

Spire Hartswood Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Hartswood Hospital is operated by Spire Healthcare Limited. The hospital has 35 beds spread over two wards. Facilities include three operating theatres, a one-bed level one enhanced recovery unit, a three bay endoscopy unit and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected surgery, medicine and outpatients.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 21 January 2020 and 4 February 2020, both of which were unannounced.

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

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

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

Services we rate

Our rating of this hospital improved. We rated it as **Good** overall.

We found the following areas of good practice:

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

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We found areas of outstanding practice:

- Patient psychological wellbeing were in mind when delivering services. Staff considered all people who attended, very much with their wellbeing in mind. There were lots of examples of staff ensuring those accessing oncology were compassionately welcomed in to the department. The need for confidentiality and a sensitive approach was demonstrated from the minute people were referred. A psychologist was employed to support people assessed as requiring additional mental health input.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Medical care
(including
older people's
care)**

Good



Rating Summary of each main service

Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led.

Surgery

Good



Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Outpatients

Good



Outpatients had a large proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

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Good



Spire Hartswood Hospital

Services we looked at

Medical care (including older people's care); Surgery; Outpatients.

Summary of this inspection

Background to Spire Hartwood Hospital

Spire Hartwood Hospital is operated by Spire Healthcare Limited. The hospital opened in 1984. It is a private hospital in Brentwood, Essex. The hospital primarily serves the communities of Barking, Dagenham, Havering, Romford and Redbridge to the West; Basildon, Billericay, Southend and Wickford to the East; Chelmsford, Colchester, Doddington, and Shenfield to the North, and Dartford, Grays and Thurrock to the South. It also accepts patient referrals from outside this area.

The hospital provides surgical, medical and outpatient care, services for children and young people and diagnostic imaging. A registered manager has been in post since September 2017.

The hospital also offers cosmetic procedures which we did not inspect.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, one assistant inspector, and two specialist advisors with expertise in surgery and oncology. The inspection team was overseen by Mark Heath, Head of Hospital Inspection (interim).

Information about Spire Hartwood Hospital

The hospital has two wards and is registered to provide the following regulated activities:

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

During the inspection, we visited inpatient and outpatient areas, theatres, and recovery. We spoke with 22 individual staff including registered nurses, health care assistants, administration staff, medical staff, physiotherapists, and senior managers and held a wider staff forum that was well attended. We spoke with eight patients. During our inspection, we reviewed 24 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was previously inspected in May 2016. We inspected the medical, surgical and outpatients and diagnostics core services, all of which we rated as requires improvement. We found breaches of regulation 17 HSCA (RA)

Regulations 2014 Good Governance and told the hospital to take action. Information received leading up to and obtained throughout this inspection indicated compliance to this regulation now.

Activity (July 2018 to June 2019)

- In the reporting period July 2018 to June 2019 there were 6,921 inpatient and day case episodes of care recorded at the hospital; of these 17% were NHS-funded and 83% privately funded.
- Of the total of inpatients 18% in the reporting period stayed overnight. Of these, 20% were NHS-funded and 80% were privately funded. The remaining inpatients were day cases.
- There were 46,765 outpatient total attendances in the reporting period; of these 84% were privately funded and 16% were NHS-funded.

There were 241 medical staff who worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a seven-day rota. Spire Hartwood employed 36.3 full time equivalent (FTE)

Summary of this inspection

registered nurses, 31.5 FTE health care assistants and operating department practitioners and 133.3 FTE other staff such as porters, receptionists and housekeeping staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (July 2018 to June 2019)

- Zero never events (this data was received as part of pre-information request; however updated information shows that the hospital reported one never event in the period July 2019 to December 2019)
- Clinical incidents 455 no harm, 83 low harm, 26 moderate harm, zero severe harm, one death
- Two serious injuries that occurred after the reporting period closed
- Zero incidents of hospital acquired Meticillin-resistant *Staphylococcus aureus* (MRSA),
- Zero incidents of hospital acquired Meticillin-sensitive *staphylococcus aureus* (MSSA)
- Zero incidents of hospital acquired *Clostridium difficile* (C.diff)
- Zero incidents of hospital acquired *E. coli*

- Forty-five complaints

Services accredited by a national body

The service holds a number of accreditations including (but not limited to) the following:

- MQEM - Macmillan Quality Environment Mark
- UKAS Pathology accreditation

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal
- Cytotoxic medicines service
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision
- Paediatric advisory support with paediatric team at local NHS trust
- Service level agreements in place for the transfer of patients to other providers as required

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Good



Are services effective?

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

Good



Summary of this inspection

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes such as MQEM - Macmillan Quality Environment Mark and prostate, bowel assessment and breast care accreditation from an international independent healthcare company.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Good



Summary of this inspection

Are services responsive?

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Good



Are services well-led?

Our rating of well-led improved. We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Good



Summary of this inspection

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Good 

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

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. Staff accessed most of their mandatory training using an eLearning system; accessible via the internet. All staff including bank staff were required to complete mandatory training modules and clinical competencies. For example, infection control, information governance, managing violence and aggression, safeguarding adults and children.

Staff compliance with mandatory training met local targets. We looked at training figures and saw that all targets for completion of mandatory training had been met or exceeded. For example, all staff were required to train in the use of National Early Warning Score (NEWS) 2 charts to monitor patients and identify deterioration quickly. Figures for compliance with this training showed 95% compliance. Staff training compliance for safeguarding adults and children and Mental Capacity Act 2005 was at 100%. Staff training in infection prevention control was 100% compliant.

For training data around life support training, please see the surgery section of the report.

Staff received mandatory sepsis training as part of the immediate life support (ILS) training and within the Acute Illness Management (AIM) course. Training compliance for sepsis was at 100%. Chemotherapy staff had additional training in the recognition and treatment of neutropenic sepsis in addition to the provider's sepsis training.

Medical staff received and kept up-to-date with their mandatory training. Medical staff provided evidence of mandatory training completed through annual appraisal based on minimum General Medical Council requirements. The resident medical officer was Advanced Life Support trained. The hospital had processes in place to monitor consultant mandatory training completion and took action when consultants were out of date with this training. Medical staff with out of date training were temporarily suspended then reinstated upon evidence of completion.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw this evidenced in data provided by the managers and staff told us they used the electronic system that sent reminders to ensure training was up to date and reviews completed within set deadlines.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. All staff were trained in safeguarding adults and children levels one and two. Training figures demonstrated 100% compliance. This meant that all staff received mandatory training to help keep children and adults safe.

Medical care (including older people's care)

Staff with additional responsibilities, for example, safeguarding champions and leads were trained to safeguarding level three or level four. This meant that staff had access to leads with advanced knowledge and had received specialist training to ensure they were skilled in assessing and managing safeguarding concerns.

Medical staff received training specific for their role on how to recognise and report abuse. Consultants were required to meet practicing privileges standards for care of children and young people which was set out in the consultants' handbook. Medical staff with out of date certificates were temporarily suspended from practice until they completed their up to date training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was evidence of staff understanding of the principles of safeguarding. There were posters on display highlighting practices to be aware of, for example, female genital mutilation and breast flattening posters. Staff we spoke with told us about their understanding of these practices and how they would escalate concerns. Staff had access to contact details for local authority teams and understood the benefits of working together to protect people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to safety and safeguarding systems, processes and practices. There was a corporate safeguarding policy with local appendices. There were links with local safeguarding children partnerships and the children and young people's lead met with the designated nurse for safeguarding and local authority to keep connected with local agencies. Staff were provided with clinical supervision which included safeguarding.

Staff followed safe procedures for children visiting the ward. Staff had access to an up to date policy for children attending the ward and knew and understood how to keep children safe.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff were employed to ensure daily cleaning. Suitable furnishings were seen throughout, including appropriate flooring and furniture coverings to carry out good infection prevention and control practice.

The service generally performed well for cleanliness. There was an infection prevention and control (IPC) lead who completed IPC audits to ensure compliance with IPC to help keep people safe from harm. Staff carried out hand hygiene audits. We looked at scorecards over a nine month period based on quarterly audits. Staff were 95% compliant in the periods April 2018 to June 2018 and July 2019 to September 2019. In both audits, one member of staff in each audit was observed to not have met the standard. Staff received immediate instructions where improvements were required.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw 'I am clean' stickers on equipment to indicate they had been cleaned when they were scheduled to be cleaned. Data provided by the hospital reported no reportable infections across all procedures. Staff reported infection prevention control (IPC) incidents and discussed at monthly committee meetings. This was an indicator of good infection prevention control.

The service had not had any reported cases of hospital associated infections in the 12 months prior to our inspection. Staff had systems in place to report and manage infection prevention control. Staff knew that they were required to report healthcare-associated infections, for example, MRSA (methicillin-resistant staphylococcus aureus) or E. coli (Escherichia coli). These can be hard to prevent if people attend the hospital already infected. However, the hospital had processes in place to prevent them from spreading.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw good infection prevention control and practice. We saw staff wear appropriate personal protective equipment, for example, gloves, aprons and spillage kits were easily accessible. Staff has access to handwashing facilities. Staff explained to us the importance of good infection prevention control to prevent the spread of infections and used learned techniques.

Medical care (including older people's care)

The hospital had a sterile services department that completed decontamination and sterilisation of all surgical equipment including endoscopes. Please refer to the surgery core service report for more details.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. The call bell system was technologically advanced; it sent a message to an electronic display screen in the ward corridor. This provided more detail as to the type of response required. Each bed had a call bell within easy reach. The call bells had three functions available. One that required an urgent response, one specifically for housekeeping and one that required a response but was not urgent. This meant staff could respond to specific needs of the patient.

The leadership team had a business continuity plan in place for managing all identified environmental emergency situations. For example, plans to respond to a flooding or fire situation, with regular testing with scenarios. This meant that patients had access to a safe environment that was assessed as suitable for their specific needs.

Staff carried out daily safety checks of specialist equipment. Staff ensured maintenance and monitoring of equipment to keep people safe. We saw evidence of electrical equipment testing, which was in date and reviewed at regular intervals. All equipment required for provision of care were in place, for example, O₂ valves and infusion pumps were in date, maintained to a good standard and compliant with national guidelines. We checked resuscitation trolleys in clinical areas, all of which were intact and sealed and daily checks were completed consistently. Rooms had oxygen and anaphylaxis treatment all of which were checked daily.

Staff had access to specialist equipment required in the care of medical patients. This included specialist infusion pumps for chemotherapy and specialist accessories for endoscopy procedures. Managers we spoke with told us that they had no issues with gaining approval to procure equipment required for the care of patients.

The service had suitable facilities to meet the needs of patients' families. The design, maintenance and use of facilities and premises kept people safe. Staff completed an environmental checklist and audit reviews at regular intervals. There was a specific environmental risk assessment for children and young people using the service. There was a dedicated day case ward facility for administration of chemotherapy with 10 single rooms on the ward. Each room met the required standards, such as appropriate hand washing facilities, call bells and piped oxygen. A recent refurbishment of the ward meant that each room had appropriate flooring and washing facilities. Each patient was allocated a room based on their individual preferences and needs. Staff told us that they would allocate rooms based on which side of the body each patient had their treatment access lines, to ensure they had easier access to toilets.

Staff disposed of clinical waste safely. Staff had systems in place for managing waste and clinical specimens to keep people safe. This included, classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste. Porters were employed and trained to use spillage kits for bodily fluids and toxic materials used for treatments, and there were locked cupboards to store equipment and spillage packs. We looked at labelling and storage, for example, we could see all non-refrigerated products were kept in a locked cupboard and there were records to keep track of contents.

Clinical chemotherapy waste was disposed of in line with national guidance, with appropriate coloured (purple) sharps containers to signify cytotoxic waste.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff identified and responded appropriately to changing risks to people who used the service, including deteriorating health and wellbeing and medical emergencies. Staff were able to seek support from senior staff in these situations. Staff used an evidence based 24 hour triage tool to risk assess patients who received chemotherapy. Staff worked together to review and

Medical care (including older people's care)

mitigate key risks on a daily basis using these tools when appropriate. Staff completed NEWS2 charts to monitor patients and identify deterioration quickly. We looked at risk assessment tools in patient records. For example, NEWS2 charts, which were completed comprehensively. We spoke with staff about completion and staff told us how to use them and how to escalate.

Staff administered oncology medicines through both long lines (directly into major blood vessels), and cannulation. The service had an in-date policy for the management of extravasation. Extravasation is the process by which any liquid (fluid or medicine) accidentally leaks into the surrounding tissue. In terms of cancer therapy, extravasation refers to the inadvertent infiltration of chemotherapy into the subcutaneous or subdermal tissues surrounding the intravenous or intra-arterial administration site.

Staff were provided with the skills and resources to assess and manage sepsis. All patients receiving anti-cancer treatment were given an alert card at pre-assessment stage. This gave information to the patient and medical staff about the possible side effects of chemotherapy treatment including neutropenic sepsis. This was in line with National Institute for Health and Care Excellence guidance 'Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients (2012)'.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed comprehensive risk assessments for people who used services and risk management plans developed were in line with national guidance. Staff used recognised assessment tools to assess and respond to patient risk.

Staff knew about and dealt with any specific risk issues. Staff worked together to ensure patient risks were assessed and responded to appropriately. Staff discussed patient specific risk details at daily handovers and ensured specific risk information was displayed in patient records. For example, patients with allergies had an alert indicator on their files. Staff were trained and had access to appropriate emergency equipment to respond to the associated risks.

Staff planned ahead for potential risks to patients. Identified risks were recorded on the risk register, for example, late arrival or missed orders of chemotherapy. To

ensure safety, there were a number of key controls identified, for example, the initiation of a 48 hour order process, incident monitoring and reporting and an escalation process. All of which meant any identified concerns could be dealt with swiftly and at the right level.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Staff attended daily department and resus safety huddles. This ensured key information was shared and staff were equipped to deliver safe care each day. Staff attended monthly health and safety meetings, there were appointed departmental representatives to share information, learning and ensure action from the health and safety meetings. Patients had access to a dedicated pre-assessment nurse to ensure safe admissions for their treatment. The nurse in charge carried out ward safety checklists to ensure the ward areas were safe. All of which helped staff deal with patient risks safely.

Staff used a specialist pathway for endoscopy investigations. The pathway had a pre-investigation checklist, investigation record and discharge checklist to ensure all risks were identified and mitigated before patients were discharged following their procedure.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended shift handovers every day. They discussed patients and plans for attendance, related issues, updated notice boards with key information, for example, staffing and patient information.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers used safe staffing tools to determine staffing levels. Each department displayed posters with planned and actual staffing numbers which was updated daily. Staffing levels were reviewed and displayed daily to demonstrate to all that staffing levels met the required standard. Managers and all staff we spoke with told us that staffing was not an issue and that staffing levels were safe.

Medical care (including older people's care)

The service had low and/or reducing vacancy rates. The number of nurses and healthcare assistants matched the planned numbers. The leadership team had reviewed staffing levels just prior to inspection and made an uplift to the establishment levels. They had added one whole time equivalent nurse to the 5.2 whole time equivalent nurse establishment and additional part time healthcare assistant and administration support to their current healthcare establishment. This meant that they had those vacancies to fill.

The service had low turnover rates. We looked at the previous four months data and saw that there had been no leavers during this period. The leadership team and staff told us that retention rate on the ward was good.

The service had low sickness rates. Sickness rate were at 2.43%, which meant there was a loss of 90 hours of a possible 36900 which was the combined contractual hours of the department. The service used no bank or agency nurses during this period due to the low levels of sickness.

Medical staffing

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

Staff had access to consultant support or advice 24 hours a day 7 days a week. Medical consultants worked in line with the providers practicing privileges. This meant that all consultants were available to attend the hospital within 30 minutes and arranged cover with a consultant colleague for periods of annual leave or if they were unavailable.

The service had enough medical staff to keep patients safe. There were two resident medical officers who rotated and were accessible to staff. One was employed by the hospital and the other was employed through an agency. Both had evidence of an induction. Both followed a seven day rota, where they worked 12 hours on duty and then 12 hours on call. Facilities were available on site for on call rest.

Managers regularly reviewed and adjusted staffing levels and skill mix. Consultant compliance checks took place to ensure their skills and qualification requirements were up to date. Any consultant with out of date requirements were

suspended until such time as their documentation evidenced compliance. At the time of inspection consultants were 100% compliant with mandatory requirements to ensure they were safe to practice.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We looked at eight care records and saw that all were contemporaneous and contained relevant information. Nursing staff entered electronic notes, consultants often provided hand written notes. Staff told us, and we found the doctors handwriting sometimes difficult to read in the hand written notes. Nursing staff told us they could contact consultants directly if they had to query content.

Staff audited records on a regular basis. For example, electronic chemotherapy records were audited monthly and demonstrated compliance in completion. We looked at records audits for the period January 2019 to March 2019. All domains audited were 100% compliant. Staff checked all relevant fields had been completed. This meant there was a checking system in place to ensure compliance with good standards of record keeping.

Records were stored securely. Staff accessed electronic records with their own log in and passwords. Staff completed information governance training which was updated annually to ensure they understood the importance of safe storage. Staff ensured hard copy records and documentation were stored securely to protect the confidentiality of those who used the service.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We observed processes for prescribing, administering, recording and storing of medicines. There was a secure, medicines preparation room. We saw safe and well managed dispensing. All oncology medicines were

Medical care (including older people's care)

prepared centrally and dispensed onto a tray while undergoing rigorous checks. Medicines checks were carried out at all times by two members of staff. Every member of staff involved in dispensing of medicines was trained.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Each patient received a cancer treatment record in the form of an informative booklet. The booklet was completed in collaboration with oncology staff. Patients were provided with mobile phone numbers that they could call in the event of an emergency and speak with an oncology nurse about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. A clinical pharmacist was employed on the ward. The pharmacist was responsible for ensuring safety in medicines practices. There were daily checks to ensure safe medicines storage and management was in line with policy. The pharmacist audited this process regularly.

Staff kept a daily checklist to ensure fridges were in range to ensure the correct temperature to ensure the efficacy of medicines. We looked at daily registers for fridges and saw there were no gaps in recording. There were two fridges for medicines. Both fridges were supported by an alarm system which electronically recorded temperatures and sent an alarm to a screen in the nurses' corridor if it deviated from the correct temperatures. This would ensure medicines were kept at the right temperature at all times.

Staff followed current national practice to check patients had the correct medicines. The oncology pharmacist and pharmacy technicians were first and second checkers for dispensing chemotherapy medicines. Staff carried out regular audits and provided reports to review errors and ensure learning. The electronic system allowed for a real time audit trail. We saw there had been learning from a recorded incident in the form of an introduction of name badge checks and an intro-infusion checklist.

Staff recorded patient allergies and other relevant information on electronic chemotherapy prescription records. Allergy information was obtained from the electronic patient record. We reviewed three prescription records of patients that attended the hospital on the day of our inspection, all the records were correctly completed

with allergy status amongst other information. The dispensing of medicines was consistently checked by two staff, and the pharmacy staff regularly audited the management of medicines.

The service ordered systematic anti-cancer therapies, such as chemotherapy medicines, from an independent supply company. Prescriptions and ordering of these medicines was screened and checked by pharmacy staff. The service had a 48-hour order and supply arrangement with the company, with access to a Spire central oncology team, and alternative suppliers, in the event of a supply problems.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff used a computerised system with a robust quality assurance system that required appropriate escalation checks by medical staff. The electronic chemotherapy prescribing system was valued by staff. It was an opportunity to tailor chemotherapy for each patient and could be adjusted when needed. It automatically calculated dosages according to the patient's height and weight and parameters could be altered with the correct level of authorisation. Staff told us it helped reduce transcribing errors, calculation errors, data was secure, and information shared easily with other members of the team for validation.

Incidents

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

Staff raised concerns and reported incidents and near misses in line with policy. Staff were trained in incident reporting. Staff had access to a policy to help guide them in the knowledge and understanding of incident reporting. Staff told us they felt confident in raising and reporting concerns. Staff told us managers responded to all recorded incidents and where appropriate followed up with staff in gathering further information or signing off incident reports. Learning and feedback was shared with individual staff or wider teams depending on the situation.

Medical care (including older people's care)

Staff reported serious incidents clearly and in line with the provider's policy. Staff had access to an incident reporting system to record incidents and managers could pull reports to look for quality of information, themes and shared learning

The service had no never events on the ward. Staff did have access to wider learning from never events that happened in other departments or from the wider organisation. We saw examples of this in documentation and in discussions with staff.

Staff understood the duty of candour. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong. There had been no reported incidents in oncology that required duty of candour. However, staff had experience of shared learning from other departments.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. A governance lead oversaw the incident reporting system. Lessons learned and shared learning was a standard process across the hospital. Learning and improvement was shared with staff using a number of methods. Learning was shared during huddles, meetings, staff forums, and videos were made to share with staff. We saw a learning board where incidents were written up with comments from patients and what the learning was. For example, a patient who went home with an infusion pump and experienced a dislodged needle. As a result, information and spillage kits were provided to take home for those assessed as needing them. This demonstrated improvements as a result of incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff used wider learning from incidents to make local changes to keep people safe. For example, an incident at another hospital had occurred, involving sutures which had not been removed at the right time and resulted in complications for the patient. Staff discussed the incident at a safety huddle. There was evidence that changes had been made as a result of feedback and changes in practice as a result of incidents at other sites.

Staff met to discuss the feedback and look at improvements to patient care. Staff engaged in reviews of incidents using a number of methods. Staff reviewed all serious incidents and undertook full root cause analysis.

Staff were supported by a national patient safety team who reviewed incidents and ensured relevant action was taken. Scrutiny panels reviewed incidents at a weekly incident review working group. Staff engaged with NHS Improvement's Learning from Deaths framework. Staff attended a clinical effectiveness meeting where morbidity and mortality was on the agenda for discussion. A report which detailed learning was published as a result.

Staff followed a 'learning from deaths policy' to help them improve care for patients by identifying concerns relating to poor outcomes and to make changes to improve outcomes. At a provider level the number of deaths was collated on a quarterly basis. The central patient safety team then published the results and shared the paper for discussion at the clinical governance and safety board meetings to explore how improvements could be made.

Safety Thermometer

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

Safety thermometer data was displayed on wards for staff and patients to see. The ward displayed daily safety crosses that noted daily safety and measured incidents. This meant the team focussed on timely solutions to keep patients safe and improve outcomes.

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

Good 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. People's physical, mental health and social needs were assessed, and their care, treatment and support delivered in line with legislation, standards and

Medical care (including older people's care)

evidence-based guidance. This included National Institute of Health and Care Excellence and other expert professional bodies, to achieve effective outcomes. For example, staff attended an established venous thromboembolism (VTE a term for deep vein thrombosis) working group and were working towards Kings College VTE exemplar status which would give the hospital evidence of excellence in VTE prevention and care.

The hospital had a service level agreement in place with a local NHS trust, for consultants to present patients within the cancer multidisciplinary team (MDT) meetings. This meant patients received care in line with national guidance and best practice agreed by the MDT.

The service had specialist care pathways in place such as the endoscopy pathway which followed best practice and national guidance.

Chemotherapy patients received a card with a contact telephone number to contact 24 hours a day to seek advice or in the event that their condition deteriorated. An oncology nurse was available to triage patients calling the line 24 hours 7 days a week. This was in line with best practice for chemotherapy care.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff received Mental Health Act training and we saw evidence of support for staff in assessing and managing mental health in the form of flowcharts with escalation and contact details contained within. Staff told us they knew and understood the principles of the Code of Practice. Three members of staff were trained in mental health first aid. The leadership team told us they were looking to employ a clinical psychologist for the service. In the absence of an onsite psychologist, all patients who were assessed as requiring a psychologist could be referred to an alternative Spire location.

Staff completed an annual audit programme. We reviewed the audit programme for 2019. All audits were completed and analysed with actions associated to a nominated person within a timeframe. Staff we spoke with were aware of the location of audits. Staff discussed areas of non-compliance with designated senior managers, escalated these for discussion to the appropriate meeting where action plans would be agreed, developed and managed. Significant non-compliance resulted in additional audits being undertaken to monitor

effectiveness of actions taken following consultation with a senior manager and clinical governance lead. In some instances, external audits were completed, for example, external audits for lasers. This meant there was a robust audit system in place to ensure ongoing safety and quality.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff ensured all cancer patients had completed baseline pre-assessments in line with national guidance. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. For example, a MUST nutritional assessment (MUST screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obesity). It also included management guidelines which could be used to develop a care plan. Audits were carried out quarterly to review compliance. Data we looked at recorded 100% compliance for completion of MUST scores.

Staff made arrangements with the hospital kitchen to supply meals which met patients religious, cultural beliefs and food allergies.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff were committed to ensuring good pain management for patients on the ward. The clinical pharmacist carried out ward rounds with the resident medical officer and nurse in charge to review patient pain. There were committees in place to monitor and improve standards with pain management. This meant there were processes in place to ensure systems supported good pain management.

Medical care (including older people's care)

Patient outcomes

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

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. Staff routinely collected, recorded and monitored information about the outcomes of people's care and treatment (both physical and mental where appropriate). Staff participated in a range of national scorecards and dashboards to monitor patient outcomes. We saw specific dashboards for cancer services and daily safety crosses, which are visual safety data collection tools that allow someone to measure safety issues in a concise way, that noted daily safety issues and measured incidents. This meant the team focussed on timely solutions to keep patients safe and improve outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an annual audit programme which was shared with staff. Staff followed provider care pathways which were developed for specialities, aligned to national best practice and latest guidelines. This meant that patients had an established pathway for all staff to follow to ensure consistency, reduce risks to patients and help empower patients by providing knowledge of what to expect. We looked at a range of cancer specialist audits which were completed on a quarterly basis. For example, we looked at the quarterly national specialist cancer audit which was 100% compliant. This audit looked at record keeping in relation to patients' cancer treatment. Staff ensured all cancer patients had completed baseline pre-assessments, pharmacy care plan compliance, venous access assessment, which were used to develop care plans.

The service was accredited by relevant schemes. Staff participated in a number of accreditation programmes to stimulate continuous improvement. For example, participation in the MQEM - Macmillan Quality Environment Mark; a quality framework used for assessing whether cancer care environments met standards required by people living with cancer. In addition, accreditation

programmes for prostate, bowel assessment and breast care established by an international independent healthcare company, to ensure standards and diagnosis of care. Participation in these schemes demonstrated a commitment to quality care. It also provided evidence to benchmark over time against those who met required standards nationally.

The hospital was working toward Joint Advisory Group (JAG) accreditation for endoscopy services. JAG is a nationally recognised standard for safety and quality. The hospital had an action plan in place to meet the requirements set out in the JAG accreditation framework. We reviewed the action which showed actions were completed within the time frames set for each of the actions, such as a feedback process for clinicians about their technique and patient outcomes.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were supported in their roles by undertaking additional specialist training. For example, all ward nurses received chemotherapy training delivered by an accredited university. There were annual top up courses to ensure staff were up to date with their competencies.

Managers gave all new staff a full induction tailored to their role before they started work. New starters received a full induction, supported by a checklist to help managers ensure staff received all necessary information before taking up duties and to help them understand policies, procedures and their role and responsibilities. We reviewed induction documentation and spoke with staff who told us they felt appropriately inducted before taking up duties.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had a completed personal review, annual appraisal, supervision and were provided with wellbeing interventions. We were provided with evidence of achievements following objectives and plans set out in appraisals. Staff told us they

Medical care (including older people's care)

were given supervision to help them make sense of clinical and operational work carried out. This meant that staff were supported in setting objectives, planning to meet those objectives and achieving results.

The provider required consultants to supply evidence of their up to date appraisal in order to maintain practicing privileges. Data supplied by the hospital showed appraisal compliance at 100% for consultants with practising privileges. A central report was generated for the leadership team on a weekly basis.

Managers monitored staff performance through the appraisal and audit processes. Managers we spoke with told us they addressed any poor or variable staff performance at the earliest opportunity and provided support to improve. In the event that performance was not improved they followed the provider's human resources policies to address this.

The hospital had systems in place for hospital staff to raise concerns about consultant behaviour or performance where this was not in line with the provider's values or policies. The senior leadership addressed these concerns with consultants directly and informed the medical advisory committee of any actions taken.

Managers made sure staff received any specialist training for their role. The clinical pharmacist had written a training programme that had been approved, signed off and being rolled out across the organisation. The training programme provided pharmacy staff with the knowledge to become first and second checkers. It was a comprehensive programme for staff registered with the British Oncology Pharmacy Association. Staff completed an assessment to pass the course successfully. This meant all pharmacy staff completed training to ensure safe medicines practice.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff had the skills, knowledge and experience to work with patients with additional needs, such as learning disabilities, autism and dementia diagnoses. These skills were developed through training and initiatives that promoted the understanding and inclusion of people with additional needs. The hospital had a dedicated dementia lead to provide advice, guidance and training and supported staff in person centred care planning for those people and their families living with dementia.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Patient care was supported by daily multi-disciplinary ward rounds. In attendance was the resident medical officer, nursing staff, pharmacy and physiotherapy teams. Staff attended to communicate risks, safety, and any other key points to provide an opportunity to anticipate patients' needs. Staff carried out multidisciplinary audits which were 100% compliant. Multidisciplinary working provided opportunities to discuss risks, prepare for changes in staffing, avoid surprises and allowed the services to run smoothly.

Patients had their care pathways reviewed by the relevant clinical staff and consultants. The medical advisory committee (MAC) met quarterly. The last MAC was in October 2019 and was attended by a range of individuals from most specialities. These meetings were an opportunity to discuss incidents raised about same day cancellations.

The hospital had a service level agreement in place with a local NHS trust for consultants to discuss patients with a cancer diagnosis at the cancer multidisciplinary team (MDT) meetings. This meant all chemotherapy patients had been discussed and a plan of treatment was agreed by the MDT. All chemotherapy treatment was overseen by named consultants who worked under practicing privileges. The hospital co-ordinated cancer care in collaboration with named consultants, hospital pharmacist and the local MDT network.

Staff worked with local healthcare providers to improve knowledge, learn lessons, educate and build relationship to improve care pathways. For example, staff attended GP engagement events. There were regular lunch and learn sessions to develop primary care knowledge. GP seminars were organised based on GP feedback on areas where they had identified further education needs. Staff attended continuing professional development events for local and external physiotherapists and osteopaths. This improved working relationships and pathways for patients who required follow on treatment.

Medical care (including older people's care)

Patients were offered a range of complimentary, holistic therapies. Physiotherapy staff assessed patient needs and offered acupuncture for sickness and a dietitian was available once a week for referrals. Complimentary therapies can reduce the side effects of cancer treatment, improve their physical and emotional well-being and improve their recovery from cancer.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Patients could access extended clinics evenings and weekends to improve accessibility.

Medical staff and members of the multi-disciplinary teams, for example physiotherapy were accessible, seven days a week. Diagnostic services and laboratory services were available seven days. Pharmacy services were available Monday to Saturday. A service level agreement was in place for pharmacy advice when the pharmacy on site was closed.

Patients had access to diagnostic imaging 24 hours a day 7 days a week. The hospital had an on-call service for diagnostic imaging outside of normal opening hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the ward. Staff gave patients practical support and advice to lead healthier lives. Staff participated in national and local health promotion campaigns. We saw evidence of health promotion. For example, at pre-assessment stage and post treatment patients were provided with information to help promote healthier lifestyles. Patients were provided with healthy menu options while on the ward.

Staff were trained to provide health promotion information to people. Three members of staff had completed a smoking cessation course and could deliver the training. Nicotine replacement therapy was promoted and provided on the ward if requested. Health promotion posters and leaflets were available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. All staff were up to date with their Mental Capacity Act and Deprivation of Liberty Safeguards training as a mandatory requirement. Staff we spoke with knew and understood the principles of the Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff assessed individual needs of patients to ensure they understood what they were consenting to. An alert at booking and admissions prompted the need for translation services. Interpreters were used face to face for consent.

Staff clearly recorded consent in the patients' records. All records we looked at had consent clearly indicated and appropriately reviewed, signed and dated. Staff audited records for consent and demonstrated compliance by achieving 100% completion. Staff checked all relevant fields had been completed and that consent was recorded on each record. This meant there was a checking system in place to ensure compliance with good standards of record keeping.

The hospital had processes in place to support patients who did not have capacity to consent. This included best interest documentation and multidisciplinary meetings for staff, patients and their families to make decision about care and treatments. Staff we spoke with, knew the process to escalate concerns about patients that did not have capacity to consent to their care and treatment or this had changed since their pre-assessment appointment.

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

Medical care (including older people's care)

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients we spoke with confirmed this to be the case. Patients who attended for chemotherapy bypassed the main reception waiting room and presented directly to the ward where they were allocated a room without having to wait. This was to alleviate anxiety in the patient group in having to wait to access their treatment and personal space within the hospital.

Patients said staff treated them well and with kindness. Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress. Counselling services were available to people who experienced both physical and emotional pain. We were given examples of when patients needed emotional support upon new diagnosis or when the pain of treatment was difficult to manage. This meant patients could access qualified staff to support them with their mental health while receiving treatment.

Staff followed policy to keep patient care and treatment confidential. Patients could access a private room for sensitive and confidential discussions. Staff only accessed and shared necessary information to the relevant people.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff showed an encouraging, sensitive and supportive attitude to people who use services and those close to them. We saw this in staff interactions with patients and those who attended appointments with them. Patients were greeted by their first names to help build rapport and reduce formality in what may have been a stressful experience.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff made sure that people's privacy and dignity needs were understood and always respected. Patients were allocated single rooms which provided privacy. The rooms could be allocated based on individual need and preference. Each room had private wash facilities. They were kept clean and comfortable.

Staff participated in the 'Civility saves Lives' initiative. The initiative was about inspiring and empowering others to make a difference individually with patients, relatives and colleagues to create a more compassionate culture.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Counselling staff were employed to work with patients who required additional emotional support. Patients accessed end of life care at a local hospice. The team had a palliative care link nurse who supported patients and staff in supporting patient emotional wellbeing. In the absence of the palliative care link nurse, there was an experienced chemotherapy lead nurse.

Staff understood the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially. We saw staff interact and communicate with patients with genuine care.

Staff carried out hourly comfort intentional rounds to ensure patients individual needs were listened to and met. Patients were allocated a dedicated quiet room which we saw being used. This was following feedback from a person who accessed the oncology ward.

Staff provided patients with appropriate one to one support and information needed about other agencies who could support them in addition to that provided by the service. A carers pathway had been introduced to provide emotional support for carers.

Medical care (including older people's care)

Patient with cultural and religious needs were considered at the hospital. Patients could access a multi-faith box in the quiet room. The box contained resources from varying faiths. A space for prayer was also accommodated if this was required.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff provided patients with the time needed to discuss their individual needs and involved those close to them, including other agencies to help them understand what their care and treatment options were. Staff provided follow up calls to all patients when treatment had been completed.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients with the need for translation services were supported by provision of interpreters. Staff could access additional communication aids for example, for those who with hearing impairments. Staff involved families, carers and other professionals when there were for example neurological conditions that required additional communication support.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and people who attended the ward with them were given feedback cards to provide information about their experience on the ward. We saw examples of when this feedback was used to make improvements. The feedback was also used to share with staff who had made a difference in a positive way to patient experience.

Patients gave positive feedback about the service. We spoke directly with three patients who all gave positive feedback of their experiences. One patient had been in treatment around two years. We looked at positive feedback displayed around the ward from patients who had appreciated the treatment and care they received. We looked at the patient feedback survey data for 43 respondents, of which were 100% positive.

Staff could give examples of how they used patient feedback to improve daily practice. For example, the quiet

room was introduced following feedback from patient and family requests for somewhere quiet on the ward they could go to for either confidential discussions or quiet contemplation.

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

Good 

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. Patients participated in a patient forum to contribute to the development of the service. The forum was set up as a result of patient feedback. The forum consisted of patients who had recently attended the hospital. Their contribution helped staff to understand their experiences and where they could make improvements. We saw evidence of 'you said, we did' feedback on the ward and we could see examples of feedback from patients and changes that had been made for the benefit of patients as a result. For example, all patients had access to a housekeeping call bell to request food or beverages. Patients had access to a menu that changed every nine weeks and rotated to ensure patients had new choices. This meant that housekeeping staff could respond in a timely way to provide food or drink as requested.

Patients were provided with opportunities to feedback their views to help drive improvements and help make sure their treatment met the changing needs of people who used the service.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Where possible, patients were offered one stop appointments to avoid multiple visits to the hospital. All patients who required urgent appointments following

Medical care (including older people's care)

consultations were seen at the same time wherever possible, for example to discuss bloods and scan results. Patients received flexibility to ensure their individual needs were met. For example, radiology staff were flexible with their working hours to accommodate patients who required urgent scans. These processes support a more efficient way of providing patient care.

Patients had access to a consultant's online booking portal. This was a direct booking option for self-paying patients. Patients could choose their consultant and appointments to suit their needs including evenings and weekend appointments. This was in response to patient requests which meant they had the flexibility to choose appointments with consultants that suited their individual preferences.

Facilities and premises were appropriate for the services being delivered. The oncology ward achieved the Macmillan Quality Environment Mark. The Macmillan Quality Environment Mark was a quality framework used for assessing whether cancer care environments met standards required by people living with cancer. This meant that patients had access to an environment assessed as being suitable for their specific needs.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff made reasonable adjustments to help patients with additional needs. For example, help for patients disabilities. All rooms could facilitate people with mobility issues and wheelchairs. People with dementia were assessed in advance and involved relevant others, for example, families to ensure the appropriate support was put in place.

Managers monitored and took action to minimise missed appointments. Patients were provided with flexibility to ensure they could access appointments to suit them where possible. Reminders could be sent and patients who did not attend appointments were contacted where appropriate. GP's or other involved professionals were copied in to missed appointment communication.

Meeting people's individual needs

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

The design of the environment followed national guidance. The oncology ward achieved the Macmillan Quality Environment Mark in 2011. The Macmillan Quality Environment Mark is a quality framework used for assessing whether cancer care environments meet specific standards required by people living with cancer. One of the quality standards to achieve the award was design and use of space in cancer care environments.

Wards were designed to meet the needs of patients living with dementia. People with dementia were supported to settle in the ward environment. For example, the use of familiar objects and photographs. Staff had made a commitment to being dementia friendly. We saw this evidenced throughout the service. The hospital director was the deputy chairman of the local dementia action alliance who were finalists for the 'Who will care' awards 2018. Over 100 staff had been trained to be dementia friends and we saw staff wear their dementia friends' badges. Staff were recently awarded a certificate by the Dementia Alliance and were working towards being dementia friendly.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The leadership team worked with external agencies to assess whether they were meeting additional needs of all people who used the service. The operations manager organised the National Disability Programme team to visit and had a British Deaf Association Review at the hospital to help improve the experience of disabled people and visitors. Additional communication needs were met. The service was compliant with the Accessible Information Standard for format of information.

The hospital promoted the Hidden Disability Sunflower lanyard scheme. The scheme was designed to alert staff to hidden disabilities, such as autism. Patients had access to lanyards, displayed around the hospital. The hospital displayed promotional material and information to alert people to its meaning.

The service had information leaflets available in languages spoken by the patients and local community. They were easily accessible in the ward areas and were available in other languages or forms.

Medical care (including older people's care)

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Translation services were available, and we were given examples of when they were used.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients had access to a varied menu that changed periodically to increase choice and variation.

Staff worked with patients by assessing their individual needs and providing tailored packages of treatment. Staff were innovative in their approach to assessing patients' needs. For example, physiotherapy staff devised referral cards for patients who accessed oncology and were assessed to determine their upper limb mobility and respiratory breathlessness.

Patients with physical disabilities had their needs met by reasonable adjustments being considered and made. For example, smooth flooring, wide access and automatic doors. Bedrooms and bathrooms were accessible to those with mobility requirements.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Staff worked collaboratively, for example, sharing information with partner agencies to provide joined up care which reduced duplication. Managers told us they worked within NHS waiting time targets and that there were no waiting times for admissions for private patients. This meant that patients were seen as quickly as possible.

The leadership team monitored waiting times for patients. Staff carried out waiting time audits three times per month to look for any themes or trends that required action to improve waiting times. Patients who were assessed were clinically assessed as appropriate, could be seen by nurses for first line antibiotics then would be sent to a local

emergency department for the remainder of their care. A handover to emergency department staff was then completed to ensure safe transition for the remainder of the course of antibiotics.

Patients received a transfer out form in the event of an emergency. Staff completed the form and presented the information to ambulance staff or nearest emergency department. A copy of the form was kept on the electronic record system.

Managers and staff worked to make sure that they started discharge planning as early as possible. All patients were provided with a patient discharge guide. The guide provided patients with information about what to expect after treatment. This guide included a space to write questions and contact numbers for specialist staff should they wish to contact them following discharge. For example, they could contact the dementia lead nurse using the ward number. This meant that patients knew what to expect and could continue to contact professionals on discharge.

Learning from complaints and concerns

People could give feedback and raise concerns about their experience with the service. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Complaints leaflets and signage were displayed to support people in raising concerns. Information was also on the service website to help people raise complaints electronically. Learning from complaints was shared widely through a number of ways including posters, newsletters, the daily 'Beat' huddle and focus weeks. We saw evidence of learning and changes made as a result. Learning was also shared Spire-wide so that lessons could be learned from other Spire locations. All patients were followed up post discharge, this was another opportunity to share feedback from their experience at the service.

Staff understood the policy on complaints and knew how to handle them. Staff had access to policies and information systems to help them learn from incidents and complaints.

Medical care (including older people's care)

Managers investigated complaints and identified themes. Managers discussed and investigated complaints following a process. All complaints were responded to in the first instance informally, then a more formal approach for those that could not be resolved locally. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. The governance newsletter provided information about complaints and compared the number against the same month previous year, which showed a 34% decrease in complaints. All staff we spoke with told us that they felt supporting in dealing with complaints and that learning was shared.

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

Good 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. The hospital was led by a senior management team. The team were made up of a hospital director, director of clinical services, operations and risk manager, governance and patient safety manager. They supported staff to develop their skills and take on more senior roles.

The senior management team were approachable and accessible. All staff we spoke with consistently shared this message. The leadership team introduced initiatives to demonstrate their support and value in staff. For example, 'time to brag', where the senior management team served dinner to staff, every couple of months. Staff at all levels provided us with examples of how they felt valued. Staff told us that they had felt valued when the leadership team prioritised renovation of the staff kitchen. A resource that staff enjoyed and saw as a demonstration of gratitude.

Staff progression and development was supported by the senior leadership team. We saw examples of when staff

were supported in achieving higher qualifications, nurse prescribing courses and specialist training packages. Staff proudly told us of their advanced training, qualifications and apprenticeship scheme. Eight apprentices had been supported, working in oncology and across other services in the hospital. Some of the apprentices had gone on to achieve further qualifications as a result.

The hospital leadership team were well established, with teams on the wards working collaboratively and contributing to service provision and a commitment to good quality care. All staff told us that the leadership team were effective, accessible and highly thought of.

Staffing issues, including performance were managed effectively. Staff, including medical staff and the leadership team told us that if there were issues with any staff, no matter what level, issues were dealt with fairly and swiftly. We were given examples of when this happened and how issues were resolved.

The leadership team communicated effectively with staff across the service providing up to date and relevant information. Information was shared in varying forms, for example, consultant newsletters, clinical dashboards and clinical scorecard dashboards. In addition, there were monthly staff forums and team meetings. The leadership team directly communicated with staff following morning briefings with key messages. This meant staff were kept up to date with issues every day.

Vision and strategy

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

The leadership team progressed against delivery of the strategy and local plans were monitored and reviewed, with evidence to show this.

Staff signed up to the purpose of the hospital. There were a series of workshops that staff attended and pledged to commit to the purpose of the hospital, which was "Making

Medical care (including older people's care)

a positive difference to our patients' lives through outstanding personalised care". All staff told us they were proud to deliver quality care to patients who were at the centre of everything they did.

Staff were aware of the hospital values and strategy. The strategy was displayed and understood by staff. The leadership team were involved in daily delivery of the service by attending daily meetings to help plan service activity and support staff in resolving issues of the day.

Culture

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

Staff were celebrated by the organisation for their contribution. There was a culture of support, value and gratitude. All staff told us that there was a culture of celebrating success. For example, postcards to say well done. Staff also thanked each other, for example, chocolates in a cup given to staff to say thank you. Celebration events, such as dinners served up by the senior leadership team to say thank you to staff for being valuable contributors to the service and providing good patient care. There was an inspiring people scheme for staff. We were told there had been over £15,000 of awards and discounts in 2019 to outstanding colleagues.

Staff had access to a freedom to speak up guardian. Staff engaged in events, such as October speak up month to encourage communication and an understanding of the role of the guardian. Staff told us that there was a culture of transparency and no blame. Staff could access a Freedom to Speak up Guardian and they could also access local freedom to speak up ambassadors. A dignity champion had been employed to increase customer services for patients and empower staff. Staff told us that this meant there was a positive culture of speaking up and being heard and putting patients first.

Staff enjoyed numerous awards. The hospital director was awarded Spire Healthcare Leader of the Year in 2019. The

award was for being the most inspiring role model and dedicated to the hospital. The housekeeping team scored 93.9% which afforded them a silver award. Staff felt pride in their achievements.

Staff at every level were provided with the development they needed, including high-quality appraisal and career development conversations. All staff we spoke with told us they were fully supported through appraisal to develop personally and professionally. We were given examples by many staff of where they had been supported to achieve further qualifications and skills. Figures for compliance were 100%. We looked at appraisal data and were assured that all staff had received an appraisal.

Governance

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

We looked at the governance meeting membership, agenda and minutes. We saw that at each meeting, there was key clinical and leadership representation. The agenda was set and expanded upon to ensure standard topics for discussion, review, learning and updates. For example, audit results with learning were reported every meeting. There was evidence of reviewing a multi-disciplinary audit relating to phlebotomy. The result of which was a dedicated phlebotomist employed in oncology to improve results.

Spire employees, non-executive advisory committee staff and non-employed consultants made up the mandatory governance structures. These were in place to ensure appropriate scrutiny and oversight of care provision. We saw evidence of regular meetings and sharing of minutes and details from meetings to ensure learning from governance.

Weekly meetings were held by the heads of departments to discuss issues around risk and performance. Items of escalation from these meetings were discussed at a monthly meeting, where the hospital director met with members of the senior leadership team. Additional monthly meetings which were minuted and ran through a

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structured process. These meetings focussed on complaints, incidents, matters relating to consultant practice relating directly to performance or practice privilege compliance.

Ward to board information sharing aligned to Spire's standards for hospital governance. Governance updates were communicated with staff via a governance newsletter on a monthly basis. There was a dedicated governance lead. There were a number of committees and boards which were attended by the senior leadership team and the heads of department, to provide oversight. For example, there was a medical advisory committee who provided medical advice and support and scrutiny of systems and processes to ensure practicing privileges were appropriately managed.

Staff kept up to date with governance information including safety performance data by viewing related information on governance quality boards. The data was displayed in visual form which was easy to read and understand. We saw that the boards were up to date and staff told us they were useful visual aids to view useful governance information.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. For example, issues on the risk register had clear plans to manage risks. They had plans to cope with unexpected events.

Staff had access to a whistleblowing policy. Staff we spoke with told us they knew and understood the process to raise concerns using the policy.

The hospital director told us incidents were dealt with in real time. All recorded incidents were sent to the hospital director and discussed at daily huddle by staff in each department. In addition, there was a central huddle attended by all leads to discuss pinch points and concerns for the day. For example, the management of a patient living with dementia, or a leaky tap. All complaints were discussed on a daily basis.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Departmental risks were discussed at heads of department meetings held weekly and escalated as required to monthly senior leadership meetings.

There was alignment between the recorded risks and what staff raised as concerns. Staff identified on the risk register that there was a risk of unratified documentation being used in some departments. A new quality and ratification procedure had been introduced and each department head had been asked to review and update documents using the ratification procedure. The risk register was robust and had clear lines of accountability and review dates to ensure risk where managed monitored and action taken to mitigate against the risks.

Referral to treatment times information was updated each month and showed the percentage of patients who were on a pathway and had been on their pathway for more than 18 weeks. The tolerance level was 8%; if the 8% was breached the commissioners could issue a penalty per patient. In December 2019, 98% of patients were on a patient pathway within the 18 weeks which exceeded the providers target of 92%.

Managing information

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

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff completed annual information governance training and told us they knew and understood how to keep patient information safe. Information systems were easy to use and accessible to staff who were trained and provided with secure log in and passwords.

Engagement

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

Medical care (including older people's care)

Staff could engage in a company-wide employee survey twice yearly. As a result of the survey, action plans were created. There was an employee engagement working group, which was led by staff bi-monthly. Issues raised were shared with staff using the 'You said we did' initiative.

People who used the hospital and those involved in their care, contributed to feedback using friends and family test. Data we looked at indicated from July 2018 to June 2019, of 717 responses, 97% of patients were likely to recommend the hospital. When we looked at patient experience, 92% of patients reported that they had their needs met. There were patient feedback boards on display on the ward and clearly highlighted changes made as a result of feedback. There was a 'you said, we did' board for patient feedback and patient experience comment board and a suggestion box.

Staff actively encouraged engagement by introducing new initiatives. For example, 'I'd like to know cards' which were for patients to ask 'silly' questions confidentially. Any stakeholder could attend a quarterly patient forum, monthly meetings and a just joined patients' association.

The leadership team told us that patient experience and good outcomes were key to the service. A new post had been created for a patient experience manager. A number of initiatives focussing on patient experience were initiated. There were focus weeks dedicated to patient experience. As a result, a board displayed information about good and bad patient experience and what was learned from it.

Staff and people involved in the service engaged in a number of charity events for cancer research. These included Macmillan World's Biggest Coffee Morning, Wear it Pink Day, Brave the Shave, the Brain Tumour-Bandana cake sale. The hospital director was a trustee of a testicular cancer charity. Staff took pride in telling us about the local charity events they had participated in and the money raised as a result. Staff had focus week displays which included a 'what are you proud of wall' and a commitment wall.

Learning, continuous improvement and innovation

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

Staff were creative in supporting patient safety. There were a number of initiatives employed on the ward to help support patient safety. For example, staff introduced a safety checklist adapted from 'fit to fly', an airline checklist that tracked patient hospital journeys from the start to finish to reduce the risk of safety incidents. There was an electronic patient prescribing system with various features to help prevent prescribing errors. Staff spoke proudly of the systems they had in place to help reduce errors and incidents and protect patients from potential harm.

Patients were offered a range of complimentary, holistic therapies. Physiotherapy staff assessed patient needs and offered acupuncture for sickness and a dietitian was available once a week for referrals. Complimentary therapies can reduce the side effects of cancer treatment, improve their physical and emotional well-being and improve their recovery from cancer.

Staff displayed their commitment to continuous improvement throughout the hospital. There were notice boards with initiatives displayed, there were murals dedicated to communicating local initiatives to support good patient care and patient feedback that highlighted where improvements had been made as a result of learning from patient experience. Patients were provided with 'I'd like to know cards' which gave patients an opportunity to ask questions anonymously. Staff brought initiatives from attendance at external events, for example, 'civility saves lives' which was promoted the power of being civil.

Staff benefitted from reward and recognition schemes. For example, employee of the month where staff received vouchers or gifts. Dinners where staff were served by members of the leadership team to offer thanks and recognition. Staff at all levels told us that this played an important role in the culture of the organisation. Staff were consistently rewarded for hard work. Staff told us they felt appreciated which encouraged team work and provided patient satisfaction.

Surgery

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

Are surgery services safe?

Good 

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

Mandatory training

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

The hospital had a mandatory training programme in place that staff had to complete on an annual basis. Mandatory training comprised of a mix of face to face and eLearning modules. The hospital had face to face training for units such as safeguarding, moving and handling and life support training. Staff had access to other modules which were completed as eLearning both at work and from their own homes.

We reviewed the training records for staff as of 30 October 2019 and saw that staff completed their mandatory training. We saw that there was 100% compliance with compassion in practice, equality and diversity, health and safety, manual handling, and safeguarding children level 2. We saw that other topics including safeguarding adults level 2, information governance, fire safety, and anti-bribery gifts also had very strong compliance, between 98 and 99%.

At the time of our inspection the mandatory training completion rate for the inpatient ward was 100%. Theatres had a mandatory completion rate of 100%.

Managers monitored staff mandatory training completion and advised staff when their training needed to be completed.

At the time of our inspection, the hospital was rolling out additional training on the National Early Warning Score 2 assessment tool which helped staff to identify patients at risk of sepsis.

Staff received mandatory training in basic and immediate life support. Training records demonstrated five of six staff received the training; One member of staff was booked onto this training following our inspection which would mean the service had a completion rate of 100%. The course provided training in life support skills to help save lives in the event of a cardiac arrest.

Staff received mandatory sepsis training as part of the immediate life support (ILS) training and within the Acute Illness Management (AIM) course. Training compliance for sepsis was at 100%.

Safeguarding

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

All clinical staff received training in safeguarding adults and children level two. Staff involved in the care of young people aged 16 to 19 years also completed safeguarding children level three. The surgical team offered care and treatment to young people if they had been assessed and staff could provide treatment safely on an adult pathway on an adult ward.

All clinical staff that worked with children and young people were expected to complete safeguarding training for children and adults to level three. This was in line with the expectation of training for this staff group in this setting, as referred to in the Safeguarding Children and Young

Surgery

People: Roles and Competencies for Healthcare Staff
Fourth edition: January 2019 intercollegiate document. The change in safeguarding training was introduced in January 2020 for the new reporting year.

Managers we spoke with told us staff reported any safeguarding concerns through the incident reporting system and completed a referral to local authority safeguarding teams. The hospital had safeguarding leads in place to support staff with any safeguarding concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to identify patients at risk of emotional and physical harm. Staff gave examples of the types of situations where they had raised concerns. One member of staff told us about concerns raised about a patient who had lost weight and appeared to not to have cared for themselves. Staff raised concerns about possible self-neglect, the investigation confirmed that the patient had been unwell prior to admission but did in fact have an appropriate support network in place.

Staff we spoke with knew their responsibilities in reporting safeguarding concerns such as but not limited to female genital mutilation, child sexual exploitation and neglect. Staff knew where to access safeguarding information and local protocols for raising concerns.

The procedure for safeguarding children and young people in Spire healthcare policy and the safeguarding adults policy supported staff with additional information and the process to raise concerns. Both policies were within the review date and referenced national guidance and legislation. The hospital had posters with contact details of the local authority safeguarding boards with flowcharts for staff to follow.

Female genital mutilation and child sexual exploitation formed part of the providers safeguarding training. Staff we spoke with told us they had completed safeguarding training within the last 12 months.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with knew the protected characteristics under the Equality Act and could explain actions they would take to protect patients from harassment and discrimination.

Cleanliness, infection control and hygiene

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

The ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and free from clutter. Each room had hand washing facilities for staff, patients and visitors to use. There were hand decontamination gel dispensers at ward entrances in corridors and at hand washing sinks.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning records we reviewed from November 2019 to January 2020, showed that cleaning had taken place in ward areas and theatres. Managers monitored cleaning records to ensure all cleaning was completed, in the event cleaning duties were not completed managers took action to address this with staff.

Staff followed infection control principles including the use of personal protective equipment (PPE). In all areas we visited, staff decontaminated their hands appropriately before and after patient care. Staff wore uniforms with short sleeves and were bare below the elbows. They used personal protective equipment in line with the provider's infection prevention and control policy and disposed of the items correctly. Theatre staff wore theatre uniforms and used masks and hats. Staff disposed of these appropriately after use to prevent the spread of hospital associated infections.

Hand hygiene was audited by observation every three months. This indicated that the service met the 95% target.

Staff worked effectively to prevent, identify and treat surgical site infections. There had been no surgical site infections (SSI) in hip and knee arthroplasties (replacements) in the period July to September 2019. The overall SSI rate for January 2018 to June 2019 was 0.9% of hip replacement surgeries and 1.3% of knee replacement surgeries. NICE guidance published in October 2013 called Quality Standard QS49 indicates that orthopaedic surgeries have an approximate SSI rate of 1% overall.

Surgical patients were screened for hospital associated infections such as MRSA and Clostridium Difficile (C-Diff).

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Surgical patients received screening during their pre-assessment appointment prior to their admission to hospital. All patients with positive results were followed up by the infection control team and were not admitted for surgery until they had three negative results.

Staff had access to the provider's infection prevention and control (IPC) policy, through the hospital intranet. The policy set out staff responsibilities in the prevention and control of healthcare associated infection. The policy was within the review date and referenced national guidance and legislation.

Theatres had robust processes in place to separate clean and dirty instruments. Theatre staff had a clear flow through theatre for surgical instruments to prevent cross contamination which was tracked by the internal tracking system for all surgical instrument sets.

The hospital had sterile services on site for the decontamination and sterilisation of surgical instruments. The sterile services quality management systems were compliant with British standards and the department was registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

The infection prevention and control nurse had oversight of all infection control audits and processes including water pipe flushing to prevent bacterial contamination.

Environment and equipment

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

The design of the environment followed national guidance. The ward had 21 single patient rooms upstairs and an additional 14 single patient rooms on the ground floor. Five of the ground floor rooms were used for medical patients for chemotherapy treatments. The ward used the rooms on the first floor as they were closer to theatres but did use rooms on the ground floor when extra capacity was required for example, for large day surgery lists.

The day surgery unit had five patient pods, one theatre and recovery area.

There were four theatres within the hospital. Two theatres had laminar flow, which were used for orthopaedic surgeries to reduce the risk of infection. One of the theatres was designed as an ophthalmic theatre (to operate on eyes).

Patients could reach call bells and staff responded quickly when called. Each bed space on the wards had a call bell system. We observed call bells were within the reach of patients, and when patients called for help, staff were prompt in responding to their needs. Patients we spoke with told us staff answered their call bell in a timely way.

Staff carried out daily safety checks of specialist equipment. Ward staff completed daily checks of the emergency resuscitation trolley. We reviewed records from November 2019 to January 2020 which showed that staff had completed these checks and there were no gaps in the records.

The service had enough suitable equipment to help them to safely care for patients. The service used a range of single use consumable equipment items such as syringes, needles and intravenous infusion lines. We randomly checked 35 items of single use equipment and found they were stored appropriately and were within their expiry date.

Electrical equipment had annual safety testing. We reviewed 15 items of electrical equipment such as blood pressure machines, cardiac monitors and anaesthetic machines and we found all items were up to date with safety testing and servicing.

Staff disposed of clinical waste safely. We saw that waste bins were monitored throughout the day and staff disposed of clinical and domestic waste appropriately. Staff disposed of sharp items, such as injection needles, in clinical waste sharps bins. We reviewed five sharps bins and found these were labelled, dated, included the clinical area and were not overfilled.

Theatres used lasers and had local rules in place for the use of lasers in patient care. Theatres had six staff members trained to use the laser, all named staff had signed the laser register. The hospital had an up to date laser safety summary report in place dated April 2019.

Assessing and responding to patient risk

Surgery

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

The hospital used the National Early Warning Score (NEWS) 2 system to identify deteriorating patients. We saw that from the hospital's clinical scorecard 98% of records were fully compliant with this, including recording the patient's temperature in recovery. This exceeded their target of 95%. We reviewed five NEWS2 charts which demonstrated that patient temperatures had been recorded for each set of patient observations. This was an improvement from previous audits which showed that patient temperatures were not recorded consistently.

Staff knew about and dealt with any specific risk issues. Staff we spoke with knew how to escalate a deteriorating patient and had access to support from the resident medical officer (RMO). Ward staff could also request support from theatre and recovery staff in the event of a deteriorating patient. The hospital used the Sepsis Trust, sepsis six care bundle to identify and treat patients with early signs of sepsis.

A one bedded extended recovery unit was available for patients who required additional monitoring following their surgery. The hospital had a service level agreement in place with a local NHS trust in the event of a deteriorating patient that required critical care. The hospital had transferred one patient from January 2019 to January 2020 for further investigation as the physiotherapist suspected a patient had dislocated their hip.

All registered nurses who worked on the ward had completed immediate life support training with an additional four members staff who had completed advance life support training. This meant that staff had the skills required to identify and manage a deteriorating patient. Daily department and resus safety huddles were held to share up to date key information between staff.

All patients undergoing surgery should have a venous thromboembolism (VTE) risk assessment. This assesses the risk of patients developing a blood clot following surgery. We saw that the hospital completion rate VTE risk assessment was 84% from April to May 2019. This was below the target of 95%. We requested updated figures which showed an improvement in the completion rates of VTE assessments to 97% from June to August 2019 but

declined to 92% from September to December 2019. However, we saw that VTE chemical prophylaxis (medicine given to prevent a VTE from developing) was given to 100% of the eligible patients with hip and knee arthroplasties. Similarly, we saw that 100% of these patients were given the prophylaxis within the recommended timescale and for the recommended duration.

The hospital provided information that from October 2018 to September 2019 0.63% of patients had a VTE following hip or knee replacement surgery.

Patients could access a clinical psychologist at another local hospital in the provider group if required. The senior leadership team were actively trying to recruit clinical psychologist under practicing privileges to be based onsite.

The service used the World Health Organisation's Five Steps to Safer Surgery checklist. This is a checklist designed to reduce the risk of errors when performing surgery. An observational audit was conducted in the theatres every three months. These audits indicated that 100% of the checklists were completed appropriately. We observed staff completing the five steps to safer surgery and found this was completed correctly.

The service had developed Local Safety Standards for Invasive Procedures (LocSSIPs) following the introduction of National Safety Standards for Invasive Procedures (NatSSIPs). The LocSSIPs and NatSSIPs were in place to prevent surgical never events. An example of a local safety standard was 'stop before you block'. The service developed this protocol following a never event, where an anaesthetic block was completed on the wrong side of a patient's body.

All patients aged over 65 years old and anyone identifying as a falls risk had their lying and standing blood pressure recorded preoperatively. Falls risk assessments and mobility assessments were completed within 24 hours of admission to the ward. The clinical scorecard from June to August 2019 indicated that 97% of eligible patients had their falls risk assessment completed and recorded. In September 2019 there had been one inpatient fall. We requested details of this incident and found the patient had not disclosed they had a history of falls during their pre-assessment appointment or during the admission process.

Surgery

Women between the ages of 15 and 55 were routinely given pregnancy tests prior to surgery to confirm they were not pregnant. We saw that 95% of women had this test documented, in line with the hospital's target.

From April to June 2019 auditing of clinical scorecards showed that 84% of records audited showed that patients' temperatures were recorded during surgery which was below the provider target of 95%. We requested updated figures which showed an improvement to 88% from June to December 2019. This was monitored through the quarterly auditing of NEWS2 scores.

The hospital had a business continuity plan in place which provided information to staff and identified staff responsibility for unforeseen events such as flooding or power loss. Staff we spoke with knew where to find the business continuity plan.

Nursing and support staffing

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

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The ward manager used the provider's staffing tool to ensure there were safe numbers of staff on each shift. The staffing tool took account of expected patient risk score. The ward manager told us the tool had to be used alongside soft intelligence such as consultants' requirements for enhanced recovery for more complex procedure which required additional staff.

All surgery was pre-booked elective surgery, so staffing levels were adjusted depending on what activity was booked. Patient dependency was calculated using an adaption of the Shelford Safer Staffing Tool, which takes into consideration actual patient numbers and the dependency of the patients. This calculated a safe number of staff and was used to ensure that on a shift by shift basis the teams were reassured in advance that staffing levels are safe. This was used in conjunction with the Red Flag Algorithm following the NICE 2015 Safe Staffing for Nursing in Adult Inpatient Wards. Theatres staffing was based upon the Association for Perioperative Practice (AfPP) Safe Staffing Within the Perioperative Setting (2014) tool.

Bank and agency staff were used at the hospital. We saw that from August 2018 to July 2019 there was an average of 8% bank and agency nursing staff used on the wards and an average of 17% bank and agency nursing staff used in theatres. For the same time period there was no agency or bank used for operating department practitioners. The theatre manager and the ward manager told us that they had a bank of staff to cover any vacant shifts and they did not routinely use agency staff. All bank staff completed the full hospital induction and required competencies.

The ward used agency staff on occasions that bank staff were unable to cover vacant shifts. The ward manager told us they requested agency staff known to the hospital and completed a local induction checklist on their arrival to the ward. We reviewed five agency induction checklist which were completed correctly signed and dated.

The average sickness rate for nursing staff from August 2018 to July 2019 was 7% for ward staff and 2% for theatres. The ward manager told us that ward had a higher than normal sickness rate due to long term sickness. All staff had returned from long term sickness and the sickness rate had stabilised.

Staff turnover rates were 18.5% for nursing ward staff and 0% for theatre staff from August 2018 to July 2019. The ward had a higher than normal turnover rate due to staff taking retirement during this time. Staffing figures as of September 2019 showed that the turnover rate for the previous three months had been at just over 1%. We also saw that the amount of bank staff used was decreasing during the three months.

Medical staffing

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

Medical staff were employed through practising privileges. To maintain practising privileges, members had to provide evidence of annual practice appraisal, indemnity cover, an up-to-date DBS, status of Hepatitis B, Hepatitis C and HIV. Part of their practising privileges agreements was that they were required to have arrangements with other medical staff to provide cover, in the event of them being unavailable.

Surgery

Consultants were required to live within 30 minutes of the hospital and remain on-call whilst their patients were in the hospital. In the evenings when consultants were not present on site, the resident medical officer (RMO) provided medical care. If a patient deteriorated the RMO would contact the consultant for them to come back and review the patient.

From August 2018 to July 2019 241 consultants had practising privileges at the hospital. Of these, five consultants had their privileges removed. This was for a variety of reasons, including the consultants' request, not producing evidence of an appraisal and due to inactivity. One consultant had their privileges suspended in the reporting period.

Two RMOs were employed at the hospital. One was employed by the hospital and the other was employed through an agency. Both had evidence of an induction. RMOs worked on a seven-day rota, where they worked 12 hours on duty and then 12 hours on call. Facilities were available on site for RMOs to rest whilst on call.

Cosmetic surgery was performed at the hospital. We saw that six consultants offered cosmetic procedures. All these consultants were on the General Medical Council's specialist register.

Ophthalmic surgery (eyes) was also carried out at the hospital. The hospital had three laser protection supervisors to support the practice and had access to a laser protection advisor for support and advice when required.

Records

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

The hospital's clinical scorecard showed that 88% of entries by consultants in patients' records were fully signed, dated and timed. We reviewed five sets of patient records, we found that they were legible, signed and dated. All records contained pre-operative assessments as part of a pre-admission assessment. The records were contemporaneous and demonstrated an on-going plan of care. All the records we reviewed had up to date risk assessments.

Patient records were stored in trolleys within staff areas of the ward and were secured with keycode lock to prevent records being accessed by those who did not have permission to access records.

The service submitted data to the National Joint Registry. We saw data that showed that 95% of prosthesis had the NHS number of the patient assigned to them, so that appropriate tracking was available.

For patients having breast implants, a process was in place for tracking the implants used. The patient's booking form was kept in the plastic surgery implant folder, with the breast registry data form. Once the implant arrived it was placed in an implant box. Patients were informed during the consent process that their data would be stored in case of issues with their implant later in life. Following surgery, the breast implant registry form was kept in a folder until electronically input into the system.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff used paper prescription charts which were kept in the secure medicine storage room.

The ward stored medicines in a temperature-controlled room secured with keycode entry system. Staff recorded room temperatures daily. We reviewed the room temperature records from November 2019 to January 2020 which demonstrated this had taken place daily without any gaps.

We observed that staff kept medicines fridges locked and monitored the temperatures daily. We reviewed the fridge temperature records on the ward and in theatres and found these were completed daily without gaps and all were within the safe temperature range.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We saw medicines were stored in locked rooms or locked cupboards. Staff kept controlled drugs in wall mounted metal cupboards in line with legislation. We checked controlled drugs on the ward and in theatres for the period November 2019 to January 2020 and found that stock levels matched the records which had been checked and signed appropriately by staff.

Surgery

Records contained clear documentation where antibiotic therapy was indicated and provided information about the medicine, dose and the duration.

Staff followed current national practice to check patients had the correct medicines. We observed staff administering medicines in theatre; they checked the medicine prescription, allergies, dosage, and the patient's wrist identity bands against the prescription chart before they gave patients their medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed key messages during their shift handovers, this included safety alerts and learning from medicines incidents.

Between June and September 2019 there were 12 medicines errors. Eight of these were due to dispensing errors, three were prescribing errors, and one was an administration error. Learning from incidents was shared at the monthly ward meetings and discussed at the daily meetings by the heads of department.

A pharmacist was present at all bed rounds for every patient, along with the RMO, and nurse in charge. This meant that the management of patients' medicines was considered by a pharmacist at every ward round.

The security of medicines storage was audited every three months. We reviewed audits from February, May and August 2019 and saw that compliance was strong. In areas that poor practice were identified, action plans were put in place to bring these areas back to compliance.

The length of time taken to turnaround discharge medicines was also audited. We reviewed audits from March, June and September 2019 and saw that all discharge prescriptions were filled and given to patients within 60 minutes.

The hospital had a medicines management policy in place for staff to follow. The policy was within the review date and referenced national guidance and legislation.

Incidents

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

service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with knew how to report an incident or near miss. Staff gave examples of incidents they had reported such as, patient falls and medicine errors. Staff demonstrated to us the electronic system they used to report incidents.

The hospital had an incident reporting policy in place which set out staff responsibilities at all levels in reporting and investigating incidents and sharing learning. The policy was within the review date and referenced national guidance and legislation.

An electronic incident reporting system was in place. Between July and September 2019 223 incidents were reported. This was a decrease of 17 from the previous three months. Most of the incidents were cancellations on the day of the surgeries (28%), unplanned inpatient admissions following day case surgeries (15%) and equipment issues (11%).

There had been no serious incidents (SI's) reported from June to September 2019. However, two SI's had been reported after the reporting period. We reviewed two root cause analysis reports and saw that the root cause was identified, and appropriate action was taken to reduce the risk of similar incidents occurring. Evidence of duty of candour was provided, in line with statutory requirements.

Managers monitored the length of time taken to close incidents. We saw that from April to June 2019, 95% of incidents were closed within 45 days. This was better than the hospital target of 80%.

There had been one never event in the 12 months prior to our inspection, this was due to a nerve block applied to the wrong side of a patient's body. Theatres had completed a full root cause analysis investigation following the incident and reinforced the stop before you block procedure to prevent a similar incident occurring again in the future.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to

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notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Managers and staff, we spoke with knew their responsibilities in relation to the duty of candour.

Incidents were reviewed at monthly governance meetings. Managers had analysed incidents and the service found that the number of avoidable cancellations had been reducing. Work was ongoing with the anaesthetic pre-assessment consultant to further reduce avoidable cancellations. Unplanned inpatient admissions had reduced by 11% from the previous three-monthly reporting period. Incident investigations had identified the main causes were patients with difficulty passing urine, patients returning late from theatre and patients complaining of dizziness.

The Medical advisory committee (MAC) discussed learning following serious incidents both at the hospital and other hospitals with the provider group. We reviewed the MAC meeting minutes from April 2019 and July 2019 which demonstrated these discussions had taken place.

Safety Thermometer

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

The ward displayed safety thermometer information within the ward office for staff to review. The information showed that the ward had achieved 100% harm free care since September 2019.

The ward displayed safety thermometer information for patients and visitors in the form of safety crosses. The ward manager told us that patients found the safety cross display easier to understand than the graphs traditionally used to display this information.

Are surgery services effective?

Good 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policy and guideline documents on the hospital intranet.

National Institute for Health and Care Excellence (NICE) guidance was sent to consultants electronically for their review and action. A NICE guidance tracker was updated and sent to all consultants, so they could see what guidance had recently been updated.

All surgery patients had pre-operative assessments which followed a documented pathway, this ensured staff gathered all the relevant information and prepared patients for their surgery. This was in line with the Association of Anaesthetists and the British Association of Day Surgery guidance.

Staff accessed evidenced based tools to identify and treat patients with sepsis. The sepsis six tool was used in conjunction with the NEWS2 assessment tool to identify patients at risk of sepsis.

Policy and pathway documents were inclusive of patients with disabilities and people with protected characteristics. Staff made appropriate adjustments for patients with complex needs and planned individualised care to meet these needs in line with trust policy, such as the consent to treatment. All of the policy documents we reviewed had an impact assessment regarding protected characteristics.

We reviewed policies such as but not limited to the consent policy and the elective adult surgical admission policy. Both policies were within the review date and made reference to national guidance and legislation.

Theatres completed the World Health Organisation five steps to safer surgery for all surgical procedures to monitor compliance with this standard.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff monitored patients' nutrition and hydration needs. Patients had access to water at their bed side.

The hospital had a dietician that worked under practicing privileges. Staff could signpost patients to the dietician for additional dietary advice and support.

Patients were offered a range of foods and menu choices during their hospital stay. The hospital catered for patients with dietary needs such as allergies, cultural beliefs and religious needs. The hospital had a wide range of menu choices for patients that had vegan and vegetarian needs.

Staff offered patients medicines for the management of nausea and vomiting where appropriate. Staff we spoke with told us that anaesthetists prescribed medicines to manage nausea and vomiting either before a surgical procedure or before patients were transferred from recovery to the ward.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

The ward had fluid champions who ensured that pre-operative patients had fluids in line with national guidance and hospital policy. The ward manager told us that staff escalated consultant practices that were not in line with hospital policy, which was addressed by the registered manager and the medical advisory committee (MAC).

We reviewed the hospital's clinical scorecard and saw that 88% of patients were fasted within guidelines. This exceeded their target of 65%.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff asked patients about their pain when taking vital observations and during medicines rounds. Patients were asked to score the pain between zero and four, four represented the highest levels of pain. Pre-assessment staff discussed pain management with patients prior to their surgical procedure.

Patients received pain relief soon after requesting it. Patients we spoke with told us their pain had been managed well by staff and told us staff administered pain relieving medicines in a timely way, after they had reported they were experiencing pain.

Recovery staff we spoke with, told us they monitored patients' pain levels and would not transfer patients back to the ward until their pain was well managed.

Staff prescribed, administered and recorded pain relief accurately. Medicine prescriptions records we reviewed showed staff prescribed appropriate pain-relieving medicines at regular intervals during the day and additional medicines for any break through pain. We observed that staff had administered pain relieving medicines to patients as they had been prescribed.

The hospital's clinical scorecard showed that 100% of patients had their pain scores recorded with every set of observations. This was higher than the target of 95%.

Patient outcomes

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

Managers carried out a comprehensive audit programme. The service had a programme of local and national audits in place to benchmark the service against other hospitals in the provider group, local policy compliance and service improvements. The service conducted a clinical scorecard review on a three monthly (quarterly) basis. This included audits on completion of National Early Warning Scores (NEWS) 2 to identify deteriorating patients and recognition of sepsis, venous thromboembolism (VTE) assessments to identify those at risk of blood clots, and pregnancy testing to ensure all female patients undergoing surgery were not pregnant.

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Managers shared and made sure staff understood information from the audits. We saw that managers displayed relevant audit results in staff areas and discussed the results within team meetings.

The service collected patient related outcome measures (PROMs). They collected the Oxford Hip Score and the Oxford Knee Score. These showed how successful hip and knee replacement surgeries were. Data collected as of September 2019 showed that the average postoperative health loss for hip replacements was 0% for the 12 months before, compared to an NHS figure of 2.5%. Similarly, the percentage of postoperative health loss for knees was 2% compared to 4.8% for NHS care. The average health gain for hip replacement was 22.3 compared to 22.2 for NHS, and for knees was 15.6 compared to 17.1 for NHS care. We saw that 65% of NHS patients completed PROMs questionnaires, which was lower than the hospital's target of 70%.

We saw that 0.07% of patients had unplanned returns to theatre in the 12 month period up until September 2019 and 0.03% of patients were readmitted within 31 days of discharge. Similarly, levels of unplanned transfers were low, with 0.12% of patients being transferred to NHS providers.

The service implemented Commissioning for Quality and Innovation (CQUINs) targets, agreed with other stakeholders such as the local clinical commissioning group (CCG). The hospital had a CQUIN for staff flu vaccinations, which aimed to minimise the spread of the virus. Other CQUINs included antibiotic prophylaxis in colorectal surgery to reduce antimicrobial resistance in patients over 18 years of age. Staff audited the number of patients who had preventative antibiotic therapy prescriptions in this patient group.

The hospital had accreditations for surgical care from an international independent healthcare company, which included prostate centre accreditation, bowel assessment centre accreditation and breast care centre accreditation.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke with had completed the appraisal process and had tailored individual development plans. Managers kept records of staff competence, and qualifications.

Managers supported staff to develop through yearly, constructive appraisals of their work. Clinical staff such as registered nurses, operating department practitioners and health care assistants participated in a meaningful appraisal.

Staff participated in a three-point appraisal process, each staff member met with their manager three times a year to monitor their progress and develop personal development plans. Data provided by the hospital prior to our inspection showed that the appraisal rate for clinical staff was 100% for both theatres and the inpatient ward.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff received a hospital induction before they started work in their appointed role, and managers tailored a local induction to the clinical area. This process was accompanied by an induction checklist with a section to be completed on the first day and other competencies to be signed off within one month.

The hospital's resident medical officer (RMO) who started in post in November 2019 and had not been in post long enough to participate in the appraisal process. The RMOs completed an induction and completed the required mandatory training prior to starting in their post. One of the RMOs we spoke with told us that they had a surgical consultant as mentor within the hospital.

The hospital monitored consultant practicing privileges and had clear processes to remove practicing privileges of consultants that did not supply copies of their annual practice appraisals, and indemnity insurance. We reviewed the medical advisory committee meeting minutes for April 2019 and July 2019 which showed that the appraisal completion rate for consultants was 100%. The minutes also showed that practicing privileges were removed where consultants did not comply with the conditions associated with the practicing privileges.

Multidisciplinary working

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

Regular and effective multidisciplinary working took place to improve patients' care. The RMO, nurses and the hospital pharmacist completed twice daily bed rounds on the ward to discuss patients and plan their care. In theatres surgeons, anaesthetists and operating department practitioners (ODPs) completed the World Health Organisation (WHO) five steps to safer surgery checklists briefing and debriefing elements appropriately.

Consultants reviewed their inpatients daily in accordance with the granted practicing privileges. Consultants had arrangements in place to cover annual leave and sickness. The ward manager told us that consultants reviewed their inpatients daily. In the event this did not happen the ward manager escalated this to the senior leadership team. They also told us that many of the consultants worked in teams to provide cover.

Staff communicated important information about a patient's admission and treatment in the discharge letter sent to the patient's GP. This meant that the GP had access to patient information in a timely way.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff had access to specialist support for patients, such as, the infection prevention and control specialist. Staff communicated with local authority safeguarding teams, social workers, community services and GPs when they planned care for their patients.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Surgery services provided consultant led care 24 hours a day, seven days a week. Consultants completed ward rounds seven days a week and were available on-call out of hours.

Staff could call for support from doctors and other disciplines, including physiotherapy and diagnostic tests,

24 hours a day, seven days a week. The service had access to all key diagnostic services such as diagnostic imaging and laboratory services seven days a week to support clinical decision making.

The pharmacy was open Monday to Friday 9am to 5pm and on Saturday 9am to 1pm. A service level agreement was in place which provided pharmacy advice when the pharmacy on site was closed.

Health promotion

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

All preoperative patients had their tobacco and alcohol consumption screened. If this identified that they drank more than recommended amounts or smoked, they were offered cessation advice and offered nicotine replacement therapy. This was in line with their CQUIN with their local clinical commissioning group (CCG).

Staff had a range of information leaflets available to patients at their pre-assessment appointment. Ward staff talked through discharge information such as wound care and activity levels. This was supplemented with written information for a patient to take home in their discharge pack.

The hospital had a dietitian that worked under practicing privileges. Staff could signpost patients to the dietitian for additional dietary advice and support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff completed Mental Health Act and Deprivation of Liberty Safeguards training which formed part of the hospital's mandatory training programme. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice. Staff we spoke with had a

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clear understanding of their role in relation to legislation and how to facilitate consent to care and treatment and safeguard patients with protected characteristics from avoidable harm.

Staff had access to the provider's consent and Deprivation of Liberty Safeguard policy through the hospital intranet page. The policies were within the review date and referenced legislation and national guidance.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff gained verbal consent for routine daily care treatment such as for assistance with washing, dressing and repositioning. We observed staff gaining consent before delivering care and treatment. Staff gained written consent from patients for all surgical procedures.

Staff clearly recorded consent in the patients' records. We reviewed five patient records, all of the patient records contained correctly completed consent forms for their procedures. Managers audited patient records for consent form completion. We saw that 96% of patients had a fully completed consent recorded in their notes in the hospital quality account published in September 2019. This was better than the hospital's target of 95%.

Staff at all levels understood their responsibilities in relation to the Mental Capacity Act. Staff and managers we spoke with knew how to escalate concerns about a patient's mental capacity. Staff gave us an example of a patient who had capacity to consent to their procedure during their outpatient appointment, however this had changed on the patient's admission to hospital. Staff had escalated their concerns appropriately to the safeguarding lead and the surgical procedure was cancelled following a mental capacity assessment.

The hospital had documents to record best interest decisions and best interest meeting record documents. These documents were completed when patients were unable to consent to their treatment. Staff had access to information to support them in identifying patients without capacity to consent to treatment and a flow chart to work through.

Staff made sure patients consented to treatment based on all the information available. We saw that theatre staff checked the patients understanding of the procedure they were having, which was included in the World Health Organisation five steps to surgical safety checklist.

Are surgery services caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff demonstrated caring, respectful and supportive relationships with their patients and those close to them. We observed staff delivering care in theatres, wards and during their pre-assessment appointments. Staff interactions with patients were professional, friendly, and kind. Staff demonstrated an understanding of the importance of treating patients, and those who were important to them, in a caring and sensitive manner.

Staff followed policy to keep patient care and treatment confidential. Staff treated patients with privacy, respect, and dignity by closing doors of patient rooms whilst administering physical and/or intimate care.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff asked patients about their spiritual or religious preferences on admission to ensure they received food and care that was tailored to their needs. Staff ensured they recorded information about patients such as if they were vegetarian or vegan to ensure they had appropriate menu choices and products derived from animals were not used in their care.

Patients said staff treated them well and with kindness. All of the staff we spoke with took pride in their work and were committed to providing the best care they could to their patients. We spoke with two patients and their relatives who told us they would recommend the service to others. Patients felt the staff cared about them, had been very kind and attended to their needs in a timely way.

The service's clinical scorecard audited patient satisfaction. The scorecard for the period July to September 2018 showed that the percentage of patients responding

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extremely likely or likely to recommend the hospital was 96%. This was slightly lower than the hospital's target of 98%. However, we saw that the percentage of patients agreeing strongly that discharge was organised and that aftercare was fully explained was down to 65% and 66% respectfully. This was below the target of 86%. The ward had addressed this feedback and at the time of our inspection had comprehensive discharge packs for each patient.

We saw that a patient experience manager was new in post at the time of our inspection. A staff member had recently been appointed a dignity champion and dignity ambassadors were in each clinical area.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The hospital had links with local churches and religious networks to provide additional spiritual support to patients.

Staff understood the impact a patient's medical condition and their treatment had on the patient's emotional wellbeing and social interactions with their friends and family. An example of this was a member of staff that had cared for a patient with complex needs and volunteered to be present when the patient was admitted for further planned care. This provided continuity of care and additional emotional support to the patient as the staff member knew and understood their needs. The member of staff was still in contact with the patient at the time of the inspection.

Noticeboards were used to display thank you cards and feedback from patients. Patient feedback comments included "staff on all levels were very informative and made me feel confident about the procedure." Another patient wrote "All staff were lovely and couldn't do enough for me. I felt relaxed and happy the whole time."

The hospital could refer patients to a clinical psychologist based at another local Spire hospital to provide emotional support to patients and those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff took the time to explain and interact with patients, offering explanations and being supportive when patients expressed concerns.

Staff supported patients to make informed decisions about their care. All patients we spoke with told us staff had provided information about their care and treatment, so they could make decisions. Patients felt they had input into decisions about their care and treatment.

One patient feedback comment we saw said "excellent service and very kind staff, very professional and made me and my family feel like we were at home and at ease."

Are surgery services responsive?

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The hospital were active members within the local sustainability and transformation partnership (STP). The hospital undertook some surgical procedures on behalf of the NHS. We saw that 17% of surgical procedures were for NHS patients.

Facilities and premises were appropriate for the services being delivered. The ward and theatres were well equipped and complied with Department of Health guidelines. The layout of the wards meant that all areas were accessible for people using a wheelchair or walking aids.

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The hospital had a standard stock of equipment to support the care of obese patients. Staff we spoke with told us they accessed specialist equipment such as bariatric equipment through the hospital's equipment store.

The main inpatient ward area had an extended recovery room which was used for patients that required additional one to one monitoring following their surgical procedure. The ward manager told us that some consultants requested additional one to one monitoring following larger procedures. Enhanced recovery staffing was factored into the staffing requirements for the ward which was planned at least two weeks in advance.

Meeting people's individual needs

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

At the time of our inspection staff had recently been awarded a certificate by the Dementia Action Alliance and were working towards gaining accreditation dementia friendly hospital status. Over 100 staff had been trained to be dementia friends. The ward made reasonable adjustments for patients with complex needs. The hospital had equipment such as red toilets seats which were fitted prior to a patient admission and the use of red plates for meal times. The theatre manager told us that the day surgery unit had been used for patients with sensory needs such as autism to reduce the noise and activity around them. The unit was used solely for these patients during their admission.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation service through a third-party provider. Staff could request face to face translators for patients whose first language was not English or for British sign language.

The service had information leaflets available in languages spoken by the patients and local community. Staff had access to print patient information in different languages where a patient's first language was not English. The hospital also had access to patient information in Braille to support visually impaired patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff used the hospital's standardised documentation, which included sections to record patient preferences. Staff developed specialist care plans in response to specific need.

The service was audited by the British Deaf Association. The report provided recommendations for the hospital to provide a fully accessible services for patients with hearing impairments. The senior leadership team were working to implement the recommendations within the report.

Access and flow

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

Patients could access the hospital either as privately funded patients or through NHS choose and book. All NHS procedures were prioritised by patient need following consultant review and agreement with the senior leadership team.

All patient admissions were planned in advance at a time to suit patients. The hospital had an inclusion and exclusion criteria in place to ensure that the hospital could safely provide care to their patients. The hospital did not have facilities to care for patients that required critical care beds following their procedure.

There was a service level agreement with a local NHS trust in place for the transfer of patients requiring critical care transfer in the event of deterioration or an emergency.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. The service monitored the amount of avoidable cancellations on the day of surgery. We saw that for the period July to September 2018 this was 0.56%, which was lower than the Spire average of 0.67%.

Managers and staff worked to make sure that they started discharge planning as early as possible. Consultants held daily ward rounds to assess their patients and provide a plan of care.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and their relatives we spoke with told us they knew how to make a complaint. All patients we spoke with were happy with their care and said they had no reason to complain.

The service clearly displayed information about how to raise a concern in patient information folders in each room.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with knew how to deal with patient complaints and concerns and tried to resolve any issues locally. In the event they were unable to resolve issues themselves they told us they would escalate the concerns to their manager.

We saw that complaints were dealt with promptly. The complaints policy set a deadline of 20 days to close level 1 complaints. We saw that 100% of complaints were closed within this timeframe in the period July to September 2018. This was better than their target of 75%. The amount of complaints received at the hospital was also lower than the Spire average, with 0.59% of discharges leading to a complaint, compared to 1.11 nationally.

The hospital director oversaw the management of all complaints. All complaints were reviewed by the director of clinical services. In the quarter three reporting period (June to September 2019) the hospital received eight formal complaints, a 38% reduction from the same reporting period in 2018. Of these complaints, seven were about surgical services.

The service was a member of the independent complaints adjudication service (ISCAS), which provided an independent review of complaints and mediation services where patients were not satisfied with the response from the provider. No complaints had been escalated within the reporting period.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Where patients or their families raised concerns, staff

took time to listen to the concerns and resolve any issues at the earliest opportunity. Staff we spoke with felt empowered and able to act on concerns or escalate these to a senior member of the team to resolve these at the earliest opportunity.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with told us they received learning following complaints. The ward managers told us that the ward had changed the discharge information pack following feedback. The discharge pack has information about recovery following procedures and when to seek medical advice.

Are surgery services well-led?

Good 

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

Leadership

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

The senior leaders for the service knew their strengths and challenges in relation to service demands, resources and the provision of safe good quality care. Leaders were visible around the hospital. The senior management team had an open-door policy and had regular meetings with staff, including 'breakfast with the boss'. They had participated in a programme called 'walking in their shoes' where senior leaders spent a day with a team member to understand different roles and challenges faced.

A team of dedicated and proactive heads of department supported the senior leadership team who received praise from the staff they managed. Each manager was fully versed in the challenges and areas of good practice in their individual areas and committed to making positive change. Staff stated that they felt valued and supported in their role.

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We observed strong leadership at a local level and staff praised their local managers and said they supported them and communicated with them regularly. Staff we spoke with told us their head of department was routinely visible and approachable.

Staff progression and development was supported by the senior leadership team. We saw examples of when staff were supported in achieving higher qualifications, nurse prescribing courses and specialist training packages. Staff proudly told us of their advanced training, qualifications and apprenticeship scheme.

Vision and strategy

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

The hospital has a vision and a strategy to turn the vision into reality. Their hospital strategy was to be 'famous for outstanding clinical quality... accessible seven day per week services, supporting the local community, whole family care, recruiting the best staff, being easy to do business with, fully refurbished hospital'. We saw that there were separate clinical strategies underpinning these. The strategy was developed in conjunction with staff.

The strategy document for the hospital also identified the risks and dependencies in achieving their vision.

The hospital also followed the corporate Spire vision which was 'to be recognised as a world class healthcare business'.

The hospital had a set of organisational values. Staff we spoke with knew the organisation values of:

- Driving clinical excellence
- Doing the right thing
- Caring is our passion
- Delivering on our promises
- Succeeding and celebrating together
- Keeping it simple

The hospital also had a purpose of 'Making a positive difference to our patient's lives through outstanding personalised care.'

Staff displayed these values at all times during our inspection.

Culture

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

Staff reported an open and honest culture and said they felt able to raise any concerns with their managers. All staff we spoke with confirmed that the needs and experience of their patients was at the centre of the service. Staff told us they could raise concerns without the fear or reprimand, and they were confident action would be taken as a result.

Staff had access to independent freedom to speak up guardians to express any concerns outside of their immediate teams if they needed to. The hospital had a freedom to speak up guardian, who fed into the national corporate guardian. In the period October to December 2019 the service had three freedom to speak up concerns, which were closed.

Staff morale was good and staff we spoke with confirmed they felt valued and well supported by colleagues and managers within their roles. Managers praised staff for their commitment and team working to meet the needs of patients and the service.

The hospital had staff awards, staff members and teams could be nominated for an award by patients and other staff members for going the extra mile for patients in their care. Most of the areas we visited had been nominated for an award either as a team or individual who worked in the area.

Governance

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

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The service set out clear roles, responsibilities, and systems of accountability to support good governance and management of the service. Staff we spoke with described the service's management and governance structure and their specific roles and responsibilities.

Weekly meetings were held by the heads of departments to discuss issues around governance, risk and performance. Items of escalation from these meetings were discussed at a monthly meeting, where the hospital director met with members of the senior leadership team.

The service had effective data collection processes, which provided the management team with service level assurance. This included a variety of meetings and working parties that fed into committees for oversight. All root cause analysis reports were reviewed by the hospital director and director of clinical services. They were then discussed at three monthly (quarterly) clinical governance meetings and monthly clinical effectiveness meetings. A tracker system was in place to ensure all parts of the incident governance process were on track. We reviewed meeting minutes from January to October 2019 which confirmed these discussions had taken place.

Heads of department shared information such as key messages and incident learning during staff handovers and team meetings. Managers told us that they communicated important information at team meetings with staff and by email or the staff notice boards, for when staff were unable to attend ward meetings or had been on leave. A monthly governance newsletter and monthly clinical dashboard was sent to all staff, so that everyone knew the key areas of focus for the month.

We saw that consultants who were employed via practising privileges had these reviewed regularly. We saw that consultants had their practising privileges removed due to overdue appraisals and a lack of indemnity insurance. Consultants who did not practice regularly at the hospital also had their practising privileges withdrawn.

The medical advisory committee (MAC) had oversight of audit results, complaints and incidents which were routine agenda items. We reviewed the MAC meeting minutes for April 2019 and July 2019 which demonstrated these discussions had taken place.

Managing risks, issues and performance

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

The hospital used risk registers based on the potential consequence of the risk and the likelihood of the risk happening again. The hospital used a red, amber, green risk rating system, to denote the high, medium and low risk. Each risk had a rating on entry to the register and a rating once mitigations were in place. All risks had a review date, a named owner, and an action plan.

The service had clear processes for managing risks issues and performance. The service had an electronic risk register linked to the incident reporting system. This included items such as risk of injury due to small storage spaces, risk of lack of understanding the fire alarm following a different alarm being fitted and the risk of not having a clear protocol for access to acute vascular services in the event of a major vascular injury. Actions were in place to reduce the chance of these risks occurring.

Departmental risks were discussed at heads of department meetings held weekly and escalated as required to monthly senior leadership meetings.

The hospital had a dedicated risk champion and risk was a monthly agenda item for hospital meetings.

The ward manager knew the top three risks for the ward. An example was consultants not always adhering to hospital policy, the hospital had report forms in place for staff to complete if consultants acted outside hospital policy. Another example was venous thromboembolism risk due to dehydration, the ward had fluid champions to ensure patients had preoperative fluids in line with national guidance.

The theatre manager knew the three top risks for theatres were, such as but not limited to, issues with the laser lock down process. A new system was in place which had some electronic issues which were in the process of being resolved.

Surgery

Managers monitored performance against internal key performance indicators. The hospital was able to monitor their performance against key performance indicators and compare the results with other hospitals in the provider group.

The MAC discussed hospital risks during the meetings every three months. We reviewed the MAC meeting minutes which demonstrated these discussions had taken place.

Managing information

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

Staff across the hospital accessed information from the hospital intranet which included policies and national guidance. Staff knew how to access information through the intranet in each of the areas we visited.

An encrypted email service was used by the hospital for sending confidential information. All consultants employed under practising privileges who removed notes off site were registered with the Information Commissioner's Office. This was a requirement of their practising privileges.

The hospital used written patient records. Staff stored this information securely either in locked offices or secure notes trolleys when they were not in use.

Theatres held records where information about the use of implants and traceability were recorded. Managers used the electronic patient records for audit purposes and to monitor the completion of the World Health Organisation (WHO) five steps to surgical safety.

We saw that the service submitted notifications to CQC as required. The service submitted eight notifications from June to September 2019. These included unplanned transfers to local NHS providers, readmissions to the hospital, a misdiagnosis, and postoperative complications.

The hospital submitted data to The Private Healthcare Information Network (PHIN) as required by the Competition and Markets Authority.

Engagement

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

The hospital held engagement meetings with local NHS providers and the public. This included presentations for patients on orthopaedics and varicose veins. Training in areas such as cardiopulmonary resuscitation (CPR) was provided to local GPs.

The service held team meetings monthly and staff confirmed that there was good teamwork and engagement.

Staff surveys were held annually. The 2018 survey had an 85% response rate. The hospital's overall engagement score was 86%.

The hospital had staff awards where staff and patients could nominate individual staff members or teams for going the extra mile. Staff we spoke with told us about these awards and several staff members told us their team had been nominated for an award.

The hospital held a patient experience committee meeting in September 2019 to gain feedback from patients.

The service participated in the hospital's patient survey. Patients and their relatives could provide additional feedback through links on the hospital's public website. The public website also provided information and news about the hospital and the provider for service users.

Learning, continuous improvement and innovation

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

The hospital had a safety checklist for each patient called 'Fit to fly'. The checklist was adapted from an airline checklist which tracked a patient through their hospital journey. The checklist ensured all care had been provided at the right time. The registered manager told us that if the hospital got the care right at the start of a patient's journey and had check points throughout that journey, it reduced the risk of safety incidents occurring.

Surgery

The ward had developed bed rounds completed by the nurse in charge of the ward, the resident medical officer and the hospital pharmacist. The twice daily rounds facilitated discharge and treatment plans and gave clinicians an opportunity to discuss plans of care with patients, so they were included in decisions about their care.

The senior leadership team had developed ways of fostering communication with staff from the floor with hospital managers. 'Brunch with the boss' gave staff and managers the chance to have open discussions and provided an opportunity for staff to make suggestions or raise concerns.

Outpatients

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are outpatients services safe?

Good 

We previously inspected the outpatients service at Spire Hartwood jointly with the diagnostic imaging department so, we cannot compare our new ratings directly with the previous ratings.

We rated it as **good**.

Mandatory training

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

Staff were assigned to mandatory training modules appropriate to their role. The hospital had a mandatory training matrix that specified what training staff needed to complete and how frequently they needed to complete it.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. We discussed training compliance with staff during our inspection. Staff told us they were given time to complete their mandatory training when on shift.

Mandatory training was provided either face to face or through online learning. Mandatory training modules included safeguarding children and young people level 2,

safeguarding adults level 2, Mental Capacity Act, manual handling, information governance, infection control, health and safety, fire safety, equality and diversity, compassion in practice and anti-bribery gifts.

Staff received and kept up to date with their mandatory training. As at September 2019 in outpatients the overall mandatory training compliance was at 100% across all but one module – where there was 97% compliance in anti-bribery gifts.

Safeguarding

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and could identify safeguarding leads if they had concerns or queries.

Staff received training specific for their role on how to recognise and report abuse. All staff in outpatients were trained in safeguarding level 2 for adults and children.

Clinical staff directly involved in the care of children and young people had safeguarding children advanced (level 3) training. Safeguarding competencies were signed off by the paediatric lead nurse with each member of staff and compliance was reviewed by the paediatric lead nurse. This was part of the induction process for all new substantive and bank staff.

Outpatients

All consultants required current Level 3 safeguarding training to qualify for paediatric practicing privileges. The hospital electronic appointment system would not process a booking with a consultant that did not have current paediatric practicing privileges.

Staff followed safe procedures for children attending the outpatient's department. Children visiting the department were always accompanied by a children's lead nurse trained in level 4 safeguarding children and young people.

Staff could access safeguarding policies to obtain information on issues such as female genital mutilation (FGM). The policies stated what actions staff should take if they had any FGM concerns. Safeguarding children and adult policies also included PREVENT advice. PREVENT aims to protect vulnerable people from becoming radicalised to support terrorism or becoming terrorists themselves.

Cleanliness, infection control and hygiene

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

The service had redecorated and refurbished the outpatients' area and replaced chairs so that they could be cleaned easily. This was an improvement since our last inspection in 2016. The physiotherapy area was scheduled to be refurbished with new changing rooms and new lockers by 2021.

All areas were visibly clean. Cleaning schedules and checklists were up-to-date in treatment rooms and in communal areas. Disposable curtains were used in treatment rooms and were in date.

Staff had access to the provider's infection prevention and control (IPC) policy, through the hospital intranet and local folders. The policy set out staff responsibilities in the prevention and control of healthcare associated infection. The policy was within the review date and referenced national guidance and legislation.

Infection prevention and control audits were carried out for the department. Hand hygiene audits for the outpatient department between January 2019 and September 2019 showed 100% compliance.

The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.

Staff cleaned equipment and labelled equipment to show when it was last cleaned. The six pieces of equipment we checked were clean and had labels attached to demonstrate when it was last cleaned.

Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff to ensure their safety and reduce risks of cross infection when performing procedures.

Staff cleaned their hands between each patient contact. All staff arms were bare below the elbow and met the requirements of the Spire uniform policy. Hand sanitiser gel was available to staff, patients and visitors in each area of the department.

Specialist equipment such as the hydrotherapy pool was regularly cleaned and audited.

Environment and equipment

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

The outpatient department had twelve consulting rooms and a waiting area. The design of the environment followed national guidance.

The physiotherapy department had five rooms, a physiotherapy gym and a hydrotherapy pool.

The service had enough suitable equipment to help them to safely care for patients. Staff maintained equipment in line with guidelines and carried out daily safety checks of specialist equipment.

The outpatient's area had been refurbished since the last inspection. New flooring had been installed and the rooms had some new equipment such as wipeable chairs and new sinks to reduce the risk of infection. Most of the rooms in outpatients had also been repainted or were due to be repainted in line with the organisation's refurbishment schedule.

Outpatients

Staff managed general and clinical waste appropriately. Sharps disposal bins were correctly labelled and were not overfilled.

Waste was separated and stored in different coloured bags to signify the different categories of waste.

The service had rooms allocated to specialties with appropriate equipment for investigations such as ophthalmology. This meant that equipment was easily accessible.

There was a paediatric and adults' resuscitation trolley and defibrillator located between outpatients and physiotherapy. All items had been checked daily and were fully stocked. All consumables were in date and the trolley was clean and dust free.

Assessing and responding to patient risk

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

Staff knew about and dealt with any specific risk issues. Staff responded promptly to any sudden deterioration in a patient's health. Staff routinely completed risk assessments and patient observations on admission.

Staff shared key information to keep patients safe when handing over their care to others. Patient records were comprehensive and included details of risk assessments conducted.

There were clear pathways and processes for the assessment of people within outpatient clinics who were clinically unwell and required hospital admission.

Patients who became medically unwell in outpatients were transferred to the local acute NHS Trust in line with the emergency transfer policy.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers included information on incidents and any relevant information from the previous shift to ensure patients were safe.

At the time of inspection, the services had stopped performing invasive procedures on children and young people. Appointments for children were therefore only for consultative appointments.

The service ensured children were safe during their time in the department. A children's nurse trained in paediatric immediate life support accompanied children when treated in the department.

Staff said if they had concerns regarding the mental health of a patient they would contact their safeguarding leads or the local mental health team in line with Spire policy.

Nurse staffing

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

The service had enough nursing staff of relevant grades to keep patients safe.

Staffing levels and skill mix were planned according to booked clinics.

The service employed five full time nurses, three part time nurses and five bank nurses.

The service did not use agency staff in outpatients.

Managers made sure all bank staff had a full induction and understood the service.

Within outpatients, the service employed one full time health care assistant (HCA) and seven HCA's that worked part time. There was one HCA vacancy that was being advertised.

Medical staffing

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

The service had enough medical staff to keep patients safe.

The hospital did not employ any consultants directly. Medical staff were mostly employed by local NHS trusts in substantive posts and all had up-to-date practising privileges with Spire. For our detailed findings on medical staffing please see the safe section in the main surgery report.

Outpatients

Records

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

All patient records were in paper format. The service had implemented a single set of patient records.

We reviewed 11 patient records and saw that they contained all the information needed to deliver safe care and treatment including test and imaging results, care and risk assessments, care plans and case notes. Records within outpatients were stored securely in a dedicated integrated wall unit that had been installed as part of the department refurbishment.

No patients had been seen in outpatients without the medical records being available for their appointment during the last 12 months.

All private patients had a set of notes made up prior to their visit by a dedicated team and NHS referrals had medical records provided including a medical history.

All medical files were made available to the outpatients' department the day before patients' appointment times.

For out of hours access to patients' medical files, an embedded process was in place, where the senior ward nurse accompanied the outpatient nurse to the medical records department to retrieve the required set of medical files.

Spire medical records were not taken off site by consultants or staff.

Consultants and their medical secretaries always had access to their outpatient diaries and could see all bookings and last minute additions. Medical secretaries that were onsite had access to the medical records department and a secure Spire email address.

Following a patient consultation, a letter was sent to the patient's GP to communicate any changes to treatment.

Medicines

Outpatients' staff used a prescription recording book to monitor used, returned or destroyed prescriptions.

For our detailed findings on medicines please see the Safe section in the Surgery report.

Incidents

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

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

Staff reported incidents clearly and in line with the Spire policy.

Managers investigated incidents thoroughly. Patients were involved in these investigations. Staff understood the duty of candour. They gave patients a full explanation when things went wrong. This included an example where a patient was misdiagnosed and subsequently received inappropriate treatment. The service issued an apology and provided a full refund.

Staff knew what incidents to report and when to report them. From January 2019 to December 2019 there had been 67 reported incidents in outpatients and 31 in physiotherapy. Of these incidents three within outpatients were moderate harm, where short term harm could be caused – all remaining incidents were no or minimal harm.

Staff received feedback from investigation of incidents, both internal and external of the service.

Staff met to discuss the feedback and look at improvements of patient care.

Are outpatients services effective?

Outpatient services were previously inspected as part of the outpatient and diagnostic services. This is the first inspection where the core services have been separated. Outpatients and diagnostic services were previously inspected but not rated.

We currently do not rate effective for outpatient services.

Outpatients

Evidence-based care and treatment

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

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

Staff could access policies on the hospitals intranet. Managers ensured staff signed confirmation of reading Spire policies to state they had read updates to policies.

Specialities within the outpatient department (OPD) delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate.

Staff in OPD had a good awareness of local policies and were able to give us examples of how to access policies electronically and when they had used them.

The outpatients service performed local audits and achieved 100% compliance from October 2019 to December 2019 for bare below the elbow, standard precautions, medical equipment and wound management. The service achieved 98% compliance for hand hygiene observation and 97% for Infection prevention control in inpatient and outpatient areas. An action plan was in place to further improve scores.

Nutrition and hydration

Patients and those close to them had access to hot drinks and water in the outpatient waiting area.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.

Outpatient staff did not routinely provide patient pain relief. However, staff assessed patients pain levels before planned admissions for procedures using appropriate pain score assessment tools. This included using images with children and young people.

Patients would bring their own pain relief medicines with them if needed for most outpatient appointments.

Staff gave patients pain advice booklets at their pre-assessment appointment to prepare them for surgery and to use as a guide following their surgery. Staff discussed and recorded patients pain levels at their pre-assessment appointments.

Patients we spoke with had not required pain relief during their attendance at the outpatient departments.

Patient outcomes

Staff did not routinely take part in national audits; however, the service monitored some aspects of effectiveness of care and treatment. They used findings to make improvements and achieved good outcomes for patients.

The service did not participate in national benchmarking clinical audits or audits on patient outcomes. However, outpatient departments do not generally participate in national or patient outcome audits.

Spire Hartswood did not have a performance dashboard for the outpatient department. The service had an overall Clinical Scorecard for the hospital. This is a dashboard to present national audits and data completed quarterly across all Spire hospitals where services are benchmarked against other similar services. For example, hand hygiene audit results, never events, patient falls, closing of incidents, complaints management. The outpatient department was able to monitor its performance against other Spire hospitals in this group.

Managers used information from the audits to improve care and treatment. Managers gave us examples of where they had made improvements to the environment and waiting times in response to audit findings.

There was a systematic programme of internal local audits used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules.

The physiotherapy service was engaged with the patient specific functional scale (PSFS) outcome measure to enable personalised patient led outcome data to be collected. In addition, an online physiotherapy survey was available for patients to complete on a tablet in the department following their appointments.

Outpatients

Competent staff

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

Managers gave all new staff a full induction specific to their role.

All appointments with children and young people within outpatients were attended by a paediatric nurse.

Managers supported staff to develop through regular, constructive appraisals of their work. Staff confirmed they would discuss their training and development needs during their annual appraisal. All staff within outpatients had received an appraisal.

Monthly team meetings were held in the department. Managers made sure staff attended team meetings when possible. If staff were unable to attend, they could access minutes from the meetings to ensure they were up-to-date.

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

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. We saw good collaborative working and communication amongst all members of the MDT. Staff reported that they all worked well as a team.

Seven-day services

Key services were not available seven days a week to support timely patient care. However, patients were offered a choice of appointment to suit their needs including evenings and Saturday clinics.

The outpatients department was open Monday to Friday 9am to 5pm and on Saturday 9am to 1pm. The pharmacy was also open during these hours a service level agreement was in place which provided pharmacy advice when the pharmacy on site was closed.

Health promotion

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

There was a range of information displayed in the waiting area on health and health promotion. There were some leaflets available to advise patients about health issues including how to live a healthier lifestyle.

Consent and Mental Capacity Act

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

Staff completed Mental Health Act and Deprivation of Liberty Safeguards training as part of the hospital's mandatory training programme. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005, they knew who to contact for advice. Staff we spoke with had a clear understanding of their role in relation to legislation and how to facilitate consent to care and treatment and safeguard patients with protected characteristics from avoidable harm.

Staff had access to the provider's consent and deprivation of liberty safeguard policy through the hospital intranet page. The policies were within the review date and referenced legislation and national guidance.

Outpatients

Are outpatients services caring?

Good 

We previously inspected the outpatients service at Spire Hartwood jointly with the diagnostic imaging department so, we cannot compare our new ratings directly with the previous ratings.

We rated caring as **good**.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

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

Staff followed policy to keep patient care and treatment confidential. Staff held confidential discussions about patients away from public areas to ensure they could not be overheard. The reception desk was positioned away from the seating area in the reception to ensure patients could speak to the receptionist without being overheard.

Chaperones were offered to patients in line with the Spire chaperone policy and signs were located throughout outpatients to inform patients.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. A patient gave an example where they had commended physiotherapy staff for the emotional support throughout their treatment journey and hugged their physiotherapist on their last appointment.

Patients told us staff alleviated any anxieties and helped them to stay calm. Staff took their time to explain procedures and provide reassurance during an appointment.

Understanding and involvement of patients and those close to them

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

All patients that we spoke with said that staff at all levels took time to make sure they understood their care and treatment.

The hospital provided patients with information prior to their clinic appointment. This included hospital location, appointment time, consultant name and details of any information to bring with them and any investigations required.

Staff gave enough information to patients and those close to them from the start of their treatment and provided regular updates. Patients felt involved in their care and treatment.

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

Are outpatients services responsive?

Good 

We previously inspected the outpatients service at Spire Hartwood jointly with the diagnostic imaging department so, we cannot compare our new ratings directly with the previous ratings.

We rated responsive as **good**.

Service delivery to meet the needs of local people

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

Outpatients

Outpatient facilities and premises were appropriate for the services being delivered. The outpatient environment was suitable for patients and visitors. There was enough comfortable seating and a separate children's waiting area.

There was clear signage throughout the hospital to guide patients to the relevant outpatient and physiotherapy departments.

All patients had access to a free car park. Patient feedback was used to improve the car parking facility. Car park attendants were used during busy times to ensure safe use of the car park and access to all. We were told that dedicated spaces were flexed to ensure no space was left unused during busy times. The leadership team had identified that one of the top three hospital risk was the surfacing of patient and staff car parks. We saw that car park resurfacing had been completed at the time of inspection. This provided a safe surface for people to walk on to access the hospital.

Staff said they used patient passports to identify specific needs. Patients living with dementia were given longer pre-assessment appointments to ensure communication was delivered at the right pace. Tours of relevant parts of the hospital were offered to help patients become familiar with their surroundings.

Meeting people's individual needs

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

The hospital had a hearing loop in place for those with hearing difficulties and access to translation services both on the telephone and face to face for those whom English was not their first language.

The outpatient environment was suitable for patients with a physical disability. The outpatient reception desk was at varied heights which accommodated patients attending in wheelchairs and all consulting rooms were wheelchair accessible. Corridors and toilets were wide enough for wheelchair users.

Patients' needs would be assessed during their referral process and during their pre-assessment appointment.

This could flag up the need for additional support to those who may need it, for example patients living with dementia could be given longer appointment slots and additional visits to familiarise themselves with the environment.

Patients had access to a variety of information leaflets in the hospital. All information leaflets were in English and the service could access written patient information in other languages through an electronic system if needed.

The service used a hospital passport for children and young people with learning disabilities coming into the hospital. This detailed specific instructions on what to do if a child was anxious, worried or upset.

Patients could access a range of patient information leaflets in the department available to explain their condition and treatment plan. The hospital could accommodate if information leaflets were needed in other languages.

Access and flow

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

Patients could access care and treatment at a time that suited them. Patients told us they were given a choice of appointments and could easily re-arrange if needed.

From January 2019 to December 2019 there had been seven clinic cancellations and eight clinics that started later than 15 minutes of their start time.

The Referral to Treatment (RTT) pathway target for NHS-funded patients outlines that no patient should wait longer than 18 weeks from referral to the start of their treatment. For December 2019 98% of patients were on a patient pathway within the 18 weeks, this exceeded the 92% target.

The department used technology to support timely access to care and treatment. Patients had the option to 'opt into' a service that sent text message reminders to ensure they were aware of their appointment details.

The service audited clinic timeliness – this is the time a patient would be waiting in the hospital. This involved

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checking 10 clinics per month as part of the audit. For August 2019, 95% of patients were either seen on time or within 15 minutes from their stated appointment time. Audits were conducted monthly and had improved performance since October 2019. Actions to improve timeliness included investigating clinic cancellations and managing performance issues of staff.

The department held different specialist clinics. The main outpatient activity was orthopaedics accounting for 27% of the outpatient department's activity. The remaining activity was spread between other specialisms including (but not limited to) physiotherapy, general surgery, plastics, dermatology and urology.

In physiotherapy the service monitored patients that did not attend appointments to make sure they were well and that appointments could be rearranged.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with had not needed to raise any concerns or to log any complaints however, they told us it would be easy to do so.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. The service had a target of 75% of complaints to receive a final response within 20 working days and there had been 100% compliance. One staff member described learning from information a patient required to help process their healthcare insurance and how forms had subsequently improved.

Information on how to make a complaint was visible in the reception area and consulting rooms.

Are outpatients services well-led?

Good 

We previously inspected the outpatients service at Spire Hartswood jointly with the diagnostic imaging department so, we cannot compare our new ratings directly with the previous ratings.

We rated well-led as **good**.

Leadership

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

The outpatients services lead had been in post for 14 months and reported to the director of clinical services. The outpatients lead was visible and accessible within the outpatients department. We saw that managers had a positive rapport with staff and communicated well with patients during our inspection. All staff praised the outpatient services lead.

The outpatients services lead had the skills, knowledge, experience for the role and was passionate about the service they led. There was a strong sense of team working in the department and all staff worked well together, whatever their role.

Leaders for each shift were clearly identified. A notice was clearly displayed next to the reception desk to inform patients who was in charge on that day.

Leaders communicated important messages to staff during staff huddles. The nurses' office had information displayed including policy updates and audit results. This ensured staff were aware of any relevant issues and updates.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision

Outpatients

and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and strategy for the hospital, which had been communicated to staff who were aware of their role in delivering the vision and strategy.

Staff discussed with their manager how their personal objectives were linked to the hospital priorities and vision, values and strategy for the outpatient department during their appraisal.

Staff told us that there had been improvements in making the pre-assessment process more effective and how this moved toward a more patient centred approach to treatment.

The strategy was aligned to local plans in the wider health and social care economy, and services were planned to meet the needs of the relevant population.

Culture

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

Staff told us that they enjoyed their work and seeing positive outcomes for patients. Staff commented that they had noticed improvements since the last inspection and attributed this to the new leadership in place.

There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked together for the benefit of patients. All staff worked well together as a team. We saw numerous examples of positive interactions between staff during our inspection. All staff told us the department was a good environment to work in. Staff in different roles and at all levels had a supportive working relationship and valued each other. Recently recruited staff felt welcomed into the team and optimistic about their future within the service.

The hospital was focussed on improving the overall health and well-being of staff. There was a staff noticeboard within outpatients that was dedicated to

staff wellbeing. The team engaged in charitable fundraising events together and celebrated these successes. There was also information about supporting colleagues and mindfulness.

Staff we spoke with said they had no hesitation in raising concerns or incidents without fear of retribution and that their input was welcomed.

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department according to an audit schedule and results were shared at relevant meetings such as the hospital clinical governance meetings.

The hospital had clear governance systems in place. The hospital held meetings through which governance issues were addressed. The meetings included medical advisory committee, clinical governance committee and infection control.

Weekly meetings were held by the heads of departments to discuss issues around governance, risk and performance. Items of escalation from these meetings were discussed at a monthly meeting, where the hospital director met with members of the senior leadership team.

Staff at all levels were clear about their roles and understood what they are accountable for, and to whom.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified

Outpatients

actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes.

The outpatient services lead had a good understanding of risks to the service. Departmental risks were discussed at heads of department meetings held weekly and escalated as required to monthly senior leadership meetings.

The service completed a monthly observational audit for the '5 steps to safer surgery' and a biannual ear, nose and throat scope decontamination tracing audit.

Consultants were up-to-date with the requirements of their practising privileges at the hospital. Each year, consultants needed to show they had an up-to-date appraisal and training to practise at the hospital.

The outpatients leadership had changed since our last inspection and there was significant improvement in knowledge and oversight of current risk. Leaders reviewed risk registers regularly and could identify key risks to the service. There was now a risk register for equipment which highlighted a concern at the last inspection.

Managing information

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

Staff had access to accurate information and up-to-date policies and procedures. Staff could access policies and procedures on the hospital intranet.

The service had clear and robust performance measures which were reported and regularly monitored

The service had robust arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards.

Staff could access the information they required.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve services.

The service held monthly team meetings and staff confirmed these were useful and they had enough input.

The service had a patient forum where participants involve those that have recently visited the hospital.

All staff felt comfortable approaching management with any concerns.

Learning, continuous improvement and innovation

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

Staff were committed to learning from incidents, complaints and when things went well. Learning was shared across the hospital to improve care and outcomes for patients.

Outstanding practice and areas for improvement

Outstanding practice

- Staff considered all people who attended, very much with their wellbeing in mind. There were lots of examples of staff ensuring those accessing oncology were compassionately welcomed in to the department. The need for confidentiality and a

sensitive approach was demonstrated from the minute people were referred. A psychologist was employed to support people assessed as requiring additional mental health input.