Spire Elland Hospital including Longlands Consulting Rooms

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Elland Hospital is located between Halifax and Huddersfield, was purpose-built by United Medical Enterprises and opened in July 1985. The hospital became part of the BUPA portfolio in 1989 and in 1998 had additional outpatient, physiotherapy and office accommodation built. The hospital was sold to Classic Hospitals Ltd in 2005 and subsequently taken over by Spire Healthcare in 2008. In 2015, Spire Healthcare extended theatre capacity at the hospital by building an additional operating theatre.

There are three theatres, 43 bed spaces (comprising 35 single en-suite rooms, two Extended Recovery Unit beds and six day-case spaces) and 10 consulting rooms. Physiotherapy is provided in three private treatment rooms or within the purpose-built gym. There are facilities for digital plain film x-ray, ultrasound and digital mammography with MRI and CT scanning provided by a Spire Healthcare owned mobile service. An accredited sterile service department is located on site for the decontamination of theatre instrumentation. The hospital works predominantly with consultants from the local NHS hospitals of Calderdale, Huddersfield, Dewsbury and Bradford.

Longlands Consulting Rooms are located nine miles away adjacent to Dewsbury District Hospital with three general consulting rooms and a treatment room providing outpatient services only. This includes physiotherapy clinics provided by the Elland Hospital team.

We rated Spire Elland Hospital including Longlands Consulting Rooms as good overall. We rated the service as good for safe, caring and responsive and well-led, and outstanding for effective.

Are services safe at this hospital/service

We rated safe as good:

There was a strong culture of being open with patients and staff were aware of how to raise incidents and gave examples of learning. We saw evidence of effective root cause analysis, application of Duty of Candour and of learning cascaded from hospital committees to team meetings. There had been no never events at the hospital. The hospital used a modified Safer Nursing Care Tool (SNCT) to monitor staffing levels on a weekly basis at a capacity meeting led by the Matron. Staffing levels, clinical safety issues and patient flow were reviewed at a daily hospital-wide morning meeting that included all department heads. The areas we inspected had a sufficient number of trained nursing staff with the appropriate skill mix to meet patients' needs. There were two safeguarding leads in place with Level 3 safeguarding training and all staff were required to achieve Level 2 child safeguarding training and Level 2 adult safeguarding training. Shared information at handover was clear, with discussion around individual patient's needs and risks and the plan for their hospital admission and discharge. Two resident medical officers (RMO) alternately provided medical cover 24 hours per day over a one-week period each and had received appropriate induction training from the hospital. Almost all of the consultant surgeons and physicians were employed by NHS organisations and had practising privileges at Spire Elland Hospital. The arrangements for anaesthetic and surgeon cover out of hours were detailed in the Consultant Handbook and staff we spoke with described the procedure for on-call arrangements for anaesthesia or surgeon consultants out of hours. However, we found that there were issues with the medicines being stored within the right temperature in theatre and the outpatients department and cleaning agent tablets were not held in secure storage at Longlands Consulting Rooms. The tablets were relocated to secure storage at the time of the inspection. Oxygen masks and ambu bags on the resuscitation trollies in outpatients did not have expiry dates; this was a known problem and had been reported by staff

Are services effective at this hospital/service

We rated effective as outstanding:

Summary of findings

There was evidence care and treatment was based on current guidance, standards and best practice. Opportunities to participate in benchmarking and accreditation were actively pursued including Joint Advisory Group for GI endoscopy accreditation for endoscopy services. Patient reported outcome measures (PROMs) April 2014 to March 2015, showed NHS funded knee replacement outcome measures were significantly higher than the national average. The hospital was working towards best practice to reduce the risk of dehydration before surgery, by ward and theatre staff using a joint approach to minimise fasting times. There was a holistic approach to planning people's discharge, which was done at the earliest possible stage. Staff appraisals were on trajectory for completion for all staff by the end of the year and staff were encouraged to develop their skills. Systems to manage and share information that was needed to deliver effective care were fully integrated and provided real-time information across teams and services. There was evidence of effective multidisciplinary working taking place. The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to other independent hospitals.

Are services caring at this hospital/service

We rated caring as good.

Feedback from patients during inspection was universally positive about the caring attitude and efficiency of the service. Comment cards received during the inspection all contained positive statements about the standard of care, support and attitude of the staff. Examples of comments included: "I was very impressed by the kindness and helpfulness shown to me." "They have got me back on my feet after years of pain, this place is fantastic." "My treatment today was prompt, friendly and very caring." The hospital collected friends and family test (FFT) survey data for measuring patient experience and satisfaction: 99% of patients said they would recommend the services. Scores for being treated with dignity and respect were 100% and 99% for having privacy when discussing their condition. All staff that we met during inspection were approachable and friendly. Patients we spoke with said that they were listened to and time was taken to ensure that they understood their care, treatment and condition. They also felt able to approach staff if they felt they needed any aspect of support. There was access to specialist nursing advice services through individual consultants, for example, breast care advice services provided by a specialist nurse to support the one-stop breast clinic.

Are services responsive at this hospital/service

We rated responsive as good.

There were effective arrangements in place for planning and booking of surgical activity including waiting list initiatives through contractual agreements with the clinical commissioning group. Patients admitted to Spire Elland Hospital were assessed for admission suitability by their consultant and by using a risk stratification system in line with local and national guidelines. This meant the majority of patients treated at the hospital were considered "low risk." Adults in vulnerable circumstances, such as patients with learning disabilities and those living with dementia were supported by open visiting arrangements for carers if required. Management had recently introduced dementia awareness champion roles and there was an initiative in progress to make the environment more dementia friendly. Staff held a daily hospital-wide meeting to discuss staffing levels, safety issues as well as patient flow in the hospital. Ward nursing staff and the nurse manager reviewed clinical activity in handovers and throughout the shift to assess capacity and patient safety. The hospital achieved better than the overall referral to treatment indicator of 90% of patients admitted for treatment from a waiting list within 18 weeks for the reporting period. It also achieved better than the indicator of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral in the reporting period. Arrangements were in place with the local NHS trust to receive unplanned transfers for further care. Complaints were responded to in a timely manner and staff were familiar with the process. There was evidence that assurance was obtained of actions arising from complaints being completed.

Are services well led at this hospital/service

We rated well-led at this service as good.

Summary of findings

A clear vision, mission and values were on display and accessible to staff. Staff talked about how the values (such as 'caring is our passion', 'doing the right thing' and 'driving excellence') were demonstrated in the way they delivered their service. The hospital had a defined governance structure in place to ensure performance, quality and clinical risk was monitored. Non-clinical risks and health and safety issues were monitored at the Health and Safety, Quality and Risk Committee, which reported to the senior management team and the hospital director. We found that the current risk register template did not record the date a risk was added to the register therefore it would not be possible to know how long the risk had been monitored. However, risk management processes and the risk register template had been reviewed at corporate level, the revised template was new and in the process of being introduced at the time of inspection. Managers were aware of their organisational and service level risks and the actions in place to mitigate the risks. Staff were well engaged across the hospital and reported an open and transparent culture. They felt they were able to raise concerns. There was strong local leadership of the hospital from the hospital director, which was effectively supported by the chair of the Medical Advisory Committee, Matron and the heads of departments.

Our key findings were as follows:

- The hospital had infection prevention and control policies and an infection prevention and control lead supported by departmental representatives. Quarterly infection prevention and control committee meetings were held. There were links to the infection prevention and control team and microbiology at a local NHS trust and we noted discussion of any infection control issues in minutes of meetings. There were low rates of wound infection and no cases of Methicillin-Resistant Staphylococcus Aureus bacteraemia (MRSA), Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium difficile infections at the hospital between April 2015 and June 2016.
- The hospital used a modified safer staffing nursing dependency and skill mix tool as a guide to assist staff to assess required staffing levels. The matron led a weekly capacity meeting to anticipate staffing needs for the following week and staffing levels were monitored on a daily basis to meet patients' needs. The areas we inspected had a sufficient number of trained nursing staff with the appropriate skill mix to meet patients' needs. Use of agency was low. There were formal on-call arrangements for theatre staff to cover out of hours, should an unplanned return to theatre be required. Shared information at handover was clear, with discussion around individual patient's needs and risks.
- All departments, patient areas and equipment were visibly clean. Antibacterial gel dispensers were available throughout the departments. We observed staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in most of the areas we visited. Hand hygiene audit standards were monitored across the hospital and these were met. Cleaning audits included room cleanliness in all areas, management of disposable curtains and carpet cleaning. Patient Led Assessments of the Care Environment (PLACE) audits were conducted annually. These assessments apply to hospitals, hospices and day centres that provide NHS funded care. The 2016 assessment rated the hospital as 100% for cleanliness (national average 98%).
- Patients had a nutritional assessment at pre-assessment or on admission to identify and address any nutritional needs. Staff we spoke with were knowledgeable around the need for accurate fluid balance and hydration in post-operative patients and the fluid balance charts we reviewed were completed appropriately. Fasting times were the focus of a detailed audit and action plan for better compliance and patient recovery. Theatre and ward staff were working together to help reduce the fasting times and keep patients hydrated. We saw this in practice and the information was recorded in the patient's records. A variety of hot and cold food was available. There was good choice for patients including vegetarian, gluten-free, lighter options and multi-cultural food choices.

However, there were also areas of where the hospital provider needs to make improvements.

The hospital should:

- Manage hazardous materials in line with current legislation and guidance.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated this service as good because: • Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. • Validation of professional registration for doctors, dentists and nurses was taking place. • Staff had the competencies and training to carry out their roles and received training on managing patient risk. • Dementia awareness champion roles had recently been developed. Management planned to source and provide training in the coming months.. • Good practice in the form of safety 'huddles' was taking place. • Patient reported outcome measures (PROMs) data from April 2014 to March 2015 showed the hospital's adjusted average health gain for PROMs - Primary Knee Replacement was significantly higher than the England average. Groin hernia repairs and primary hip replacements were between expected or higher than the national average. • The results from audits and monitoring were used to improve the quality of patient care. • Feedback from patients, those close to them and stakeholders was positive about the way staff treated people. • The leadership, governance and culture supported the delivery of person centred care and staff were committed to the delivery of high quality patient care. • There was a vision and set of values for the service. There was evidence of the effective operation of governance and performance management. Staff were aware of lessons learnt from incidents or complaints. The risks reported on the risk register correspond to the themes from incidents or issues described by the management and staff. • There was an open and transparent, no blame culture where staff felt supported and valued.

Summary of findings

- Staff appraisals were taking place and on trajectory for completion by the end of the year.

Outpatients and diagnostic imaging

Good

We rated this service as good because:

- We saw evidence of effective root cause analysis, application of Duty of Candour and learning being shared. Staff were aware of how to raise incidents and gave examples of learning.
- At the time of this inspection, it was clear that appropriate measures had been put in place to minimise the chances of an incident of radiation over exposure (low harm) and learning had been shared amongst all radiographers within the department. An action plan was in progress to strengthen the quality assurance programme for in-house testing of radiology equipment and we saw there was a World Health Organisation (WHO) Surgical Safety checklist in place for radiological interventional procedures.
- Waiting and clinical areas were clean and tidy and we observed good practice in relation to infection prevention. The service scored well on cleanliness audits.
- We saw that competencies were in place for each nursing role in outpatients and a record of annual competencies and training were held in personal files. Staff appraisal rates were 100%.
- Feedback from patients during inspection was universally positive about the caring attitude and efficiency of the service. A breast care specialist nurse offered support to patients and families when receiving difficult news and, in partnership with local NHS trusts; systems were in place for advice and support to be available to patients 24 hours a day.
- Spire Elland Hospital had no patients waiting longer than six weeks in diagnostic imaging for all modalities during the reporting period (Apr 15 to Mar 16). The hospital achieved better than the target of 92% of incomplete patients beginning treatment within 18 weeks of referral for each month in the reporting period (Apr 15 to Mar 16). It also achieved better than the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting

Summary of findings

period before the targets were abolished (Apr 15 to May 15). Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (Jun 15 to Mar 16).

- The service received a low number of complaints in the past year (six). We saw complaints were responded to within timescales and where there had been a delay in response, the complainant was informed.
- The hospital had a primary care liaison officer who focused on raising the profile of the hospital and offering training to local GPs and practice nurses. This included specialist consultants providing clinical education lectures. The hospital also sent out a quarterly 'primary care news' newsletter which covered topics about the services offered.

However we found that,

- Cleaning agent tablets were not held in secure storage at Longlands Consulting Rooms. These were relocated to secure storage at the time of the inspection.

Summary of findings

Contents

Good

Spire Elland Hospital and Longlands Consulting Rooms

Services we looked at
Surgery; Outpatients & Diagnostic Imaging

Summary of this inspection

Background to Spire Elland Hospital including Longlands Consulting Rooms

Spire Elland Hospital provides a range of diagnostic imaging, outpatient, day surgery and surgical inpatient treatments for NHS and other funded (insured and self-pay) patients. The hospital works predominantly with consultants from the local NHS hospitals of Calderdale, Huddersfield, Dewsbury and Bradford and serves the population of West Yorkshire. Longlands Consulting Rooms are located adjacent to Dewsbury District Hospital.

The hospital offers a range of outpatient services to NHS and other funded (insured and self-pay) patients including a rapid access breast care clinic, physiotherapy, orthopaedics, ear, nose and throat, pain management, ophthalmology, gynaecology, cosmetic surgery, cardiology and general medicine. Inpatient and day case surgical services include endoscopy, breast surgery, oral and maxillofacial surgery, orthopaedic surgery, general surgery, ear nose and throat, gynaecological surgery, urology, pain injections, ophthalmic and plastic/cosmetic surgery. The hospital also provides consultation-only outpatient services for children 16 years and above on a risk-assessed basis.

At Spire Elland Hospital, there are three theatres, an endoscopy service, 43 bed spaces (comprising 35 single en-suite rooms, two Extended Recovery Unit beds and six day-case spaces), seven general consulting rooms, three ophthalmic consulting rooms plus a minor treatment room. Cosmetic surgery and beautician outpatient services are provided in the Springfield Suite with two consulting rooms, a minor treatment area and a beautician area. Physiotherapy is provided in three private treatment rooms and the purpose-built gymnasium. There are facilities for digital plain film x-ray, ultrasound and digital mammography with MRI and CT scanning provided by a Spire Healthcare owned mobile service. An accredited Sterile Service Department is located on site for the decontamination of theatre instrumentation. At Longlands Consulting Rooms, there are three general consulting rooms and a treatment room. Outpatient services include physiotherapy clinics provided by the Spire Elland Hospital team.

The registered manager is the Hospital Director and has been in post since 2003. The Hospital Director also acts as the Accountable Officer for Controlled Drugs.

The hospital was inspected as part of our planned inspection program. This was a comprehensive inspection and we looked at the two core services provided by the hospital: surgery and outpatients and diagnostic imaging.

Our inspection team

Our inspection team was led by:

Inspection Lead: Imogen Hall, Care Quality Commission Inspector

The team included three CQC inspectors and a variety of specialists: senior surgical services manager, senior theatre manager and senior outpatients department manager.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Summary of this inspection

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. We carried out an announced inspection visit on 9th and 10th August 2016 and an unannounced inspection on 16 August 2016.

We spoke with staff individually and in two focus groups. We talked with patients and staff from the ward, operating department, radiology, physiotherapy, pharmacy and outpatient services. We observed how people were being cared for, talked with patients and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Spire Elland Hospital and Longlands Consulting Rooms.

Information about Spire Elland Hospital including Longlands Consulting Rooms

Spire Elland Hospital provides a range of diagnostic imaging, outpatient, day surgery and surgical inpatient treatments for NHS and other funded (insured and self-pay) patients. The hospital works predominantly with consultants from the local NHS hospitals of Calderdale, Huddersfield and Dewsbury and serves the population of West Yorkshire. Longlands Consulting Rooms are located adjacent to Dewsbury District Hospital.

The hospital offers a range of outpatient services to NHS and other funded patients including a rapid access breast care clinic, physiotherapy, orthopaedics, ear, nose and throat, pain management, ophthalmology, gynaecology, cosmetic surgery, cardiology and general medicine. Inpatient and day case surgical services include endoscopy, breast surgery, oral and maxillofacial surgery, orthopaedic surgery, general surgery, ear nose and throat, gynaecological surgery, urology, pain injections, ophthalmic and plastic/cosmetic surgery. The hospital also provides consultation-only outpatient services for children 16 years and above on a risk-assessed basis.

The hospital does not admit emergency patients. Spire Elland Hospital contracts services for blood transfusion and histopathology, chemotherapy, waste management, computerised tomography and magnetic resonance image scanning, laser protection, laundry, medical equipment maintenance, occupational health, pathology and radiation protection. These services do not form part of this inspection report.

Activity

Spire Elland Hospital operates 35 inpatient rooms, two extended recovery beds and six day case spaces. It is registered for 43 beds.

The hospital employed 153 WTE staff as of June 2016 and had 143 consultants with practicing privileges. Temporary bank were mainly used to cover staffing shortfalls with use of agency nursing when required.

There were 1,485 inpatient and 4,489 day case episodes of care at Spire Elland Hospital from April 2015 to March 2016.

The ten most common procedures performed were:

- Facet joint injection 344
- Knee arthroscopy 241
- Phakoemulsification with lens implant 232
- Diagnostic colonoscopy 207
- Knee replacement 255
- Hip replacement 188
- Inguinal hernia repair 135
- Cholecystectomy 131
- Joint injection under x-ray control 116
- Sub-acromial decompression 89

In the reporting period from April 2015 to March 2016, there were:

- No Never Events.
- No patient deaths at the hospital. CQC received two statutory notifications from the hospital of one expected and one unexpected death in local NHS hospitals, which occurred following discharge after surgery at Spire Elland Hospital. This was an appropriate action by the hospital. Neither death was attributed by the coroner to the surgical procedure.
- No serious injuries reported.
- One incident of hospital acquired PE. A root cause analysis was undertaken and confirmed that the VTE risk assessment was completed and the prescribed prophylaxis treatment was given.

Summary of this inspection

- Six unplanned transfers to an NHS hospital, six cases of unplanned readmissions and five cases of unplanned return to theatre. The assessed rate of these events (per 100 inpatient attendances) is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

In the reporting period from April 2016 to June 2016, there were:

- No Never Events
- No patient deaths at the hospital and no deaths reported post-discharge.
- No serious injuries reported.
- Three incidents of hospital acquired Pulmonary Embolism. Root cause analyses confirmed that the VTE risk assessment was completed and the prescribed prophylaxis treatment was given.
- One unplanned readmission and two unplanned transfers to an NHS hospital.

There were no reported cases of Clostridium Difficile (C.Diff), Methicillin-resistant Staphylococcus Aureus (MRSA) or Methicillin-sensitive Staphylococcus Aureus (MSSA) between April 2015 and June 2016.

There were 30,873 outpatient total attendances between April 2015 and March 2016; of these 53% were NHS funded and 47% were other funded. Outpatient services cover 18 different specialities. The specialties with the highest outpatient activity are orthopaedics, general surgery, ear, nose and throat, gynaecology, plastic surgery, ophthalmology and urology. Eleven of the day cases during that period were children aged 16-17 years; however, from July 2016, the Spire Elland Hospital took the decision to withdraw paediatric services to children under the age of 16 years. The hospital provides consultation-only outpatient services for children 16 years and above on a risk-assessed basis.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	☆ Outstanding	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	☆ Outstanding	Good	Good	Good	Good

Good

Surgery

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

Information about the service

The Spire Elland Hospital is located between the towns of Halifax and Huddersfield. It provides day surgery and surgical inpatient treatments for NHS and private patients. These include orthopaedics, ophthalmology, gynaecology, urology, ENT surgery, plastic surgery, breast surgery, vascular surgery, colorectal and general surgery.

The facilities include 35 single en-suite rooms, two Extended Recovery Unit beds, six day-case spaces, three operating theatres, endoscopy service and an accredited sterile service department used for the decontamination of theatre instrumentation. The hospital works predominantly with consultants from the local NHS hospitals of Bradford, Calderdale, Huddersfield and Dewsbury.

There were 1,485 inpatient and 4,489 day case episodes of care at Spire Elland Hospital from April 2015 to March 2016. Eleven of the day cases were children and from July 2016, Spire Elland Hospital no longer provides this service.

The inspection took place on the 9 and 10 August 2016 and was part of an announced comprehensive inspection. As part of the inspection, we also carried out a follow up unannounced visit on the 16 August 2016. We inspected the day surgery, in-patient facilities, theatres and the sterile services department.

We spoke with seven patients and 13 staff. This included ward sisters, nurses, healthcare assistants, the resident medical officer (RMO), operating department practitioner, consultants and senior managers. In addition, we also held two staff focus group meetings to hear their views of the service they provide. We observed care and treatment, inspected nine sets of care records and we reviewed the hospital's audits and performance data.

Summary of findings

We rated this service as good because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- Validation of professional registration for doctors, dentists and nurses was taking place.
- Staff had the competencies and training to carry out their roles and received training on managing patient risk.
- Dementia awareness champion roles had recently been developed. Management planned to source and provide training in the coming months.
- Good practice in the form of safety 'huddles' was taking place.
- Patient reported outcome measures (PROMs) from April 2014 to March 2015, showed NHS patient funded knee replacements were significantly higher than the national average.
- The results from audits and monitoring were used to improve the quality of patient care.
- Feedback from patients, those close to them and stakeholders was positive about the way staff treated people.
- The leadership, governance and culture supported the delivery of person centred care and staff were committed to the delivery of high quality patient care.
- There was a vision and set of values for the service. There was evidence of the effective operation of governance and performance management; where

Good

Surgery

staff were aware of lessons learnt from incidents or complaints. The risks reported on the risk register corresponded to the themes from incidents or issues described by the management and staff.
- There was an open and transparent, no blame culture where staff felt supported and valued.
- Staff appraisals were taking place and on trajectory for completion by the end of the year.
- The hospital was working towards best practice to reduce the risk of dehydration prior to surgery by carrying out fasting audits.
- Work was in progress to improve risk register management supported by a corporate initiative.

Are surgery services safe?

Good

We rated safe as good because:

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- The hospital clinical scorecard for quarter one 2016 showed they scored 85% for the closing of all incidents within 45 calendar days. The Spire Healthcare target was set at 75% compliance.
- There were good infection prevention and control systems in place. Hospital acquired infection rates were very low.
- Care pathways were used and individualised to meet patients' needs. Record keeping was of a good standard. Records were stored securely in line with data protection procedures.
- Safeguarding procedures were in place and staff knew what action to take should they have concerns.
- Staff had received training on managing patient risk and there was a dedicated room should a patient require an increased level of monitoring.
- The service used patient dependency and capacity planning to help determine the staffing levels. Consultant cover was available 24 hours a day and seven days a week.
- We saw good practice in the form of safety 'huddles' were taking place; for example in theatres where surgeons discussed allergies and patient safety with all staff.
- There was a business continuity plan, which identified keys risks that could affect the provision of care and treatment.

Incidents

- Staff were encouraged to report incidents using an electronic reporting system. The staff members we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.
- There had been no never events reported during the period April 2015 - July 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how

to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- From April 2015 to March 2016, CQC received two statutory notifications from the hospital of one expected and one unexpected death which occurred following discharge after surgery at Spire Elland Hospital. This was an appropriate action by the hospital. Neither death was attributed by the coroner to the surgical procedure.
- During the same period, there were 492 incidents reported. Of these 398 caused no harm, 55 low harm, 38 moderate harm and one was reported as having caused severe harm.
- The hospital clinical scorecard for quarter one 2016 showed they scored 85% for the closing of all incidents within 45 calendar days. The Spire Healthcare target was set at 75% compliance.
- There was one serious incident (SI) reported in May 2016. The patient had a pulmonary embolism (PE) following surgery and a subsequent deep vein thrombosis (DVT). A root cause analysis (RCA) took place. An RCA is a method of analysis that seeks to identify the root cause of an incident, identify learning and the actions to mitigate the risk of the event happening again. The RCA showed that although this was a known risk of surgery, there was no single identifiable root cause. We reviewed two additional RCAs and comprehensive investigations had taken place. Each report included a key learning summary, recommendations where appropriate and an action plan.
- Staff were aware of the outcome of the incident and confirmed lessons learnt from incidents were shared with staff. The matron and governance manager reviewed all incidents and ward managers and senior staff investigated them.
- Common themes of incidents included cancellations and day cases staying overnight. This information was reviewed at the Medical Advisory Committee (MAC) meetings and action taken when required. The meeting minutes in May 2016 showed that the cancellation rates might have been overstated. As a result, the information was being checked on a daily basis.
- The April 2016 minutes of the monthly clinical effectiveness meeting showed patient safety incidents were discussed together with the monitoring of action taken. The minutes of that meeting referred to two incidents where patients had a latex allergy. The theatre minutes dated June 2016 referred to the same RCA report. As a result, theatre staff replaced all latex catheters with non-latex ones. This was an example of action taken following learning from an incident.
- The Duty of Candour (DOC)is a regulatory duty that relates to openness and transparency and requires providers of health services to notify patients (or other relevant persons) of certain incidents and provide reasonable support to that person. Staff were aware of the requirements of DOC and had received training supported by a policy and a staff booklet on implementing the regulation.
- We saw an example of where DOC had been applied. The process included a thorough investigation followed by an apology and discussion about actions taken with the patient. This showed the hospital was open and transparent with families when things went wrong or not according to plan.

Safety thermometer or equivalent

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at patient harms such as falls, venous thrombolysis embolism (blood clots, VTE), pressure ulcers and catheter related urinary tract infections.
- During the period July 2015 - June 2016, data provided by the hospital showed, with the exception of September 2015 when the hospital scored 66.7%, patients received 100% harm free care. The reduction in score for September 2015 was attributed to one patient developing a urine infection. This was better than the average 97.4% score for a similar size independent hospital.
- The corporate clinical scorecard showed the hospitals set performance targets for quarter one, 2016. The results included compliance with VTE risk assessment screening which was 100% and there had been no pressure ulcers of category 2 or above.

Cleanliness, infection control and hygiene

- There was a proactive and robust approach to managing infection prevention and control demonstrated by the investigation of infections, audit activity and developing staff knowledge. The IPC lead was studying for a master's degree in advanced practice for infection prevention and control.

Good

Surgery

- There were no cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium Difficile (C.Diff) infections at the hospital for the period April 2015 to March 2016.
- MRSA screening took place prior to all surgical procedures. The hospital provided an information booklet about what patients should expect and this included what to expect if the results were positive.
- From April 2015 to March 2016, there were no surgical site infections (SSIs) resulting from hip operations and one SSI resulting from knee operations (0.45% per 100 surgeries). This was lower than the national average of surgical site infection for knee replacements in the NHS 2015/2016 (0.5%).
- The areas we visited were visibly clean and equipment had stickers on them, which showed they were clean. Disposable bed/cubicle space curtains were changed six monthly and we saw evidence of dates when this had taken place.
- The central sterilising department had accreditation with a national certification body. The manager responsible for this service told us the turnaround for instrument decontamination was four hours. They also had equipment kits on loan, which had helped with the increase in demand when the third theatre was commissioned.
- Reusable endoscopes (which are used to look inside a body cavity or organ) were cleaned and decontaminated in accordance with best practice guidelines. Water testing every five days took place to comply with the national guidance for endoscopies, Health Technical Memorandum 01-06, Part B, Water quality and water treatment.
- Examples of infection prevention and control audits were seen for the wards and departments. For example, in August 2015 the sterile services department scored 95%. The information included an action plan with dates for completion and a person responsible to make sure the work took place.
- In line with best practice for infection prevention, all clinical areas had hard floors in place including patient bedrooms. Corridors and waiting areas on the wards were carpeted; these were cleaned monthly and spot checks were undertaken. Staff said in the event of a spillage, the carpets would be cleaned following the appropriate procedure. The Patient Led Assessment of the Care Environment (PLACE) showed they were 100% compliant for infection control in the ward and acute environment. This was higher than the national average of 97%.
- We saw staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance of the ward and inside of bedrooms. There was clear signage encouraging visitors and staff to wash their hands and use the hand gel to reduce the risk of infection. Hand hygiene audits measured the use of skin sanitisers per day in 20 occupied rooms. The results showed a ratio of 16:2 skin sanitiser used per room / each day. The result was positive, with a rating of green, which denoted good hand hygiene compliance.
- Staff told us that they completed infection prevention and control training. Data provided by the hospital showed that 77.4% of staff had completed this training as at July 2016 and they were on target for all staff to complete the training by the end of the year.

Environment and equipment

- Visitors to the service were required to sign in and wear a visible identification badge. This made sure patients and staff were protected from unauthorised personnel.
- The Patient Led Assessment of the Care Environment (PLACE) showed the service was 98% compliant for the condition, appearance and maintenance of the environment. This was higher than the national average of 92%.
- Staff told us that equipment was readily available and the hospital loaned, replaced items or purchased new equipment when needed in a timely manner. Safety testing of electrical equipment was taking place and dated stickers were on the equipment to show it was tested.
- The hospital's sterile services department was accredited by Société Générale de Surveillance (SGS) under ISO 13485.
- The hospital had a computerised planned maintenance system for their equipment. Multi-vendor maintenance agreements were in place for equipment such as diagnostic imaging and biomedical equipment.

- Appropriate resuscitation and emergency equipment check were taking place in each area we inspected, including theatres. This meant the equipment would be available in an emergency.
- The anaesthetic machine checks were completed daily and records kept.
- Health and safety meetings took place and we saw the minutes from the July 2016 meeting. The minutes referred to health and safety audits, which took place a minimum of annually. The information included action plans and timescales when identified work was to be completed.

Medicines

- There was an in-house hospital pharmacy and procedures in place for staff to obtain patients medicines when it was closed.
- In line with hospital protocols, antibiotics were routinely prescribed following joint replacement surgery. Between January and July 2016, hospital data showed there was 100% compliance with their antibiotics protocols. Ongoing monthly audits took place to monitor compliance with antibiotic provision following joint surgery.
- We inspected 12 medicines administration records; two from the day surgical unit and 10 from the inpatient ward. The documentation included the patient's allergies and prescribed oxygen, where appropriate. Several signatures were illegible on the medicines administration records; however, a record of the staff names and signatures was kept in the patient's file to make sure the members of staff could be identified.
- There were appropriate arrangements in place for storing, recording and managing controlled drugs. All medicines, including those for emergency use were checked at regular intervals and records showed they were in date.
- Ward records showed that medicines requiring refrigeration were stored at the correct temperatures between 2 and 8°C.
- In theatres, we saw medical gases were stored in line with current guidance and records had been maintained for the blood storage refrigerator.

Records

- The hospital had an on-site medical records department and fully integrated care records. Patient records were comprehensive and included a care pathway and records shared by all disciplines of staff. Clinical information and records were easily accessible to staff including electronic test results and provided real-time information across teams and services. There was also a team of medical secretaries on both sites to support consultants.
- We inspected nine sets of patient records and they had been completed to a good standard. They were paper based and stored securely in line with data protection procedures, preventing the risk of unauthorised access to patient information. The hospital used a data encryption service, which reduced the opportunity for sending unencrypted patient identifiable data.
- Pre-operative assessments took place at an outpatient appointment so that clinical information was available for staff on admission. A physiotherapy pre-operative assessment took place for patients having major orthopaedic surgery such as, a hip or knee replacement. This was to assist with the patient's early mobilisation and discharge.
- Audits of records took place four times a year and the information showed a good standard of record keeping. Where issues were identified, action had been taken.
- The hospital matron was the Caldicott Guardian. (A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing.)
- Ninety eight percent of staff had received the NHS information governance training between April 2015 and March 2016.

Safeguarding

- The Matron and the Governance Lead were the hospital safeguarding leads for adults and children and each was trained to Level 3. No safeguarding concerns were reported to the CQC in the reporting period from April 2015 to March 2016. The hospital was no longer providing consultation or treatment to any child under the age of sixteen.
- Child and vulnerable adult safeguarding policies were in place and provided a framework for all staff when identifying, responding to escalating any aspects of safeguarding. The hospital had guidance in place for Child Sexual Exploitation (CSE) and a standard operating procedure for Female Genital Mutilation (FGM).

- Training levels as at July 2016 for child safeguarding Level 2 were 85% (ward staff) and 80% (theatre staff) and 90% (ward staff) and 93% (theatre staff) for adult safeguarding Level 2. Training compliance rates were on track to meet hospital targets by the end of the year.
- The staff we spoke with were aware of how to identify potential abuse and report safeguarding concerns. The policy contained contact details for the Local Authority safeguarding team.
- Staff we spoke to knew how to recognise and escalate safeguarding concerns. All staff knew how to make a safeguarding referral or who to contact if they needed further advice. Senior staff were able to provide an example of appropriate action they had taken in relation to a safeguarding concern.

Mandatory training

- The service mandatory training target was 95% and last year's figures showed that their compliance rates were between 94 – 98%. Mandatory training was delivered either face to face or by e-learning. It included topics such as safeguarding for adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS), resuscitation, infection prevention and control, manual handling, fire safety, information governance, equality and diversity, and PREVENT (protecting people at risk of radicalisation).
- The resident medical officer was the Advanced Adult and Paediatric Life Support (ALS and APLS) trained person on duty 24 hours a day and was supported by an additional ALS provider who was also on duty during each shift.
- Staff told us mandatory training availability was good and other courses could be requested to further staff development. They told us that they were up to date or on track for completing their training by the end of the year.
- The information provided prior to the inspection showed that the compliance rates for mandatory training ranged between 76 - 96% and was on track to meet the target levels by the end of year.

Assessing and responding to patient risk

- There was a corporate admission and discharge policy in place and registered nurses assessed patients in pre-assessment clinics prior to surgery. Any concerns or additional information were communicated to the patient's consultant and anaesthetist prior to the patient's admission. Staff we spoke with were knowledgeable about the pre-assessment process and the criteria for admission.
- Anaesthetists and pre-assessment nurses calculated the patient's American Society of Anaesthesiologists (ASA) risk grade as part of their assessment of a pre-operative patient. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels, with Level 1 being the lowest risk.
- There was a flow chart for staff to follow to escalate concerns about managing a deteriorating patient. This was supported by a policy and training. Staff were aware of the flow chart and the action they should take. Senior staff had attended a one-day workshop on managing patient risk.
- Each morning the pager alert system, which was used to alert staff in the event of an emergency was tested.
- There were two extended recovery beds should a patient require an increased level of monitoring and care postoperatively. Should an unplanned transfer be required, the hospital had a service level agreement for the transfer of critically ill patients to the local acute NHS trust and within the regional critical care network.
- There were 12 staff members and the RMO with current advanced life support training. Trained staff included operating department practitioners and registered nurses on the wards.
- The theatre staff used the National Safety Standards for Invasive Procedures (NatSSIPs). The standards were developed to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures. This allowed organisations delivering care to standardise the processes that underpin patient safety.
- The World Health Organisation (WHO) devised five stages of checks that should be taken when a patient has an operation. One of these is the safety briefing in theatre and we observed two safety briefings at the beginning of theatre lists. The safety briefings were comprehensive and involved the entire theatre team (anaesthetists, nurses, operating department staff and surgeons). The briefing covered information the staff should be aware of about each patient such as allergies; the requirements for the theatre list including equipment and the time each case was expected to take.
- The hospital was using the WHO surgical safety checklist for all surgical procedures, local anaesthetic procedures

and developing it for use when performing endoscopies. Staff we spoke with were aware of how to use the checklist. The checklist was complete in each of the patient records we inspected.

- An audit of the WHO checklist was carried out each month. The May 2016 audit of 10 records showed 100% compliance in five out of the seven areas checked. There was 98% compliance for completion of the checklist documentation.
- The National Early Warning System (NEWS) tool was in use. The tool was a way to identify deteriorating patients by recording observations such as blood pressure, respirations and level of consciousness. The observation chart was appropriately completed in the records we inspected.
- Sepsis guidance and a screening tool were in use with instructions to be applied if the NEWS screening was above a certain score or infection was suspected. There was also a Sepsis 6 care pathway for staff to follow (this is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis). The sepsis guidance stated all qualified staff working in clinical areas should possess the knowledge and skill to identify sepsis and initiate resuscitation if appropriate. Staff spoken with on the ward area were aware of the processes and the procedures to follow regarding sepsis management.

Nurse Staffing

- There were sufficient staff with the right skills to meet patients' needs and the service used a patient dependency and capacity planning tool which was based on the Safer Nursing Care tool (SNCT). It incorporated a nurse to patient ratio of between one nurse to five patients and one nurse to seven patients. The modified SNCT is an evidence-based tool that enables nurses to assess patient acuity and dependency.
- At a focus group meeting with staff we asked what was good about working at the hospital. Staff told us that staffing levels had increased to meet patient demand.
- We were informed that the duty rotas were arranged four to six weeks in advance and were adjusted to meet the demands of the service. We inspected the duty rotas for the ward area and theatre and discussed the staff cover for day care. The staffing levels during the inspection were the same as those planned. Continuity of care was maintained by using in-house bank staff and agency staff only when required.
- Staffing levels were discussed in advance for the following week at the weekly capacity meeting where the modified safer staffing tool was used. This meeting took place each Friday and decisions were evaluated each morning.
- In theatre, there were 11.5 whole time equivalent (WTE) nursing and midwifery registered staff and 11.6 WTE operation department practitioner (ODP) and health care assistants (HCA).
- The use of bank or agency staff was between 2.9% and 4.8% during the reporting period of April 2015 to March 2016. (Bank to agency staff was 10:1) There were no vacant posts reported from January to March 2016. Sickness rates for theatre staff was low compared to other independent acute hospitals. There were no theatre staff vacancies on the 1 April 2016.
- We saw there were arrangements in place for induction of staff. This included an induction for student nurses, bank and agency staff. We saw an induction record for registered nurses, which included arrangements for having a mentor.
- We observed a morning nursing staff handover from night to day staff. The handover was comprehensive and the information recorded to enable staff that started their shift later to have the same information as their colleagues. This also made sure all staff working on the ward was aware of the patient's treatment and care.
- There was an on call rota for clinical staff and aadministration/management and staff knew how to contact the managers on call. We inspected the on-call rotas for April, May and June 2016 and saw there was a manager on call each day from both areas of responsibility.

Surgical staffing

- The hospital worked predominantly with consultants from the local NHS hospitals of Calderdale, Huddersfield, Dewsbury and Bradford. The consultants and anaesthetists were responsible for their individual patients during their hospital stay. Practising privileges required that consultants were within 30 minutes of attending their patients or nominated a deputy to attend if needed. This also applied to the anaesthetists.

- Staff were aware of consultant cover arrangements and we saw printed information about specific consultant cover on the staff notice board.
- There were two resident medical officers (RMOs) employed by the provider through an agency for six month periods. They worked a 24 hour - 7 day a week service on a rotational basis. During this time, they were on site and available 24 hours a day. Handovers took place between the RMOs at the end of each seven-day period. The RMO said they had support from consultants, including anaesthetists and escalated patient care to consultants as needed.

Major incident awareness and training

- There was a business continuity plan, which identified keys risks that could affect the provision of care and treatment. For example, bomb threats, floods, fire, suspicious packages and loss of service. Accompanying the action plan were contact details of key staff and support organisations.

Are surgery services effective?

Outstanding ☆

We rated effective as outstanding because:

- There was evidence care and treatment was based on current guidance, standards and best practice.
- Opportunities to participate in benchmarking and accreditation were actively pursued. Patient reported outcome measures (PROMs) April 2014 to March 2015, showed NHS funded knee replacement outcome measures were significantly higher than the national average. The hospital was in the process of applying for JAG accreditation for endoscopy services.
- The hospital was working towards best practice to reduce the risk of dehydration before surgery, by ward and theatre staff using a joint approach to minimise fasting times.
- There was a holistic approach to planning people's discharge, which was done at the earliest possible stage.
- The systems to manage and share information that was needed to deliver effective care were fully integrated and provided real-time information across teams and services.
- There was evidence of effective multidisciplinary working taking place.
- Staff appraisals were on trajectory for completion for all staff by the end of the year.

Evidence-based care and treatment

- We saw the service used care pathways and patient care was carried out in line with national guidelines such as the National Institute for Health and Care Excellence (NICE). This included the use of the NICE guidelines (NG45) in routine preoperative tests for elective surgery. For example, the guidance referred to pregnancy testing. The audit of 20 (female) patient records carried out quarterly between August 2015 and March 2016 showed 100% compliance.
- Care pathways started with patient assessments and ended with their discharge. The care pathways were multidisciplinary and outlined the care expected for a patient undergoing for example, a hip or knee replacement. The pathways also varied to meet individual patient needs.
- Policies were based on national guidelines and NICE guidance. There was evidence the policies were updated and reviewed on a timely basis. For example, the policy for reporting medicines errors was reviewed in April 2016, with a further review date of April 2018.
- We saw how the cosmetic surgery pre-assessment included thorough documentation and guidance on providing patients with the recommended two-week cooling off period prior to surgery.
- Policies and procedures for the endoscopy service were in line with national guidance including HTM 0–06 Management and decontamination of flexible endoscopes.
- The hospital was working towards Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation and had an endoscopy management system installed. They had submitted two global rating scale audits to JAG which evaluate the quality of service provided and were on track with their application for accreditation.
- Entries in nursing and medical records were in line with NMC and GMC guidance.

Pain relief

- Staff we spoke with on the ward were able to describe the pain assessment tool and process to follow to manage pain effectively.

- We saw pain assessment scores were recorded as part of the routine observations and monitoring of patient care on the national early warning system assessment chart and during intentional rounding.
- Staff used an assessment score of 0 to 4 to assess the pain level and discomfort of patient. Records we inspected confirmed that patients were offered pain relief and their pain was controlled in a timely manner.

Nutrition and hydration

- Patients were offered a suitable and nutritious diet and alternative options to meet cultural needs were available. Staff were seen offering patients drinks at regular intervals. Jugs of water were seen in reach in patient's rooms. A cold-water drinks machine was available at the nurse's station for patients, visitors and staff to help themselves.
- The hospital was working towards best practice to reduce the risk of dehydration before surgery, by ward and theatre staff using a joint approach to minimise fasting times. At pre-operative assessment, patients were advised about when to fast prior to admission and were provided with written information. Intentional rounding took place during admission and information relating to the time a patient last had fluids was documented. Where there were delays in going to theatre, the theatre staff telephoned the staff on the ward and gave advice as to whether the patient could have a further drink or not. We saw this in practice and the information was recorded in the patient's records.
- In the minutes of the April and June 2016 staff meeting, we saw fasting times audits were reported to staff. The June minutes reminded ward staff to document as much information as possible and give patients a drink if within the fasting time. This showed the service was committed to providing a service that met patients' needs and complied with current guidance.
- A Malnutrition Universal Screening Tool (MUST) nutritional assessment was completed during pre-surgery assessments. This was to assess nutritional needs and the Body Mass Index (BMI) score. Patients who were not suitable for treatment at the hospital due to their medical condition were referred back to their general practitioner. An audit of the MUST tool was scheduled for December 2016.
- In the 2016, patient led assessment of the care environment (PLACE) in relation to food the hospital scored 93.5%. This was higher than the national average of 88.5%.

Patient outcomes

- Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.
- PROMs data from April 2014 to March 2015 showed the hospital's adjusted average health gain for primary knee replacement was significantly higher than the England average, higher than the expected range for groin hernia repairs and within the estimated range for primary hip replacements.
- The hospital reported that 93% of patients made improvements in validated outcome measures following physiotherapy. This included improvements relating to patients who had hip, knee or shoulder conditions who had physiotherapy.
- The hospital also participated in the National Joint Registry and submitted information on all hip, knee and shoulder replacement operations. This national audit monitors the performance of joint replacement implants and the effectiveness of different types of surgery. The hospital had a patient consent (to participate) rate of 99.8% in 2015/16.
- The hospital reported surgical site infections to Public Health England and reported performance against Commissioning for Quality and Innovation improvement measures (CQUINs) agreed with the clinical commissioning group. There were three CQUIN targets including one related to patients being given advice about medication on discharge. A new form had been implemented and either pharmacy or nursing staff were required to complete this before the patient was sent home with medication.
- From April 2015 to March 2016, there were five unplanned returns to theatre (0.08 per 100 visits to the theatre); six readmissions to surgery within 28 days (0.1 per 100 patients and six unplanned transfers of inpatients to other hospitals giving a rate of 0.1 per 100 patients. These figures were within a normal range when compared to a group of independent acute hospitals that submitted data to CQC.

- The manager of the endoscopy unit had visited other units and completed informal benchmarking as part of working towards the joint advisory group (JAG) on endoscopy accreditation.

Competent staff

- Evidence submitted by the hospital showed from January 2015 to December 2015, the appraisal rate for staff in the surgery service was 100%. We were assured that the service was on trajectory for completion of staff appraisals by the end of this year (2016).
- Systems were in place for revalidation of medical staffing and for the effective management of consultants' practising privileges, which included contributing to their annual appraisal. Appraisals were based on GMC guidance and completed by a medically qualified appraiser. The hospital team worked closely with the medical director at the relevant NHS trusts and provided performance and activity information to inform the consultant appraisal process.
- The corporate medical director was the revalidation officer for the two consultants without NHS contracts and their appraisal was carried out by consultants in Spire Healthcare with appraisal training.
- Validation of professional registration post-application check for doctors, operating department practitioners and nurses was 100%.
- Seven medical practitioners held practicing privileges for cosmetic surgery and were on the General Medical Council specialist register.
- The RMOs received clinical supervision from their medical staffing agency. Copies of their documentation including details of work experience and validation of registration were supplied by the agency. The matron carried out the RMO's appraisals and a consultant provided clinical support.
- Staff confirmed they had competency assessments to enable them to do their job and we saw records of these in the five staff files we inspected. There were clinical supervision guidelines for staff to follow.
- External training courses were held at the hospital and these provided funding for guest speakers to attend. Staff told us they were encouraged and supported to keep up to date with their training and competencies.
- Hospital sterile supplies department (SSD) staff had national vocational qualification (NVQ) level training for decontamination in endoscopy.

Multidisciplinary working (in relation to this core service only)

- Each weekday morning at 9.30am, a multidisciplinary team (MDT) safety brief took place on the ward. The MDT meeting included the matron, a physiotherapist, ward administration manager, ward sister or nurse in charge, theatre manager and the RMO. The purpose of the meeting was to identify any anticipated risks that may affect the safety to the patient or efficiency of the running of the wards and theatres. Staff discussed current inpatients, admissions and discharges, bed capacity, staff skill mix, nurse to patient ratio and the quality of the RMO rest overnight. Staff also reviewed theatre staffing levels, operation list changes and cancellations and any equipment issues that had been identified.
- The theatre manager and theatre team also held a morning meeting. This was to plan the daily activity of the running of the department and included any issues that may have arisen the previous day. This meeting was followed by a briefing meeting with the surgical team prior to the start of each theatre list.
- Each week, there was an MDT capacity planning meeting that discussed the forthcoming weeks admissions and took into account areas such as planned cases for admission, the complexity of a case, specialist nursing input required, specialist equipment required in theatre, bed capacity and theatre start and end times. Consultant holidays were also noted. Any problems highlighted were discussed and actions to resolve the situation implemented. Minutes of the discussions were circulated to the MDT.
- A clinical communication sheet, (a salmon coloured sheet, also known as 'the salmon sheet') was visible in each patient's notes. This ensured all staff were aware of the treatment given during the patient's episode of care. For example, whether the investigations required had been carried out.
- The surgeons, anaesthetists and physiotherapist saw patients at preoperative outpatient visits. Discharge planning was started at the earliest opportunity by the multidisciplinary teams to make sure the patients had the best outcomes of care.
- In theatres, the consultants, theatre manager and leaders had a daily capacity meeting and worked together to build the theatre list with the cases listed in the appropriate order.

- Staff from the theatre had recently set up meetings with the ward staff. This helped to improve communication and strengthen working practices between the two areas.
- Staff reported they had good relationships with the local GPs. GP training was offered by the consultants at Spire Elland Hospital.

Seven-day services

- Consultants were available out of hours as per their practising privileges and were supported by the resident medical officer (RMO).
- The RMO provided 24-hour medical cover and staff reported they did not have any difficulty in obtaining a medical review of patients. The RMO told us they could contact a consultant when needed.
- There was an on call rota for plain film imaging (x-ray). This service was provided where an x-ray was required urgently out of hours, or prior to a patients discharge.
- When the hospital pharmacy was closed, there was a procedure for the RMO and qualified nursing staff to obtain medicines for their patients.
- Physiotherapy also offered an on-call service over the weekend and during bank holidays.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, national guidance and e-learning.
- Fully integrated single patient records were maintained on site. Clinical information and records were easily accessible including electronic test results and provided real-time information across teams and services. Staff reported no concerns about accessing relevant patient information. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- Staff reported good communication between the hospital staff and GPs and the hospital was moving towards electronic discharge letters. Staff also reported they had good access to patient records from other hospitals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed three consent forms and saw that patients were appropriately consented and any risks had been discussed with the patient. Policies and procedures were in place for the consent process, including the Mental Capacity Act and Deprivation of Liberty Safeguards. Patients told us staff explained their care and treatment to them and sought consent prior to delivering care. The hospital audited patient confirmation of consent and reported the outcome to the clinical commissioning group but the quality of consent documentation was not audited.
- Staff had MCA and DOLS training and were able to describe their responsibilities around capacity assessment. Patients that lacked capacity were individually assessed and appropriate steps taken to ensure their care could be safely delivered within the hospital. Where this was not deemed in the best interest of the patient, they would be directed to NHS services for treatment. To maintain staff awareness and confidence, staff briefings and updates around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) were being rolled out.
- The admission and discharge information for patients explained the meaning of the MCA. It provided information about advice a patient should expect to receive from the staff and about external services that were able to offer further support and advice.
- At the time of inspection, no patients lacked capacity or were deprived of their liberty in the surgical service.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback from patients and those close to them was universally positive about the way staff treated people.
- Patients were treated with dignity, respect and kindness and were supported in decision-making.
- People were communicated with and received information in a way they could understand.
- The patient satisfaction survey showed consistently high results and the percentage of patients that would recommend the hospital to family or friends was high.

Compassionate care

- We spoke with three patients and received comment cards from patients during our inspection. They all gave positive feedback about the service and told us they

were happy with the care they received. Patient written feedback on comment cards included: "I have been overwhelmed by the standard of compassion, caring, individual attention and professional skills … given to me." "I wish all patients' care in all hospitals was as good." "Excellent service, first class treatment and efficient, friendly staff."

- Patients told us they were treated with kindness, dignity, and respect. All patient rooms were single rooms, which meant their privacy and dignity was maintained.
- During our inspection, a patient admitted to the ward was booked for theatre later in the day. A relative of the patient had recently died. We heard how the ward staff member contacted the theatre staff and informed them of the extra care and support the patient may need. This showed how the staff were caring and empathetic when meeting physical and psychological needs.
- The NHS Friends and Family Test (FFT) is a survey that measures patients' satisfaction with the healthcare they have received. From April to July 2016, an average of 99% of patients agreed that they would recommend the hospital to friends and family, which was equal to the average across the independent sector in England for the same period. The average monthly response rate by the hospital (42.8%) was better than the average response rate for the independent sector (41.3%) April to July 2016.The hospital scored 100% in May 2016 for patients agreeing they were treated with respect and dignity at all times.

Understanding and involvement of patients and those close to them

- We saw that ward managers and nursing staff were visible on the inpatient wards and patients were able to speak with them. We observed that medical staff took the time to explain to the patient and relatives the next stages in the plan of care.
- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risk and benefits of treatment, their discharge arrangements and actions required prior to discharge. Patients said they were aware of whom to approach if they had issues regarding their care, and they felt able to ask questions during pre-assessment and on the ward.
- Patients we spoke with said that staff communicated in a way that was easy to understand, was appropriate and respectful. They said that medical terminology was explained to them and they had all the relevant literature before admission.
- The May 2016 FFT survey results showed that 93% of all patients felt involved as much as they wanted to be in decisions about their care and treatment.

Emotional support

- We witnessed staff interacting with patients in a supportive and reassuring manner encouraging them to regain their independence in line with their post-operative progress.
- Relatives and carers told us they received support from staff and were able to visit or telephone the patient at any time.
- Staff provided support to patients in a timely, professional way. We observed staff giving reassurance to patients who were anxious when awaiting surgery and while recovering from anaesthetic. We saw staff responding compassionately to relieve patients with pain and discomfort.
- Psychological assessments took place prior to cosmetic surgery and patients were provided with support during their decision-making process.

Are surgery services responsive?

Good

We rated responsive as good because:

- There were clear access criteria for patients who used the service.
- The needs of people were taken into account when planning and delivering services including risk-assessing patients for sensory, psychological and physical impairments to ensure appropriate support mechanisms were in place and developing dementia-awareness champion roles.
- Flexibility and choice were reflected in the services provided such as bariatric facilities and evening pre-assessment clinics.

Good

Surgery

- Referral to treatment (RTT) data for April 2015 to March 2016 showed that the hospital met the indicator of 90% of admitted NHS patients for all months except January (86%) and February (85%). This was due to reporting rule changes and returned to 91% in March 2016.
- Patients and relatives/carers were listened to when they raised a concern or complaint. Complaints were taken seriously and responded to in a timely way.

Service planning and delivery to meet the needs of local people

- The service was planned to meet the local population and commissioning needs. For example, the hospital built a new theatre in 2015 to extend service provision for day case procedures in accordance with commissioning demand.
- The hospital was working towards Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation and had an endoscopy management system installed.

Access and flow

- Patients were referred to the hospital by their GP, self-referral or NHS referral. NHS referrals were directly commissioned through the NHS choose and book patient pathway.
- There were 4,489 day case patients and 1,485 inpatients admitted to the hospital between April 2015 and March 2016.
- Between April 2015 and March 2016, the provider cancelled 84 patient procedures for clinical and non-clinical reasons. Eighty patients were offered another appointment within 28 days, which was within expectations.
- In June 2015, the national target for beginning treatment within 18 weeks of referral was abolished. Referral to treatment (RTT) data for April 2015 to March 2016 showed that the hospital met the indicator of 90% of admitted NHS patients for all months except January (86%) and February (85%). This was due to reporting rule changes and returned to 91% in March 2016.
- The patients we spoke with did not have any concerns in relation to their waiting times, admission or discharge arrangements.

Meeting people's individual needs

- There were clear access criteria for patients who were cared for by the surgical service.
- Staff risk assessed patients for sensory, psychological and physical impairments during pre-assessment and on admission to ensure appropriate support mechanisms were in place. For example, hearing and sight impairment, learning disabilities, mental health needs and living with dementia. There were links between specialist (NHS) nurses and ward staff to ensure continuity of care and support for patients.
- The environment was assessed using a King's Fund assessment tool, 'Is your hospital dementia friendly'. Following the assessment, an action plan was developed and dementia awareness champion roles were allocated. A document was developed for future use to help staff to care for patients who have dementia.
- In the patient-led assessment of the care environment (PLACE) for 2016, the hospital scored 88.1% for dementia-friendly (national average 75.3%) and 86.4% for disability-friendly (national average 78.8%).
- Patients whose first language was not English could access an interpreter. The service also used a telephone interpreter service. Staff could describe how they accessed the service.
- The service provided bariatric facilities such as specialised beds.
- Physiotherapy was located on the ground floor of the hospital and there was easy mobility access to surgical services.
- We heard how extra pre-assessment clinics sessions were held such as during the evenings and on Saturday mornings in order to meet the needs of the patients who could not easily access clinics during the week.

Learning from complaints and concerns

- Information on how to make a complaint was contained in an information booklet in patients' rooms. Patients we spoke with knew how to complain; they told us they had no concerns.
- Staff we spoke with were clear about the complaints process and the action they should take if someone wished to complain.
- From April 2015 to March 2016, the provider received 25 complaints relating to surgery. We reviewed five of these. We saw complaints were responded to in a timely manner and where there had been a delay in response, the complainant was informed.

Good

Surgery

- We saw evidence in one of the complaints reviewed that the duty of candour had been applied. We saw the complainant had received an explanation and apology when things had not gone according to plan.
- The five complaints related to areas such as a patient not happy with their consultation and late billing where the fee was waived.
- Formal complaints were investigated by the matron and hospital director. These were discussed at monthly senior managers meetings and quarterly clinical governance meetings. Learning was shared with staff at team meetings.

Are surgery services well-led?

Good

We rated well led as good because:

- Staff talked about how the values (such as 'caring is our passion', 'doing the right thing' and 'driving excellence') were demonstrated in the way they delivered their service.
- The hospital had an effective governance structure in place to ensure service quality and risks were monitored.
- Staff in each department and inpatient service had developed local service objectives to drive improvement.
- Performance in patient experience, safety and clinical effectiveness was regularly reported through the clinical scorecard to corporate management and the clinical commissioning group.
- The senior leadership team were highly visible within the hospital. Staff felt supported and valued; there was an open and transparent, no blame culture.
- There was a robust system in place to ensure that relevant documentation to support practising privileges was held for each consultant.

Leadership of the service

- The hospital had a stable management team with well-established relationships with the staff and consultants. They were experienced members of staff that had worked at the hospital for a number of years and staff were positive about the level of support they provided on a personal and professional level.
- Staff confirmed that the managers and hospital management team were visible, approachable and had an open door policy. They felt confident that any type of concern would receive a supportive response.
- Consultants we spoke with were positive about the senior management team and the way in which services were run. The hospital conducted an annual survey of consultants to obtain their views of the service.
- Flexibility amongst the workforce was encouraged and achieved to meet the needs of the patients.
- Sickness rates were mainly low and staff turnover was not high for the reporting period (Apr 15 to Mar 16) when compared to other independent acute hospitals. A staff member said that they had to work on the hospital bank before applying for a permanent post, as there were no vacancies for some time.

Vision and strategy for this core service

- The corporate vision of the provider was to be recognised as 'a world-class healthcare business'. The local vision for the hospital was to 'be recognised as the local independent provider of choice by delivering our clinical strategy and enabling a positive patient experience and outcome'.
- The corporate vision, mission and values were displayed and staff were familiar with these. Staff in each department and inpatient service had developed local service objectives to drive improvement. These were summarised for all departments and displayed on a poster in each department for all staff to see. For example, the theatre manager told us their service aimed to provide quality care in a safe environment. They aimed to support this by accessing the most up-to-date training to develop their skills.

Governance, risk management and quality measurement for this core service

- The hospital had a defined governance structure in place to ensure performance, quality and risk was monitored. The Clinical Effectiveness Committee and Infection Prevention and Control Committee reported to the Clinical Governance Committee, which reported to the Medical Advisory Committee (MAC), the senior management team and the hospital director. Non-clinical risks and health and safety issues were monitored at the Health and Safety, Quality and Risk Committee, which also reported to the senior management team and the hospital director. We

reviewed two sets of MAC meeting minutes, which demonstrated quality and safety issues and the remedial action being taken to improve systems and processes were discussed. These included incidents, complaints, RCAs and the actions taken in response.

- There was regular corporate oversight and scrutiny of the performance scorecard supported by action to secure improvement. The senior management team met bi-monthly. Items discussed included clinical highlights from the clinical governance meeting, risk management and the risk register, complaints and minutes of the MAC. The heads of department also met monthly and the hospital director and matron attended these meetings. Areas discussed included quality and complaints, policy updates, health and safety, risk assessments and the patient friends and family test results.
- The ward meeting minutes showed information was disseminated from the senior management meetings. The minutes also contained information and updates relevant to the ward staff about audit outcomes, safety issues and complaints.
- Managers we spoke with were aware of their organisational and service level risks and the actions taken or planned to mitigate the risks identified. The senior management team meeting minutes from 10 May 2016 showed an away day was planned later that month to develop the risk register. We heard how through a corporate initiative, work was in progress to strengthen risk register management and update the register template. The new corporate risk register template was being populated by the heads of department at the time of inspection. We noted the template did not include a date for when the risks had been added to the register. Nine out of the 12 risks did not have key actions in place, identify the responsible officer or have an action review date. However, we saw the risk register was still in the process of development and staff were aware of this.

Culture of service

- Staff spoke positively about working at the hospital and their working relationship with their colleagues. They told us they felt valued by the management and they would recommend the service as a place to work. All staff we spoke with said they felt comfortable to raise any concerns or ideas of innovation they might have.
- 97% of staff were likely to recommend the hospital to their friends and family for treatment and 96% would be happy with the standard of care provided for a friend or family member.
- Staff were passionate about their service and the standard of the care provided to patients. There was a strong team spirit, a willingness to be flexible to support each other and a caring approach towards staff well-being. Staff were rewarded for innovation and 'going the extra mile' and this was valued by them.
- On occasions, individuals were nominated for one of the staff recognition awards called "Inspiring People."
- There were procedures in place covering whistle blowing, bullying and harassment and staff knew what to do if they had concerns.

Public and staff engagement

- The response rate to the 2015 staff survey was good at 79%. The 2016 staff survey had not yet taken place. The 2015 staff survey showed 97% of staff were likely to recommend the hospital to their friends and family for treatment and 96% would be happy with the standard of care if provided for a friend. Two years ago, the survey showed that staff felt that communication from management could be improved and in response, minutes for all meetings were made available and the heads of departments increased their level of communication with staff. The 2016 staff survey had not yet taken place.
- 60% of staff said managers took time to share positive feedback.
- The hospital conducted an ongoing patient survey that included the Friends and Family test, and incorporated a number of other questions about the patient experience. The hospital director reported that much of the feedback from patients was positive and was shared with staff, which had proved motivational.

Innovation, improvement and sustainability

- The hospital was due to commence submitting performance data to the Private Healthcare Information Network (PHIN) in the month of inspection.
- The hospital was developing its inpatient facilities to cater for people living with dementia including assessing the environment and developing staff knowledge and expertise.

Good

Surgery

- The fully integrated electronic patient record provided staff with access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- The hospital was working towards best practice to reduce the risk of dehydration before surgery, by ward and theatre staff using a joint approach to minimise fasting times.

Good

Outpatients and diagnostic imaging

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

Information about the service

Spire Elland Hospital provides a range of outpatient services at two sites: Longlands Consulting Rooms and Spire Elland Hospital. Longlands Consulting Rooms are located adjacent to Dewsbury District Hospital and have three general consulting rooms and a treatment room. Services include physiotherapy clinics provided by the Spire Elland Hospital team. Spire Elland Hospital has seven general consulting rooms, three ophthalmic rooms plus a minor treatment room. Physiotherapy is provided in three private treatment rooms and the purpose-built gymnasium. Cosmetic surgery and beautician outpatient services are provided in the Springfield Suite with two consulting rooms, a minor treatment area and a beautician area.

Outpatient services cover 18 different specialities. The specialties with the highest outpatient activity are orthopaedics, general surgery, ear, nose and throat, gynaecology, plastic surgery, ophthalmology and urology. The hospital provides services for adult patients of all ages.

The hospital provides a range of diagnostic imaging services including digital plain film x-ray, digital mammography and ultrasound. Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scanning is provided by a Spire Healthcare owned mobile service.

Between April 2015 and March 2016 there were 30,873 outpatient total attendances; of these 53% were NHS funded and 47% were other funded.

During our inspection, we visited the outpatient departments at both sites and the diagnostic imaging department at Spire Elland Hospital. We spoke with 10 members of staff, including heads of departments, nurses, healthcare assistants, radiographers, physiotherapists, administrators and receptionists. We looked at four sets of records, spoke with five patients and received 23 comment cards about outpatient services. Before the inspection, we reviewed performance information from, and about the hospital.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated this service as good because:

- Staff were aware of how to raise incidents and gave examples of learning. We saw evidence of effective root cause analysis, application of Duty of Candour and learning being shared.
- At the time of this inspection, it was clear that appropriate measures had been put in place in response to an incident of radiation over exposure (low harm) and learning had been shared amongst all radiographers within the department. An action plan was in progress to strengthen the quality assurance programme for in-house testing of radiology equipment and we saw there was a World Health Organisation (WHO) surgical safety checklist in place for radiological interventional procedures.
- Waiting and clinical areas were clean and tidy and we observed good practice in relation to infection prevention. The service scored well on cleanliness audits.
- Feedback from patients during inspection was universally positive about the caring attitude and efficiency of the service. For example, a breast care specialist nurse offered support to patients and families when receiving difficult news and, in partnership with local NHS trusts; systems were in place for advice and support to be available to patients 24 hours a day.
- Spire Elland Hospital had no patients waiting longer than six weeks in diagnostic imaging for all modalities during the reporting period (April 15 to March 16). The hospital achieved better than the target of 92% of incomplete patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 15 to March 16). It also achieved better than the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period before the targets were abolished (April 15 to May 15). Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 15 to March 16).
- The service received a low number of complaints in the past year (six). We saw complaints were responded to within timescales and where there had been a delay in response, the complainant was informed.
- The hospital had a primary care liaison officer who focused on raising the profile of the hospital and offering training to local GPs and practice nurses. This included specialist consultants providing clinical education lectures. The hospital also sent out a quarterly 'primary care news' newsletter which covered topics about the services offered.

However we found that,

- Cleaning agent tablets were not held in secure storage. These were relocated to secure storage at the time of the inspection.
- During our inspection, the temperature in the outpatient treatment room was greater than 25 degrees. This is above the recommended temperature for medications to be stored and there was stock held in this room. This was reported to the Hospital Director and Pharmacist who reviewed the management of the air-conditioning unit in that room and took immediate action to remove the affected medication stock from use.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

Summary

We rated safe as good because:

- Staff were aware of how to raise incidents and gave examples of learning. We saw evidence of effective root cause analysis, application of Duty of Candour and learning being shared.
- Records were stored securely and there was a system in place to ensure that patient records and investigation results were available before appointments.
- Each department had a daily meeting to assess staffing levels, activity and safety concerns. A weekly senior management meeting reviewed capacity and staffing for the following week to resolve any problems in advance.
- Systems and processes for safeguarding were in place and staff knew what action to take should they have concerns.
- Waiting and clinical areas were clean and tidy and we observed good practice in relation to infection prevention. The service scored well on cleanliness audits.
- We saw there was a World Health Organisation (WHO) surgical safety checklist in use for radiological interventional procedures.
- An action plan was in progress to strengthen the quality assurance programme for in-house testing of radiology equipment to ensure the radiation exposure to patients is kept as low as reasonably practicable. Appropriate expert support was in place to complete this action.

However we also found that:

- Cleaning agent tablets were not held in secure storage at Longlands Consulting Rooms. These were relocated to secure storage at the time of the inspection.
- During our inspection, the temperature in the outpatient treatment room was greater than 25 degrees. This is above the recommended temperature for medications to be stored and there was stock held in this room. This was reported to the Hospital Director and Pharmacist who reviewed the management of the air-conditioning unit in that room and took immediate action to remove the affected medication stock from use.

Incidents

- From April 2015 to July 2016, there were no Never Events within the outpatients and diagnostic imaging departments. Never Events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the electronic reporting system. The staff we spoke with in outpatients and diagnostic imaging were able to describe the process of incident reporting and understood their responsibilities to report safety incidents.
- During the period April 2015 – March 2016, there were 45 clinical incidents across the outpatient and diagnostic imaging departments. Of these, 28 caused no harm, 13 low harm and four caused moderate harm.
- The hospital clinical scorecard for quarter one 2016 showed that 85% of all incidents were closed within 45 calendar days. The corporate target was set at 75% compliance.
- Staff in the diagnostic imaging department understood their responsibilities for reporting IR(ME)R incidents. We reviewed the investigation and implementation of lessons learned following a recent externally reportable incident where a patient received a radiation dose greater than intended, but which caused low harm.
- This was reported to the Health and Safety Executive (HSE) as required by the Ionising Radiations Regulations 1999 (IRR99). It was also reported to the Care Quality Commission IR(ME)R team as it was unclear during initial investigations whether the cause was due to operator error or equipment fault. The incident was repeated a few days later; however, this did not need to be reported to any external bodies as the radiation exposure threshold for external reporting was not reached. Following a full investigation by the hospital, medical physics team and the equipment engineers, it was discovered to be an equipment error.

Good

Outpatients and diagnostic imaging

- A root cause analysis (RCA) is a structured method used to analysis incidents. We reviewed two RCAs relevant to outpatient and diagnostic imaging services and these demonstrated a thorough investigation being carried out involving the relevant staff and people who used the services. Each report included a key learning summary, recommendations where appropriate and an action plan.
- Any lessons learnt from incidents were cascaded via clinical governance meetings, management meetings and team meetings. We saw evidence of this in individual department meeting minutes and from information held in the department 'governance folder' about lessons learned from RCAs. At the time of this inspection, it was clear that appropriate measures had been put in place to mitigate the chances of a repeat error of radiation over exposure and learning had been shared amongst all radiographers within the department. In outpatients, a patient developed a minor soft tissue injury while wearing a plastic cast. The lesson learned resulted in a new information leaflet being developed to support the advice given for skin care.
- 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 incidents and provide reasonable support to that person. Staff were aware of the requirements of Duty of Candour and had received training supported by a policy and a staff booklet on implementing the regulation. No incidents in outpatients had met the threshold for Duty of Candour to be implemented. The two incidents of overexposure of radiation resulted in low harm and both patients were informed of the incident by senior clinical staff including the radiologist. Further support was offered to the staff involved and the patients.

Cleanliness, infection control and hygiene

- During the period April 2015 – March 2016, there were no incidences of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. difficile) or Methicillin Sensitive Staphylococcus Aureus (MSSA) within outpatient and diagnostic imaging services.
- The departments we visited at Spire Elland Hospital and Longlands Consulting Rooms were visibly clean. We saw cleaning schedules and completed cleaning checklists.
- All of the consulting rooms were visibly clean and cleaning assurance stickers were used to indicate when a piece of equipment had been cleaned.
- We saw personal protective equipment (PPE) for example; gloves and aprons were available in clinical areas. In the diagnostic imaging department, local rules were in place to manage use of personal protective equipment. PPE equipment including lead coats was in good condition. Staff checked and maintained the condition of the lead coats as part of a monthly audit programme within the department.
- Antibacterial gel dispensers were available throughout the departments. We observed staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in most of the areas we visited. Hand hygiene audit data was not available specifically for the outpatient and radiology department but standards were monitored across the hospital and these were met.
- Public corridors and waiting areas within all departments we visited had carpeted floors; facilities were available for the prompt and effective removal of any spillage: Carpets were cleaned monthly and spot checks were undertaken. Staff said in the event of a spillage, the carpets would be cleaned following the appropriate procedure. Outpatients received a score of 100% for cleanliness in the annual PLACE audit.
- If staff suspected a patient had a communicable disease, staff said they would seek advice from the matron or the infection prevention control lead nurse. Within diagnostic imaging, staff said that any patient with an infection would be scheduled at the end of the list and no further patient would be seen until equipment had been decontaminated.
- People with suspected communicable diseases such as tuberculosis were assessed for suitability for treatment at the hospital. Where the outcome was not in the best interest of the patient or the hospital, they would be referred to NHS service providers. The hospital reported all communicable diseases to the Public Health England.

Environment and equipment

- Patient led assessments of the care environment (PLACE) assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. In 2016, the hospital scored

higher than the England average for cleanliness, condition, appearance and maintenance, dementia, food, organisational food, privacy, dignity and wellbeing and ward food.

- Resuscitation equipment was readily available in the outpatients department and the Springfield Suite. We checked the resuscitation trolleys and found checks had been completed in line with best practice and all the trolleys were secured with tamper-proof tags. However, the oxygen masks and ambu bag had not been issued with any expiry date from the manufacturer. This was a known problem and had been reported by staff. In the event of an emergency at Longlands Consulting Rooms, basic life support would be given and an ambulance called.
- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments we visited.
- At Longlands Consulting Rooms, cleaning agent tablets were stored in an unlocked cupboard located in the sluice room which did not have a door lock. This was reported to the Hospital Director and the tablets were stored securely until a door lock could be installed on the sluice room.
- A service level agreement was in place with a national company for the service, maintenance and repair of equipment. The maintenance schedule was managed via the company's web-based application. Staff could plan equipment downtime around clinics to reduce disruption to patient care.
- We checked a range of equipment and found that most pieces of equipment had visible evidence of electrical testing and service checks. Where service dates were not visible on specialised pieces of equipment, the hospital was able to produce electronic evidence of recent testing.
- The imaging rooms were clean, uncluttered and spacious. Regular manufacturer servicing was carried out and recorded, along with level B (high-level quality assurance) medical physics testing on the x-ray equipment. The HSE had noted in their notification of contravention that the level A (routine quality assurance) in-house radiographer testing of the x-ray room was insufficient. There was a quality assurance programme in place at the time but this was not sufficiently robust to ensure to ensure the radiation exposure to patients was kept as low as reasonably practicable. We saw that an action plan was in place and in progress to resolve this issue.
- We saw evidence of risk assessments being carried out for new or modified use of radiation. These assessments considered occupational safety as well as consideration of risks to people who use services and public.
- Staff wore personal radiation dosimeters (dose meters) and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionizing radiation.
- Appropriate environmental measures and signage was in place to identify areas where radiological exposure was taking place in line with IR(M)ER regulations. This ensured that staff and visitors did not accidentally enter a controlled zone.

Medicines

- We checked the storage of medications in the departments we visited. We found that medications were stored securely in appropriately locked rooms and fridges. No controlled drugs were stored in the department. The medicines and medical gas cylinders we checked were all in date.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. We saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range. Staff could describe the process for reporting if the fridge temperature went out of range.
- Medication stock was stored in a cupboard in the outpatient treatment room. During our inspection, the temperature in the room was greater than 25 degrees. This is above the recommended temperature for medication storage. This was reported to the Hospital Director and Pharmacist and found to be related to management of the air conditioning in that room. The air conditioning issue was resolved and action taken to remove the medication stock.
- Prescriptions written by consultants in outpatients were sent to the in-house Pharmacy to be filled, which supported the audit trail in line with safe and secure management of medicines national guidance.
- Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal

structures during radiography. These materials were safely stored in the diagnostic imaging department and could only be prescribed by the Resident Medical Officer (RMO) or radiologist.

Records

- Fully integrated single patient records were maintained on site with a dedicated medical records team managing the system. There was also a team of medical secretaries on both sites to support consultants. Over the previous three months, the hospital reported that 99% of patients were seen in outpatients with all relevant medical records being available. Staff said all records could be requested and available for the next day. In the rare event that the record could not be located, the medical records team had the facility to make up a temporary set of notes using the most recent consultant letters and any investigation results reproduced from the electronic archive systems.
- Paper records were used in the outpatient and physiotherapy department. Radiology used a mixture of electronic and paper records. We saw that records were appropriately stored within the departments we visited.
- All diagnostic imaging documents seen on inspection were in date with exception of the Local Rules (required under IRR99), which were currently being reviewed by the radiology service manager and radiation protection advisor.
- We saw limited evidence of document control within the diagnostic imaging department with many of the documents available only in paper form; however, these processes were under review to meet HSE requirements. Documents were readily available and all staff knew how to access them.
- We reviewed four sets of records across the outpatient and physiotherapy departments. All were legible and contained the relevant information such as patient history, allergies and information relating to the planned treatment or procedure.
- Records were not taken off-site. All staff were aware that in accordance with the group patient records policy and practising privileges policy, staff were not to take any patient records off-site unless there was a clinical emergency such as a critical care transfer and insufficient time for copies to be generated.
- Information governance training was provided annually. Training records showed 98% of hospital-wide staff had completed the training. Data for individual departments was not available.
- There was a system in place to request diagnostic images taken at a local NHS provider. These images could be shared using a secure portal and made available for patients attending outpatient appointments.

Safeguarding

- The hospital was no longer providing consultation or treatment to any children under the age of sixteen. Children aged 16 and over were seen in dermatology and psychology as outpatients only and received no invasive treatments.
- Child and vulnerable adult safeguarding policies were in place and provided a framework for all staff when identifying, responding to and reporting any aspects of safeguarding.
- All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to Level 2 (Safeguarding children and young people: roles and competences for health care staff: Intercollegiate Document, Third edition: March 2014). This was the policy for safeguarding children training at Spire Elland Hospital.
- Training levels for safeguarding children Level 2 were 73% (outpatient staff), 64% (physiotherapy staff) and 73% (radiology staff). Training levels for adult safeguarding Level 2 were 76% (outpatient staff), 64% (physiotherapy staff) and 82% (radiology staff). Clinical staff in dermatology and psychology outpatients were trained to Level 3 in safeguarding children. These levels were as of mid-year and the hospital was on target to achieve 100% training levels by the end of the year.
- The Matron took overall responsibility for adult and children safeguarding. The Matron and the Governance Lead were the hospital safeguarding leads for adults and children and each was trained to Level 3. No safeguarding concerns were reported to the CQC in the reporting period from April 2015 to March 2016.
- Staff were clear about how to recognise and escalate a safeguarding concern and knew who to contact if a concern arose. Senior staff knew how to make a safeguarding referral or who to contact if they need further advice.

- The hospital had guidance in place for Child Sexual Exploitation (CSE) and a standard operating procedure for Female Genital Mutilation (FGM) and this was readily accessible.

Mandatory training

- Mandatory training topics included areas such as fire safety, health safety, manual handling, child and adult safeguarding, infection prevention and control, compassion in practice and equality and diversity.
- Staff we spoke with all confirmed training was accessible and the majority of training was completed via e-learning. Practical training sessions such as moving and handling were face to face.
- Training data showed that at July 2016, 75% of outpatient staff, 71% of physiotherapists and 81% of radiology staff had completed all the annual mandatory training modules. The annual training level targets of 95% were expected to be reached by the end of the year. Training levels were at 98% for the previous year.
- All registered nurses in the outpatient department had completed intermediate life support training and the health care assistants had completed basic life support training.

Assessing and responding to patient risk

- The hospital had a two resident medical officers who rotated being on-duty for one week at a time. They provided a 24 hour, seven day a week service.
- It was a requirement of the hospitals practising privileges policy that consultants need to reside or work within 30 minutes of the hospital to be able to respond in a timely manner. In addition, the hospital had a 24 hour, seven day a week anaesthetic on call cover.
- The hospital had a service level agreement with a local NHS trust to transfer patients in the event of an emergency or if a deteriorating patient required an increased level of care. Staff were able to describe the process they would follow if they were concerned that a patient was deteriorating. All consulting rooms had emergency buttons that could be pressed in an emergency situation.
- The hospital had a service level agreement with an external radiation protection advisory body as required under IRR99. This body also provided medical physics expert advice as per Ionising Radiation (Medical Exposure) Regulations 2000 [IR(ME)R].
- The HSE had noted in their notification of contravention that there was no prior risk assessment for mini c-arm (a small portable fluoroscopy used for imaging of feet and hands) used by the orthopaedic surgeons in theatre. Since the HSE notification, the hospital had worked hard to rectify this non-compliance and we saw evidence on inspection of actions relating to this enforcement notice. The radiology service manager was reviewing documentation in the department and implementing the recommendations from HSE.
- We saw there was a World Health Organisation (WHO) surgical safety checklist in place for procedures such as joint steroid injections under x-ray control and a screening questionnaire for patients being booked for an intravenous contrast examination.
- We saw systems were in place to ensure the service identified women who may be pregnant and radiographers checked the status of all women of child-bearing age prior to examination.
- Within diagnostic imaging, an appointed radiation protection supervisor was responsible for ensuring equipment safety and quality checks, and ionising radiation procedures were carried out in accordance with local and national guidance.
- Appropriate environmental measures and signage was in place to identify areas where radiological exposure was taking place in line with IR(ME)R regulations. This ensured that staff and visitors did not accidentally enter a controlled zone.

Nursing staffing

- Data submitted by the hospital showed that as of April 2016, the outpatient department employed 9.2 whole time equivalent staff (WTE). This consisted of 5.6 WTE nursing staff and 3.6 (WTE) health care assistants. At the time of the inspection, there was a 0.8WTE vacancy for a qualified nurse in outpatients.
- In diagnostic imaging, there was one radiology manager, three contracted radiographers and four bank radiographers employed.
- The service used a modified safer staffing tool to calculate staffing levels at the weekly capacity meeting to review service demands for the following week. Additionally, the hospital had introduced a daily hospital-wide meeting for heads of departments to review and manage staffing levels and any capacity issues. The hospital used dedicated bank staff as and when required from the hospital bank. Between April

2015 and March 2016, the average monthly use of bank staff as a share of total staff was 13.4%. Bank staff said they completed a local induction and completed competencies. Between April 2015 and March 2016, no agency staff were used in the outpatient department or within diagnostic imagining. This was lower than the average of other independent acute hospitals.

- The sickness rates for staff working in outpatient departments were variable compared to the average of other independent acute hospitals and there was no staff turnover during the reporting period.
- Staff received a structured induction programme and the staff we spoke with felt supported on joining the hospital. The service did not have a dedicated children's nurse as the service had withdrawn paediatric services for children up to the age of 16 years in outpatients.
- The diagnostic imaging department consisted of two full time radiographers and three part time radiographers (2.11 whole time equivalent). These radiographers covered mammography, plain film and fluoroscopy within the department and in theatre. At the time of the inspection, the department was also utilising two locum radiographers, one working full time and the second working three days a week. These locums were to cover long-term sickness of one radiographer and the second was to relieve the acting radiology manager from all clinical duties. Since starting their role, the acting radiology manager has recommended the addition of two further radiographer posts within the department. There was also a part time health care assistant in diagnostic imaging, whose role included chaperoning patients in ultrasound and providing support to the radiographers.

Medical staffing

- There were appropriate numbers of consultant staff in the specialties required to meet contractual and patient need.
- Data showed all medical staff had had access to a responsible officer and their registration validated in the last 12 months. The hospital director and MAC chair liaised with the local NHS trusts to maintain updated records on appraisal outcomes and to check for any concerns or restrictions on practise for individual consultants.
- There was an effective system in place to ensure the relevant professional documentation for each consultant with practicing privilege was up-to-date. This included appraisal, professional registration and revalidation. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there.
- The hospital completed relevant checks with the Disclosure and Barring Service (DBS) for employees and for staff with practising privileges.
- The hospital outsourced the provision of its resident medical officers (RMO) to a national agency. An RMO was on-site 24 hours a day when on-duty. Each RMO worked a rota of one week on and one week off. Continuous professional development opportunities were provided by the agency.
- Staff said that medical staff were supportive and advice could be sought when needed. Medical staff were contacted by telephone, email or via their secretaries to offer advice to staff if they were not present at the hospital and there was an arrangement in place for consultants to provide cover for each other if required. The Medical Advisory Committee was in the process of discussing ways in which to formalise the cross cover arrangements for surgeons and anaesthetists.
- Radiologists covered ultrasound lists and a small number of 'interventional' procedures (generally limited to arthrogram injections where contrast media is injected into a joint prior to an MRI scan). Consultant radiologists were generally not required to be on site as they could report studies via the Picture Archiving and Communication System (PACS) from their NHS base. An on-call rota was in place to provide a 24-hour radiology service.

Major incident awareness and training

- The hospital had a business continuity plan in place to deal with incidents such as flooding and loss of services. The hospital did not participate in regional major incident planning. Impact risk assessments were carried out when carrying out changes to the service. The service had a backup emergency generator in case of power failure and two-way radios to issue to staff in case of communications failure.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Effective was inspected but not rated.

We found that:

- Performance and quality indicators were closely monitored. The hospital ran a quarterly audit programme to monitor their performance in meeting NICE and national standards such as pre-operative fasting, Venous Thromboembolism (VTE) risk assessment and prescribing compliance. The outcomes informed their quarterly clinical scorecard detailing 39 indicators.
- We saw that competencies were in place for each nursing role in outpatients and a record of annual competencies and training were held in personal files.
- All outpatient nurses and health care assistants had received an appraisal in the current appraisal year
- Patients had access to a breast care specialist nurse and consultant supported by radiology and histopathology in the one-stop breast care clinic.

Evidence-based care and treatment

- Within outpatients and diagnostic imaging, corporate and local policies and procedures had been developed and referenced to National Institute for Health and Care Excellence (NICE) and national guidance. These were accessible to all staff on the hospital's intranet.
- The radiology department had a comprehensive rolling audit plan that encompassed many areas relating to clinical practice. Audits included a check of adherence to the three-point identification check of patients, the completion of the WHO checklist and the inclusion of imaging laterality markers on plain film images.
- The medical physics service performed regular dose audits and had provided the department with local diagnostic reference levels (DRLs) which provide an indication to radiographers as to dose levels expected for each examination.
- The hospital used an accredited software package to manage the clinical records for ophthalmology patients including specialist modules for specific conditions.
- Prescribing standards were monitored and audited by Pharmacy and reported to the Clinical Effectiveness Committee where actions were agreed and implemented.
- The hospital ran a quarterly audit programme to monitor their performance in meeting NICE and national standards. The outcomes informed their quarterly clinical scorecard detailing 39 indicators.
- The hospital participated in the following national audits: National Joint Registry, PROMS, Public Health England - Surgical Site Infections, CQUINS measures agreed with the CCGs and the Safety Thermometer.

Pain relief

- Some of the minor procedures that took place in the outpatient department were performed under local anaesthetic. When patients reported experiencing pain, staff said that they would assess the level of pain and the consultant or registered medical officer would prescribe pain relief medication if required.
- The physiotherapy service was looking at trialling an acupuncture clinic for relief of chronic pain.

Patient outcomes

- The diagnostic imaging department carried out regular audit of the work carried out in plain film. We saw evidence of a rolling audit that reviewed all plain film images for quality. The majority of staff participated in this audit and looked at different examinations each month to evaluate the quality of the images. The results were fed back to the staff during the monthly staff meetings, where learning was shared.
- The clinical scorecard was used to benchmark clinical performance across the 38 Spire sites and to identify opportunities to share learning and good practice.
- The hospital held external accreditation from BUPA as a breast care centre and a colorectal care centre as well as accreditation for the sterile supplies service.
- The hospital was due to commence submitting performance data to the Private Healthcare Information Network (PHIN) in the month of inspection.

Competent staff

- We saw that competencies were in place for each nursing role in outpatients and a record of annual competencies and training were held in personal files.
- We saw training records that demonstrated that radiology staff had the theoretical knowledge and

practical skills to meet the minimum standard for safe practice in compliance with IR(ME)R. Whilst these training records appeared basic, we were told that the acting radiology manager was in the process of revising these documents to include a broader oversight of what training had been completed as well as staff entitlement under IR(ME)R 2000. The radiology manager was the qualified RPS within the hospital. Training certificates were also seen for the orthopaedic surgeons on the use of the recently purchased mini c-arm. This training, provided by applications specialists, included both theoretical training around radiation protection and practical training on the use of the piece of equipment.

- Data provided by the hospital showed that 100% of outpatient nurses and health care assistants had received an appraisal in the current appraisal year (January 2015 to December 2016). Staff described the appraisal process as a valuable experience and felt that their learning needs were addressed; they were also given the opportunity to attend courses to further their development. For example, a member of staff was completing modules for a master's degree.
- The Consultant's Handbook was in place to manage granting practising privileges. Practising privileges are 'the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital'. The handbook clearly documented the process for application, granting and conditions for maintaining practicing privileges. The hospital completed an annual review of practising privileges and maintained a record of a consultant's General Medical Council registration, appraisal and medical indemnity arrangements. Any concerns about a consultant would be shared with their responsible officer within their NHS employment.
- The hospital had a contract with a private agency for the Resident Medical Officers (RMOs). The RMOs received clinical education from the agency. Copies of their documentation including CV and details of disclosure and barring service (DBS) and validation details were supplied by the agency. The matron carried out the RMO's appraisal and a consultant provided clinical support.

Multidisciplinary working

- Report turnaround time for medical staff requesting diagnostic imaging to be carried out was usually 24 hours or two to three days if the consultant requested a specific radiologist. Outpatients are able to request previous diagnostic images in time for clinic appointments by using the Image Exchange Portal, which is a national service that enables the safe and secure transfer of images held on the local trust's picture archiving and communication system.
- A breast care specialist nurse and consultant worked in the rapid-access breast care clinic supported by radiology and histopathology. Physiotherapists worked with the medical and surgical consultants and nursing to provide a therapeutic service for post-operative patients and those with musculo-skeletal disorders.
- A designated Outpatient Sister was linked with all of the MDTs held at the local NHS trust and ensured comprehensive information from Spire Elland Hospital was available to support the process. Investigation reports, including histopathology slides if requested, were forwarded to the NHS trusts where the MDT takes place. Copies of all MDT reports for Spire Elland patients are received from the MDT and filed in the single patient records held for each patient.

Seven-day services

- The radiographers had an on-call rota for imaging required urgently or prior to patient discharge out-of-hours. The mobile MRI scanner visited three days a week and the CT scanner once a week. This covered the demand for the service; however, if an out-of-hours urgent scan was required, the patient would transfer to the local NHS trust.
- An RMO was on-site 24 hours a day when on-duty. Each RMO worked a rota of one week on and one week off.
- Whilst outpatients do not provide a seven-day service, clinic hours had been extended with a number of evening and Saturday clinics taking place to provide access for patients not wishing to take time out of working hours.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, national guidance and e-learning.
- Staff reported no concerns about accessing relevant patient information. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.

Good

Outpatients and diagnostic imaging

- Fully integrated single patient records were maintained on site. Over the last three months, 99% of patients were seen in outpatients with relevant medical records being available. In the event that a record could not be located, the team had the facility to make up a temporary set of notes as the most recent consultant letters and any investigation results could be reproduced from the electronic archive systems.
- Discharge letters were hard copy but the hospital was moving towards electronic discharge letters to send to the GP. The letters were produced in a timely way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to describe their responsibilities with regards to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). There was a current DOLS policy in place and training provided. Patients that lacked capacity were individually assessed and appropriate steps taken to ensure their care could be safely delivered within the hospital. Where this was not deemed in the best interest of the patient, they would be directed to NHS services for treatment. To maintain staff awareness and confidence, staff briefings and updates around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) were being rolled out.
- The Consent Policy contained guidance about assessing and responding to lack of capacity when consent is sought with reference to MCA requirements. Staff briefings and reference materials around MCA and DOLS were being rolled out to raise confidence in bringing any concerns to the hospital safeguarding leads.
- Staff reported that they were aware of the Consent Policy and how to access this on the hospital intranet. Staff had a broad understanding of issues in relation to capacity. They explained that any concerns would be escalated to the safeguarding leads for further advice or assistance.
- No patients who lacked capacity or deprived of their liberty were in the outpatient and diagnostic imaging departments during our inspection. We saw that consent forms were completed, patients were appropriately consented, and any risks had been discussed with the patient.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Feedback from patients during inspection was universally positive about the caring attitude and efficiency of the service.
- Patient feedback demonstrated that patients were listened to and time was taken to ensure that they understood their care, treatment and condition.
- We observed compassionate interactions between staff, patients and relatives.
- All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further information.
- Training on chaperone competencies was provided and notices were displayed to raise awareness of the availability of chaperones.
- A specialist breast care nurse worked with the consultant surgeons providing a one-stop breast clinic. She offered support to patients and families when receiving difficult news and, in partnership with local NHS trusts, systems were in place for advice and support to be available to patients 24 hours a day.

Compassionate care

- We spoke with five patients in the outpatient and diagnostic imaging waiting area. All patients spoke positively about their experience and told us that staff had respected their privacy and dignity. Additionally we received 23 comment cards for outpatient services. Feedback was universally positive. Comments included:
- “I was very impressed by the kindness and helpfulness shown to me.”
- “They have got me back on my feet after years of pain. This place is fantastic.”
- “Excellent service and excellent facilities.”
- “My treatment today was prompt, friendly and very caring.”
- We observed staff interacting with patients and their families in a respectful manner. This included staff visiting the waiting area to check on the status of patients waiting for appointments.

Good

Outpatients and diagnostic imaging

- The hospital collected friends and family test (FFT) survey data from outpatients: The results were published for Spire Healthcare as a corporate group and were not available individually for Spire Elland Hospital.
- The hospital had a policy in place for the use of chaperones; this provided guidance on the use of chaperones for any patient undergoing an intimate examination. Training on chaperone competencies was provided and notices were displayed to raise awareness of the availability of chaperones.
- Private changing facilities were available for patients in the physiotherapy and radiology departments to promote privacy and dignity.
- Within the outpatient department, the siting of the reception desk offered privacy and conversations could not be overheard by waiting patients.

Understanding and involvement of patients and those close to them

- Patients felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further information.
- Following their appointments, patients were given a letter detailing the time and date of their next appointment and information about who to contact if they had any concerns about their condition or after receiving treatment. The majority of patients told us they understood when test results would be returned to them.
- We reviewed four sets of records in the outpatient department. All the records had evidence of patients' involvement in discussions about their treatment options, and the risks and benefits of the different treatments.
- Within the diagnostic imaging department, patients told us that they received appropriate information about their care and treatment.
- Patients were kept informed in the event that there were changes to clinics such as delays or rescheduling.
- Patient feedback demonstrated that patients were listened to and time was taken to ensure that they understood their care, treatment and condition.

Emotional support

- Staff we spoke with had an understanding of the emotional impact care and treatment could have on patients. Treatment options were discussed with people and they were encouraged to be part of the decision making process.
- We observed compassionate interactions between staff, patients and relatives. Staff reassured patients and relatives about the care and treatment they received.
- A specialist breast care nurse worked with the consultant surgeons providing one-stop breast care clinics. She offered support to patients and families when receiving difficult news and, in partnership with local NHS trusts, systems were in place for advice and support to be available to patients 24 hours a day.
- Specialist care was also available in ophthalmic and cosmetic surgery and psychology. The cosmetic surgery service was based in the Springfield Suite which had a separate entrance to allow patients to have discreet access to the service if they wished.
- The majority of people we spoke with said they felt they received emotional support from staff, or this would be available if needed.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Spire Elland Hospital had no patients waiting longer than six weeks in diagnostic imaging for all modalities during the reporting period (April 15 to March 16). The hospital achieved better than the target of 92% of incomplete patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 15 to March 16). It also achieved better than the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period before the targets were abolished (April 15 to May 15). Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 15 to March 16).
- Clinics ran on time and this was supported by patient comments during the inspection. The service received a

low number of complaints in the past year (six). We saw complaints were responded to within timescales and where there had been a delay in response, the complainant was informed.
- The provision of an additional theatre in 2015 enabled the hospital to meet increasing demand for services. Clinic hours had been extended to evening and Saturday clinics to provide access for patients not wishing to take time out of working hours.
- Management had recently introduced dementia awareness champion roles and staff training was to be sourced. The environment was assessed using a King's Fund assessment tool, 'Is your hospital dementia friendly.' Following the assessment, an action plan was developed with a view to improving the environment to be more dementia friendly.

Service planning and delivery to meet the needs of local people

- The outpatients waiting area was comfortable and had sufficient seating, toilets and magazines.
- Parking was limited on site and this was a known problem for staff and patients. An extension to parking facilities was being considered. Signage was clear and easy to follow and staff were seen to offer help if patients needed directions.
- We observed that clinics generally ran on time and this was supported by patient comments during the inspection.
- Clinic hours had been extended to provide a number of evening and Saturday clinics to provide access for patients not wishing to take time out of working hours.
- Clinics held at Longlands Consulting Rooms including physiotherapy enabled patients in the Dewsbury area to access the same aftercare service that would have been provided at the main site in Elland. The hospital also provided some services in an outreach clinic in Holmfirth in partnership with one of the health centres, as there were limited public transport options from that area.

Access and flow

- Between April 2015 and March 2016 there were 30,873 outpatient total attendances; of these 53% were NHS funded and 47% were other funded.
- Spire Elland Hospital had no patients waiting longer than six weeks in diagnostic imaging for all modalities during the reporting period (April 15 to March 16).
- The diagnostic imaging department had a target of 24 hours for the report turnaround time for all imaging examinations carried out on site. The hospital did not audit the turnaround time as almost all of the radiologists' reports were being produced within the 24-hour target.
- The provider achieved better than the target of 92% of incomplete patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 15 to March 16).
- The provider achieved better than the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period before the targets were abolished (Apr 15 to May 15). Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 15 to March 16).
- Patients had a choice for booking the dates and times of appointments. Patients we spoke with confirmed appointments were offered that suited their needs. None of the patients we spoke with raised any concerns about being able to access appointments in a timely manner or delays in clinic. We heard reception staff booking patients for future appointments; patients were all offered a choice of times and dates.
- The hospital did not collect data on waiting times however; staff in all departments told us the wait times for appointments were short. Patients we spoke with were pleased with the choice, availability and timeliness of appointments.
- Did Not Attend appointment rates were not monitored; however, patients would be contacted if they missed an appointment and referred back to the GP if they missed a second appointment.

Meeting people's individual needs

- There were systems and processes in place to meet people's needs. For example, patients whose first language was not English could access an interpreter. The service also used a telephone interpreter service. Staff could describe how they would access the service.
- The outpatient services, including physiotherapy were located on the ground floor of the hospital to increase accessibility.
- We were told by staff that if a patient required extra support, additional staff would be provided. We heard

at the morning hospital-wide meeting capacity being discussed with a view to providing extra staff where needed to meet individual patient's needs. This included the outpatients and radiology departments.
- Management had recently introduced dementia awareness champion roles and staff training was to be sourced. The environment was assessed using a King's Fund assessment tool, 'Is your hospital dementia friendly.' Following the assessment, an action plan was developed with a view to improving the environment to be more dementia friendly.

Learning from complaints and concerns

- In the last 12 months, the provider received six complaints relating to outpatients. We saw complaints were responded to within timescales and where there had been a delay in response, the complainant was informed.
- Information on how to make a complaint was contained in an information booklet, which was readily available in departments. Patients we spoke to were very positive about the service provided and had no complaints. Patients said they felt they would be taken seriously if they did need to complain and would feel confident to speak to a nurse or doctor if they wanted to make a complaint.
- Staff we spoke with were clear about the complaints process and action they should take if someone wished to complain.
- Formal complaints were investigated by the matron and hospital director. These were discussed at monthly senior managers meetings and quarterly clinical governance meetings. Learning was cascaded via the team meetings.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- The hospital had an effective governance structure in place to ensure performance, quality and risks were monitored. Performance in patient effectiveness, safety and patient experience was regularly reported through the clinical scorecard to corporate management and the clinical commissioning group. It was also summarised in the annual hospital governance report.
- Staff talked about how the values (such as 'caring is our passion', 'doing the right thing' and 'driving excellence') were demonstrated in the way they delivered their service. The senior leadership team were highly visible within the hospital. Staff spoke positively about the matron and hospital director and said they knew staff by name and were very approachable. In the 2015 staff survey, 94% of staff agreed that 'I believe what I do at work makes a positive difference to my hospital' and 93% agreed they were 'proud to work for the hospital'.
- There was a robust system in place to ensure that relevant documentation was held for each consultant with practising privileges. This included up-to-date professional registration, appraisal documentation and indemnity insurance.
- Risk management processes were under corporate review at the time of inspection and a new hospital risk register was being developed.

Leadership of service

- The heads of departments in diagnostic imaging, outpatients and physiotherapy were easily accessible. Staff reported good support and guidance from their managers. Managers were passionate about their service and there was a caring approach towards staff well-being. There was a strong team spirit and the willingness to be flexible to ensure the service met patients' needs such as changing duty rotas. Department heads had undertaken or were planning to attend an in-house management training course.
- The senior leadership team were highly visible within the hospital. Staff spoke positively about the matron and hospital director and said they knew staff by name and were very approachable. The weekly capacity meeting and daily safety meeting around staffing and clinical activity ensured effective communication between the various levels of leadership.
- The heads of outpatients and physiotherapy were experienced in their clinical specialty and management role. The radiology service manager (RSM) was new in role and receiving management support from the

matron and an RSM from another Spire hospital as required. The RSM also sought support from the medical physics expert and radiation protection advisors under a service level agreement when required.

Vision and strategy for this core service

- The corporate vision was to be recognised as a 'world-class healthcare business'. The vision, mission and values were on display and accessible to staff and they talked about how the values (such as 'caring is our passion', 'doing the right thing' and 'driving excellence') were demonstrated in the way they delivered their service.
- Staff in each department and inpatient service had developed local service objectives to drive improvement. The outpatient and diagnostic imaging departments had developed objectives which aligned with the business plan and were monitored at team level.
- The radiology service manager was newly appointed and working to complete the actions surrounding the HSE enforcement notification. A strategy for the department was in the early stages of development.
- The 2016 annual operating plan included plans to refurbish the outpatients department and delivering a safe and efficient service supported by objectives for safety improvement.

Governance, risk management and quality measurement for this core service

- The hospital had a defined governance structure in place to ensure performance, quality and risk was monitored.
- The Clinical Effectiveness Committee and Infection Prevention and Control Committee reported to the Clinical Governance Committee, which reported to the Medical Advisory Committee (MAC), the senior management team and the hospital director. Non-clinical risks and health and safety issues were monitored at the Health and Safety, Quality and Risk Committee, which also reported to the senior management team and the hospital director.
- Due to the audits carried out within the diagnostic imaging department, there was good oversight of the quality of work carried out by the radiographers. Results of any audit and points for improvement were regularly discussed within the team meetings.
- The hospital was using a new corporate template for the risk register at the time of the inspection. We found that the template did not record the date a risk was added therefore it would not be possible to know how long the risk had been monitored. The revised template was in the process of being introduced and the register content in development at the time of inspection. Managers were aware of their organisational and service level risks and the actions taken or planned to mitigate the risks.
- Performance in patient effectiveness, safety and patient experience was regularly reported through the clinical scorecard and monitored to corporate management and the clinical commissioning group. It was also summarised in the annual hospital governance report.
- Service level agreements were in place and monitored for outsourced services such as radiation protection, pathology and clinical waste.
- The roles and responsibilities of the Medical Advisory Committee were set out in the Consultant Handbook, which was issued to all consultants with practising privileges.
- The hospital director supplied data on consultant activity to the relevant NHS medical director to inform the appraisal and revalidation process for each consultant.
- There was a robust system in place to ensure that relevant documentation was held to demonstrate that the requirements for practising privileges were met for each consultant.

Culture of service

- Staff were proud of the organisation as a place to work and spoke positively of the culture. In the 2015 staff survey, 94% of staff agreed that 'I believe what I do at work makes a positive difference to my hospital' and 93% agreed they were 'proud to work for the hospital'.
- Staff told us they were happy working at the hospital and Longlands Consulting Rooms and felt that all staff valued each other's role. They also told us team working and communication were good and they felt confident to ask questions. Staff were rewarded with free lunches in recognition of 'going the extra mile' in delivering care or service.
- We saw evidence that behaviour or competency that was inconsistent with the vision and values, regardless of seniority, was addressed.

- There was a strong culture of openness and honesty and evidence of where this had been implemented in response to safety incidents. There was a staff booklet explaining to staff how and when Duty of Candour was implemented as well as a policy being in place.
- Staff received an annual update on equality and diversity and demonstrated awareness of how discrimination was avoided.
- During the inspection, we observed the staff in the radiology department work cohesively as a team and regularly peer review each other's work. Tasks were cascaded through the team and team members felt valued in their roles.

Public and staff engagement

- Staff described the senior leadership team as having an 'open door policy'. Staff felt able to confidently raise concerns, that they would be listened to and appropriate action taken. A whistleblowing policy was in place. Team meetings, heads of department meetings and senior management meetings were all held regularly.
- The response rate to the 2015 staff survey was good at 79%. The 2016 staff survey had not yet taken place. The 2015 staff survey showed 97% of staff were likely to recommend the hospital to their friends and family for treatment and 96% would be happy with the standard of care if provided for a friend. Two years ago, the survey showed that staff felt that communication from management could be improved and in response, minutes for all meetings were made available and the heads of departments increased their level of communication with staff.
- The hospital conducts an ongoing patient survey that includes the Friends and Family test, which incorporates a number of other questions about the patient experience. The hospital director reported that much of the feedback from patients was positive and was shared with staff, which has proved motivational.

Innovation, improvement and sustainability

- The hospital had a primary care liaison officer who focused on raising the profile of the hospital and offering training to local GPs and practice nurses. This included specialist consultants providing clinical education lectures. The hospital also sent out a quarterly 'primary care news' newsletter which covered topics such as the roll-out of the electronic discharge letter process, waiting times performance for the main specialties and the availability of the rapid access breast clinic. In addition, Spire Elland Hospital undertook an annual independent Primary Care Satisfaction Survey to identify areas of service improvement and service benefits to general practice.
- The hospital was due to commence submitting performance data to the Private Healthcare Information Network (PHIN) in the month of inspection.

Outstanding practice and areas for improvement

Outstanding practice

- Fully integrated single patient records were maintained on site. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- The hospital was working towards best practice to reduce the risk of dehydration before surgery, by ward and theatre staff using a joint approach to minimise fasting times.
- PROMs data from April 2014 to March 2015 showed the hospital's adjusted average health gain for primary knee replacement was significantly higher than the England average.
- Staff in each department and inpatient service had developed local service objectives to drive improvement.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should manage hazardous materials in line with current legislation and guidance.