patients with reduced mobility. A non-gender specific disabled toilet was available for patient use.

Part of the waiting area was shared with the radiology department, although there was sufficient social distanced seats. There was a television screen that displayed patient information. This included details about translation services written in a number of languages. An interpreter service could be accessed to support patients whose first language was not English. A hearing loop was available for patients with a hearing impairment.

There was a water machine that was now back in service following a break due to the pandemic. If patients were unexpectedly delayed in the department, food could be sourced from the in-house catering staff.

There were no newspapers or magazines, at the time of inspection. There were no leaflets displayed, however; we were told that these could be sourced as needed including in a larger font size.

There were two lifts available for patients needing to attend physiotherapy, however; there was no Braille buttons or voice system to indicate the floor.

A hoist could be sourced, from the ward area if needed in transferring a patient. There was also equipment to support bariatric (obese) patients such as dedicated seating, a bariatric wheelchair and a bariatric commode. Whilst bariatric surgery was not offered, the hospital could routinely treat patients with a body mass index (BMI) of up to 40. The department was championing certain staff with special interests including a nurse who was reviewing care for patients living with dementia and a nurse, recently appointed with experience of caring for patients with autism.

A dementia box was being developed, although; had only an individualised blanket present at the time of inspection. Staff completed a training competency in the care of patients living with dementia.

A prayer box was available for patients, visitors or staff containing items to support any spiritual needs. There was no designated multi-faith room, however; a consulting room not in use could be accessed if needed.

# Outpatients

There was a separate waiting area for any children attending. This included some wipeable activities for different ages.

## Access and flow

**People could access the service when they needed it and received the right care promptly.**

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

From January to October 2021, the waiting time from referral to first appointment within six weeks was between 87% and 97%. August reported the longest waits as patient choice during the summer holiday season. January 2021 was 91% when there was an increase in isolations with the pandemic.

The service reported the percentage of patients seen within six weeks was 91% (January 2021) and 92% (February 2021). The service reported performance was impacted by Christmas and rise in self-isolations due to COVID-19. The percentage of patients seen within six weeks was above 95% for March 2021, April 2021 and June 2021.

The service reported the percentage of patients seen within six weeks was 92% (May 2021 and July 2021), 87% (August 2021) and 90% (September 2021). The service reported performance was impacted by a number of factors, patient choice (due to peak holiday periods) and travel restrictions due to COVID-19.

Managers and staff worked to make sure patients did not stay longer than they needed to within the department.

The provider captured information to *show how long patients were in the outpatients from arrival to the hospital, to being escorted into the consulting room through the monthly outpatient survey. Records showed the proportion of patients responding that were seen on time ranged between 68% and 88% per month between December 2020 and November 2021.* This was in line with the average performance across all Spire Healthcare (75%) over the past 12 months. The response rate ranged between 32 and 77 patients per month during this period. For COVID-19 reasons, they requested patients arrived five minutes prior to arrival for the registration checks, and COVID-19 checks (including sanitising hands and using a new mask). We were told that most patients were seen on a timely basis and the staff raised any clinic overruns in daily huddles. This happened for two consultants earlier in the year, whose clinics were running late.

There were posters displayed, in the main waiting area, in the shape of a cross, for staff and visitors, to view, that were changed monthly. Each day was crossed either green if there was no incidences and red if one or more incidence had occurred as below. For the 19 available dates, at the time of inspection there were;

- two days when clinics were cancelled late,
- 12 days when patients had waited longer than 30 minutes,
- 10 days when there were clinic overruns,
- three days when there were late starts to clinics,
- no occasions where any children or young people waited longer than 30 minutes.

Managers worked to keep the number of cancelled appointments to a minimum. We were told that outpatient and physiotherapy cancellations had remained stable with patients given the option of a video consultation if they were isolating for COVID-19, however; there had been a peak in COVID-19 numbers in January and February 2021.

# Outpatients

From November 2020 to October 2021, in outpatients there were between 6% and 9% of patients that did not attend (DNA) and between 12% and 20% of patients who cancelled their appointment. In physiotherapy, from January 2021 to October 2021, there were between 5% and 8% of patients who had either cancelled or did not attend. There were no details provided about number of patients cancelled by the services or breakdown of the cancellations into clinical or non-clinical reasons.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. The provider did not capture details about re-booking cancelled appointments, although we were told that staff tried to call patients on the same day, to rebook them into an alternative appointment, and where there was an expected delay, they would offer an alternative consultant.

## 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.**

There was information displayed on posters, in public areas, about how to provide feedback as well as on the waiting room television.

There were two complaints in the 12 months prior to inspection in the outpatient service and none for physiotherapy.

We saw that any learning from complaints was shared across the organisation in provider briefings.

## Are Outpatients well-led?

Good 

This is the first time we have inspected outpatients at this hospital as a separate core 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 staff.**

Refer to surgery section for hospital details.

There were clear management structures that identified lines of accountability. We found managers responsive to feedback in order to improve patient care.

There was clearly defined and visible leadership in place in the service. The manager was the lead for outpatients, diagnostic and temporarily the physiotherapy service.

All staff we spoke with felt supported by their manager. The manager had an open-door policy and was visible in the department.

# Outpatients

## Vision and Strategy

**The service had a vision for what it wanted to achieve. Leaders and staff understood and knew how to apply them and monitor progress.**

Refer to surgery section for hospital details.

The outpatients department and physiotherapy followed the strategy that was a hospital-wide strategy.

The outpatient department vision was: *“To provide outstanding patient care through consultant engagement, compassion and commitment to every patient using the Outpatient service.”*

The hospital’s vision was displayed in public areas in the department and available for staff and visitors to view.

## 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.**

There was an open culture and staff sought support across the hospital departments.

Staff, including clinical and support staff, we spoke with liked working at the hospital and had positive experiences throughout the location.

Staff had worked there for varying amounts of time, but all reported similar experiences of good team spirit.

Being a smaller location, staff reported that they knew each other across departments.

There were positive working relationships between nurses, reception staff and consultants in the outpatient department that included a diverse workforce.

Staff were supported to learn and develop and were appraised annually.

## 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.**

Refer to surgery section for hospital details.

There was a service level agreement with a laser protection adviser (LPA) to support the ophthalmology yttrium aluminium garnet (YAG) laser service.

There were a total of 128 consultants and 16 support specialists who were working under the organisation’s practising privileges process.

There was a medical advisory committee (MAC) that consisted of consultants from a range of specialists at the hospital.

# Outpatients

The outpatient services held monthly clinical staff meetings. Meeting minutes from September 2021 showed that discussions took place around incidents, workforce, performance and governance issues and key risks, along with shared learning. Meeting minutes showed action plans were in place and these were followed up at subsequent team meetings.

The outpatient manager attended clinical governance meetings with other departmental leads. Operational information followed a set agenda including reviews of incidents, audits, training needs and staffing.

Staff were assigned areas of responsibility and had frequent opportunities to discuss any needs or concerns to improve services.

There were no onsite pathology services. Any specimens for analysis were stored securely in the outpatient treatment room and couriered to another local hospital for the organisation. For specimens that could not be processed by the provider, a service level agreement was in place with the local NHS trust, however; the copy we reviewed was not signed or dated.

## 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.**

Refer to surgery section for hospital details.

There was a risk register for the service that fed into the hospital risk register. The manager was cited on the top risks for the service and these were reviewed as needed with mitigations included appropriately.

A risk manager, for the hospital, supported the outpatients manager with the risk register.

## Information Management

**The service collected 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.**

Refer to surgery section for hospital details.

The hospital maintained dashboards to monitor information gathered regarding patient outcomes and audit data. These linked into the organisation systems where they could be internally benchmarked.

Information governance was included in mandatory training for all staff. There was 100% compliance in physiotherapy (12 staff) and 92% compliance in outpatients (23 staff). The remaining staff had until the end of March 2022 to complete outstanding training in line with the provider's training calendar.

## Engagement

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

# Outpatients

Outpatients participated in the NHS friends and family test (FFT) and the hospital completed a patient satisfaction survey.

The organisation's occupational health advisor was available to support staff. The team visited the site once a week to speak with staff if required.

The manager was visible and approachable, therefore; staff had ongoing informal meetings.

Staff attended daily departmental safety huddles and the manager attended the hospital daily meeting to share information and discuss any concerns. Staff attended monthly team meetings where information could be disseminated from governance and operational meetings in the hospital and across the organisation.

Records of excellence by named staff members were reported onto the organisation's electronic system with a recognition of showing organisational values. Staff were named when they had 'gone the extra mile' and recognised with a gift from the organisation.

The hospital produced a weekly feedback newsletter, on a Friday. This was in addition to the organisations '48 hour flash alerts'.

There was no dedicated staff room for outpatient staff and the hospital dining area was limited by size and social distancing requirements.

## 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.**

Refer to surgery section for hospital details.

The hospital was undertaking a number of quality improvement programmes; these included the whole patient pathway such as the booking process.