Spire London East Hospital

Quality Report

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Date of inspection visit: 5 to 7 November 2019
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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?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

Spire London East Hospital is operated by Spire Healthcare Group plc. The hospital has 27 inpatient beds and 16 day case rooms called 'pods'. Facilities include four operating theatres, an endoscopy suite, a three-bed level one extended recovery unit, pharmacy and x-ray, outpatient and diagnostic facilities.

The hospital provides surgery and outpatients, physiotherapy, diagnostics and imaging services. It also provides some limited outpatients medical appointments for adults, children and young people. We inspected the surgery, outpatients and diagnostic imaging services.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 5-7 November 2019. This was an announced visit.

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.

Where our findings on outpatients apply to other services, we do not repeat the information but cross-refer to the outpatients service level.

Services we rate

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

- The hospital 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 hospital infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- We observed the clinical and reception areas were clean and tidy. The service used stickers and cleaning schedules to identify when areas had been last cleaned.
- The hospital had a dedicated infection prevention and control (IPC) lead that monitored compliance with IPC practices, supported by link practitioners in theatres, wards and paediatrics. The IPC Lead nurse managed the annual audit of infection prevention and control practices across surgical wards and theatres, which was used to inform an annual IPC report.
- We observed good hand hygiene practices in place across surgical wards. All staff (including non-clinical) received training in Aseptic non-touch technique (ANTT) for prevention of the spread of infection.
- Since the last inspection the hospital has reviewed practice in this area and improved the processes in line with best practice. This included new decontamination equipment and refurbishment of the endoscopy areas, which reduced the risk of contamination, ensuring there was a sterile processing technician team available throughout the endoscopy list.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- In surgery, staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration. Staff used the national early warning scores (NEWS 2) system to assess and monitor risk of deterioration in patients.
- Patient risk was discussed each day in the morning huddles and twice daily nursing handovers. The morning huddle provided an overview of activity (including any alterations to theatre lists) and key risks each day, and included attendance from surgery staff, as well as the heads of department. Notes from each morning huddle were typed up and shared with staff by email.
- In surgery, the hospital used the World Health Organisation (WHO) Surgical Safety Checklist to minimise the risk of incidents during surgery. We

Summary of findings

observed multiple examples of the WHO checklist in use on inspections. In all cases they followed a standardised, accurate approach that were well led and had good staff engagement.

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date 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.
- The service had enough nursing 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 staffing levels and skill mix, and gave agency staff a full induction.
- There was sufficient access to medical staffing on the ward, and out of hours consultant support if needed
- Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- In surgery, staff made sure patients had support with nutrition and hydration to meet their needs. Any patients that had specific dietary needs would be identified at pre-assessment for surgery, and catering staff could then prepare accordingly.
- In surgery, 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 pain relief to ease pain. The hospital had a senior lead nurse with responsibility for pain management care for surgery patients.
- 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 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.
- The service had a practice development lead nurse (PDN) in post with responsibility for monitoring mandatory training, ensuring staff competencies, and supporting staff development. The PDN ran regular training sessions for ward staff, often in collaboration with consultants on specific topics. Staff told us they were positive about the support and involvement of the PDN.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- The hospital had policies in place for the process to obtain informed consent, and for the management of patients under MCA and DoLS.
- At the time of the last inspection, we found some consent forms were unsigned so could not clearly show confirmation of consent. On this inspection we found staff clearly recorded consent to surgery to treatment in the patients' records as necessary.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- During the inspection we saw staff on the surgery ward treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they delivered to patients during their interactions. Care that we observed was patient centred.
- Patients and family members spoke very positively about the care they received, and how they were treated by the staff on the wards

Summary of findings

- Parents could accompany their child to the anaesthetics area before the patient proceeded to theatres. This was meant to alleviate some of the anxiety prior to surgery for both the child and their family.
- Staff understood the impact that patients' care, treatment and condition had on wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the interactions we observed.
- Surgery wards had access to a patient concierge, who could provide patient centred and individual support as needed. Staff were able to provide numerous examples of input from the patient concierge that improved the experience of patients using the service.
- Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care. The hospital also had dignity champions appointed across the hospital to provide enhanced person-centred care.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- Family members of patients were positive about the care the patients received and stated that staff members were professional and welcoming.

- 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 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.
- Surgery wards provided food that catered to dietary requirements and cultural preferences. Patients told us they were happy with the quality of the food that they received.
- Staff were aware of how to access translation if patients or families were unable to communicate in English.
- People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.
- In surgery, the recovery area had a designated recovery bed for young people, so that they were segregated from older patients. The paediatric recovery space had been decorated to accommodate young patients.
- In surgery, there were adequate discharge arrangements in place with patients provided with contact details of who should be contacted should any problems occur. Patients stated that they would contact the ward if they had any concerns, and some patients who had done so stated they received a quick reply from their consultants.
- 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.

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Staff we spoke with stated that the senior leadership team was visible on the wards and were approachable to all staff, operating an “open door” policy. Staff we spoke with told us that there was a no blame culture, and that they felt valued and respected.
- The Hospital had a clear vision and strategic goals, which was aligned to the national corporate clinical strategy. The paediatric services delivered at the hospital had also introduced strategic goals for their service, which were currently in development.
- Staff were proud of the work they carried out. Staff stated they enjoyed working at the service and were enthusiastic about the care and services they provided for patients.
- There was a robust corporate governance framework in place which oversaw service delivery and quality of care.
- The hospital had a regular patient experience committee which discussed feedback from patient and how to improve the patient journey. The hospital also had input from patient ambassadors, who were patients that had used the service in the past and now provided feedback and advice to hospital leadership.

Summary of findings

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However:

- The hospital did not have a dedicated dietitian, input from a provider level dietician was available to provide advice and support if needed.
- In surgery, there had been two 'never events' reported at the hospital from June 2018 to July 2019, both relating to incorrect site surgery. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The service had taken appropriate action to address the issues highlighted by these events.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals (London)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated this service as good because it was safe, effective, responsive and well-led. The service was outstanding for caring.
Outpatients	Good 	We rated this service as good because it was safe, effective, caring, responsive and well-led.
Diagnostic imaging	Good 	We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

Spire London East Hospital

Services we looked at
Surgery; Outpatients; Diagnostic imaging;

Summary of this inspection

Background to Spire London East Hospital

Spire London East Hospital is operated by Spire Healthcare Limited. It is a private hospital in East London. The hospital primarily serves the communities of the London and West Essex area It also accepts patient referrals from outside this area.

In 2018, the hospital changed its name from Spire Roding Hospital to Spire London East Hospital in response to feedback from staff, service users and the local community.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector one other CQC inspector, an assistant inspector and five specialist advisors with expertise in outpatients, surgery and diagnostic imaging services. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about Spire London East Hospital

The hospital has one ward 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 the ward area (comprised of 27 individual rooms), consulting rooms, treatment rooms, the day case unit, the operating theatre suite, endoscopy suite, pharmacy and outpatients area.

We spoke with more than 40 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 20 patients and five relatives. During our inspection, we reviewed 15 sets of patient records.

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12 months before this inspection. The hospital has been inspected six times, and the most recent inspection took place in November 2017, at which the hospital was rated requires improvement.

Activity (June 2018 to July 2019)

In the reporting period July June 2018 to July 2019 58% of impatient episodes of care were NHS funded and 42% were other funded.

There were 54483 outpatient total attendances in the reporting period; of these 27% were other funded and 53% were NHS-funded.

269 consultant doctors, including surgeons, anaesthetists and radiologists worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a one week on, one week off rota. The hospital employed 34.3 whole time equivalent (WTE) registered nurses, 26.5 WTE care assistants as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

Two Never events

Summary of this inspection

644 clinical incidents reported in the hospital, 566 of which (88%) caused no harm. This included three that were categorised as severe harm.

One case of hospital identified Methicillin-resistant Staphylococcus aureus (MRSA)

One case of Escherichia coli (E. coli)

Zero cases of Clostridium difficile (C. difficile).

77 complaints

Services accredited by a national body:

BUPA accreditation: breast and colorectal

Macmillan Quality Enviromental Mark

SGS ISO 13485:2003, EN ISO 13485:2012, Directive 93/42/EEC

London City University accreditation for placements for student nurse training

BUPA accreditation: multi parametric prostate imaging

BUPA Accreditation: MRI and CT

Services provided at the hospital under service level agreement:

Electrocardiogram report

Blood transfusion serice

Dexa scanner service

Dietetic service

Nuclear medicine

Occupational therapy service

Paediatric nurses

Radiation protection advisor

Resident medical officers provision.

Coloplast stoma nurse

Laser protection advisor

SATS Ambulance transfer services

GE Multivendor Contract for Medical Equipment

Patient Transfer agreement with local trust

Gas detection Crowcon in MRI

Daniels Sharp Safe

Jenpen Ltd Occupational Health Services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The hospital infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- We observed the clinical and reception areas were clean and tidy. The service used stickers and cleaning schedules to identify when areas had been last cleaned.
- The hospital had a dedicated infection prevention and control (IPC) lead that monitored compliance with IPC practices, supported by link practitioners in theatres, wards and paediatrics. The IPC Lead nurse managed the annual audit of infection prevention and control practices across surgical wards and theatres, which was used to inform an annual IPC report.
- We observed good hand hygiene practices in place across surgical wards. All staff (including non-clinical) received training in Aseptic non-touch technique (ANTT) for prevention of the spread of infection.
- Since the last inspection the hospital has reviewed practice in this area and improved the processes in line with best practice. This included new decontamination equipment and refurbishment of the endoscopy areas, which reduced the risk of contamination, ensuring there was a sterile processing technician team available throughout the endoscopy list.
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- In surgery, staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration. Staff used the national early warning scores (NEWS 2) system to assess and monitor risk of deterioration in patients.
- Patient risk was discussed each day in the morning huddles and twice daily nursing handovers. The morning huddle provided an overview of activity (including any alterations to

theatre lists) and key risks each day, and included attendance from surgery staff, as well as the heads of department. Notes from each morning huddle were typed up and shared with staff by email.

- In surgery, the hospital used the World Health Organisation (WHO) Surgical Safety Checklist to minimise the risk of incidents during surgery. We observed multiple examples of the WHO checklist in use on inspections. In all cases they followed a standardised, accurate approach that were well led and had good staff engagement.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date 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.
- The service had enough nursing 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 staffing levels and skill mix, and gave agency staff a full induction.
- There was sufficient access to medical staffing on the ward, and out of hours consultant support if needed

However:

- In surgery, there had been two 'never events' reported at the hospital from June 2018 to July 2019, both relating to incorrect site surgery. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The service had taken appropriate action to address the issues highlighted by these events.

Are services effective?

Good

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

Summary of this inspection

- Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- In surgery, staff made sure patients had support with nutrition and hydration to meet their needs. Any patients that had specific dietary needs would be identified at pre-assessment for surgery, and catering staff could then prepare accordingly.
- In surgery, 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 pain relief to ease pain. The hospital had a senior lead nurse with responsibility for pain management care for surgery patients.
- 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 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.
- The service had a practice development lead nurse (PDN) in post with responsibility for monitoring mandatory training, ensuring staff competencies, and supporting staff development. The PDN ran regular training sessions for ward staff, often in collaboration with consultants on specific topics. Staff told us they were positive about the support and involvement of the PDN.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- The hospital had policies in place for the process to obtain informed consent, and for the management of patients under MCA and DoLS.
- At the time of the last inspection, we found some consent forms were unsigned so could not clearly show confirmation of consent. On this inspection we found staff clearly recorded consent to surgery to treatment in the patients' records as necessary.

However:

Summary of this inspection

- The hospital did not have a dedicated dietitian, input from a provider level dietician was available to provide advice and support if needed.

Are services caring?

Outstanding 

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- During the inspection we saw staff on the surgery ward treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they delivered to patients during their interactions. Care that we observed was patient centred.
- Patients and family members spoke very positively about the care they received, and how they were treated by the staff on the wards
- Parents could accompany their child to the anaesthetics area before the patient proceeded to theatres. This was meant to alleviate some of the anxiety prior to surgery for both the child and their family.
- Staff understood the impact that patients' care, treatment and condition had on wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the interactions we observed.
- Surgery wards had access to a patient concierge, who could provide patient centred and individual support as needed. Staff were able to provide numerous examples of input from the patient concierge that improved the experience of patients using the service.
- Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care. The hospital also had dignity champions appointed across the hospital to provide enhanced person-centred care.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- Family members of patients were positive about the care the patients received and stated that staff members were professional and welcoming.

Summary of this inspection

Are services responsive?

Good

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

- 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 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.
- Surgery wards provided food that catered to dietary requirements and cultural preferences. Patients told us they were happy with the quality of the food that they received.
- Staff were aware of how to access translation if patients or families were unable to communicate in English.
- People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.
- In surgery, the recovery area had a designated recovery bed for young people, so that they were segregated from older patients. The paediatric recovery space had been decorated to accommodate young patients.
- In surgery, there were adequate discharge arrangements in place with patients provided with contact details of who should be contacted should any problems occur. Patients stated that they would contact the ward if they had any concerns, and some patients who had done so stated they received a quick reply from their consultants.
- 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.

Are services well-led?

Good

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

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Staff we spoke with stated that the senior leadership team was visible on the wards and were approachable to all staff, operating an “open door” policy. Staff we spoke with told us that there was a no blame culture, and that they felt valued and respected.

Summary of this inspection

- The Hospital had a clear vision and strategic goals, which was aligned to the national corporate clinical strategy. The paediatric services delivered at the hospital had also introduced strategic goals for their service, which were currently in development.
- Staff were proud of the work they carried out. Staff stated they enjoyed working at the service and were enthusiastic about the care and services they provided for patients.
- There was a robust corporate governance framework in place which oversaw service delivery and quality of care.
- The hospital had a regular patient experience committee which discussed feedback from patient and how to improve the patient journey. The hospital also had input from patient ambassadors, who were patients that had used the service in the past and now provided feedback and advice to hospital leadership.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	☆ Outstanding	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

Mandatory training

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

Staff completed mandatory training or provided evidence that it had been completed at another service (which included agency staff). The service provided training directly to nursing staff and allied health professionals, while some consultants and Resident Medical Officers (RMO) could complete training at another service or NHS trust and share the evidence.

Staff would be informed by managers when their mandatory training was due to run out. If staff had not completed training, or if they did not provide evidence of their mandatory training being completed elsewhere, they would be suspended. Between August 2018 and July 19, the hospital had suspended 22 staff members for this reason, with staff reinstated once evidence of training was provided.

Mandatory training modules was a mix of classroom delivered training and e-learning. Staff stated they felt this worked well and they were given adequate time to complete training. Staff could access training at other hospitals owned by the corporate provider if necessary.

The mandatory training courses included resuscitation training, infection control, fire safety, complaints handling, safeguarding adults and children (both level two), moving and handling, conflict resolution, and information governance amongst others.

The hospital and corporate targets for training were 80%. Completion rates for training at the hospital were 100% for most mandatory training modules, with an overall average of 97% for staff.

As well as mandatory training for the hospital, staff working with paediatric patients completed training in paediatric basic life support (BLS) or paediatric immediate life support (PILS), while service leads completed advanced paediatric life support (APLS). Surgery wards and theatres always had at least one member of staff on shift with APLS.

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.

As of the time of the inspection 99% of staff had completed the appropriate level of safeguarding training for their roles. This included staff working with both adults and children, and staff in managerial roles. The hospital lead for adult safeguarding was the director of clinical services, supported by the deputy matron (who also lead on child safeguarding).

The hospital adult safeguarding lead and paediatric services lead participated in local safeguarding meetings for the boroughs represented by the hospital. We saw evidence of attendance at these meetings, and local safeguarding issues being discussed in hospital and departmental meetings.

Staff had a good understanding of when they would need to report a safeguarding concern, what to look out for, and how to report a concern if they needed to. Staff were aware of specific safeguarding issues that may present as part of

their roles, such as female genital mutilation (FGM), child sexual exploitation (CSE), child who was not brought to appointment (WNB) and PREVENT (Protecting people at risk of radicalisation).

Patient records for surgical wards had a section relating to safeguarding, which we observed was completed in records we reviewed. The service had a specific patient record pathway for children and young people, which also included sections relating to safeguarding to be completed at pre-assessment and admission.

Safeguarding concerns were reported through a specific safeguarding referral form. All staff were aware of how to report safeguarding concerns, and we saw posters on surgical wards advertising who to contact for support and advice for safeguarding. The director of clinical services for the hospital was the safeguarding lead for the hospital.

We reviewed the hospital safeguarding policy, which detailed what to do in the event of a safeguarding concern and reflected the service's obligations under safeguarding legislation. We saw evidence that the service had updated the policy to reflect intercollegiate guidance on safeguarding.

Cleanliness, infection control and hygiene

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

We observed the clinical and reception areas were clean and tidy. The service used stickers and cleaning schedules to identify when areas had been last cleaned.

Surgical wards provided staff with personal protective equipment (PPE) such as gloves and aprons. Staff told us they wore PPE where necessary, and we observed all staff adhered to the 'bare below the elbows' protocol and use of PPE in clinical areas. Availability of PPE was also checked and audited regularly.

Cleaning schedules were used to monitor the completion of daily, weekly, and monthly infection prevention and control tasks. Cleaning was completed by a mix of nursing staff in clinical areas and by supporting housekeeping staff. We observed these tasks being carried out, such as cleaning of patient rooms on surgical wards and cleaning preparation trollies, and then being signed as completed.

The hospital had a dedicated infection prevention and control (IPC) lead that monitored compliance with IPC practices, supported by link practitioners in theatres, wards and paediatrics. The IPC lead nurse managed the annual audit of infection prevention and control (IPC) practices across surgical wards and theatres, which was used to inform an annual IPC report. The report contained specific action plans for improving IPC practices throughout the hospital. The hospital held quarterly IPC committees which reviewed performance in relation to IPC and progress against action plans.

We observed good hand hygiene practices in place across surgical wards. All staff (including non-clinical) received training in Aseptic non-touch technique (ANTT) for prevention of the spread of infection. Performance for hand hygiene was regularly audited as part of the clinical audit programme, and any areas of poor performance were flagged for improvement.

The hospital had a suitable control of substances hazardous to health (COSHH) policy and procedures in place for staff to follow. COSHH risk assessments were undertaken, and the service ensured compliance with COSHH arrangements through monitoring. For example, hazardous substances and materials were kept in secured areas only accessible by staff. The service also has a nominated COSHH lead with responsibility for ensuring processes were followed.

Waste was separated and disposed of in line with best practice guidance relating to clinical waste and sharps. Staff were well informed of local arrangements relating to clinical waste disposal and sharps bins.

The hospital had an up to date infection control policy and we observed good compliance in relation to the policy. This policy was updated regularly to reflect best practice.

There had been four incidents of surgical site infection during the reporting period. In theatres, we observed that staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and followed recommended best practice. Where a surgical site infection was identified, the IPC nurse would lead on a root cause analysis to establish if performance could be improved.

In the period between June 2018 and July 2019, the service reported one case of hospital identified Methicillin-resistant Staphylococcus aureus (MRSA), one case of Escherichia coli (E. coli), and no cases of

Clostridium difficile (C. difficile). Admissions to the surgery ward were assessed for MRSA and C. Difficile, and we saw this reflected in the patient records. Specific patients are also assessed for MSSA.

At the time of the last inspection we found the decontamination area for endoscopy and processes was not in line with the British Society of Gastroenterology (BSG) guidelines for decontamination of equipment for gastrointestinal (GI) endoscopy. Since the last inspection the hospital has reviewed practice in this area and improved the processes in line with best practice. This included new decontamination equipment and refurbishment of the endoscopy areas, which reduced the risk of contamination, and ensuring there was a sterile processing technician team available throughout the endoscopy list.

Environment and equipment

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

The surgical provision consisted of 27 inpatient beds and 16 day case rooms ('pods') on a co-located ward. Surgical facilities also included four operating theatres (three were operational at the time of inspection and were laminar flow) a level one extended recovery unit, and a separate paediatric area.

Three of the four theatres had laminar flow air filtration systems. These were mainly used for orthopaedic procedures and enabled containment and control of airflow, so reducing the risks of cross contamination and infection due to air borne organisms.

Emergency equipment such as resuscitation trolleys and crash bags were available. Staff checked resuscitation equipment daily in line with guidance from the Resuscitation Council. The hospital had introduced new emergency boxes in all departments including the boardroom, containing laminated action cards for dealing with an emergency e.g. fire, cardiac arrest. This meant that staff had access to an immediate protocol in all areas. The hospital had introduced new emergency boxes in all departments including the boardroom, containing laminated action cards for dealing with an emergency e.g. fire, cardiac arrest. This meant that staff had access to an immediate protocol in all areas.

Medical gases were securely stored and we saw evidence of quarterly air quality testing in conjunction with up to date training competencies.

Entrances to the ward and theatres were controlled by security card and visitors to the building were required to sign in. Any visitors presented to the reception area, which was manned during visiting hours.

Clinical areas contained areas for staff to wash their hands before and after delivering patient care. The communal areas on the wards and bathrooms also had hand washing stations and gel dispensers.

We observed that electrical equipment displayed the most recent electrical testing date, and any equipment we observed that required regular servicing was in date. Staff told us that the hospital was quick to address any environmental or equipment issues identified.

Since the time of the last inspection the endoscopy suite had received Joint Advisory Group (JAG) accreditation. JAG accreditation includes environmental standards for the endoscopy suite and recovery areas, which the service had met. Staff we spoke with stated they were proud to have met the requirements to meet the accreditation standards.

The hospital site had recently had a number of incidents relating to thefts and misuse of the hospital parking grounds. The hospital had put this on the risk register due to concerns from staff and issues raised by service users. To address this issue, security staff regularly checked the car park and ensured any issues were reported, there was also security cameras installed which had number plate recognition software, a barrier which shut at night and shrubs had been trimmed down for better visibility.

All Resident Medical Officers (RMOs) have access to their own room on site which they could use while off duty or on-call, with access to the restaurant and also to areas where they can prepare their own food.

The hospital participated in Patient-led assessments of the care environment (PLACE) visits. PLACE visits are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. PLACE reports were reviewed by the senior leadership team to establish areas for improvement.

Assessing and responding to patient risk

Good

Surgery

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used the national early warning scores (NEWS) system to assess and monitor risk of deterioration in patients. We saw the NEWS form used by staff to monitor any deterioration in the patient's status, and observed staff recording the NEWS scores in patient records. The paediatric service used the paediatric early warning score (PEWS) as this was more appropriate for young patients.

Surgery wards and theatres had an escalation procedure for deteriorating patients. Any patients identified as meeting an alert level NEWS score was assessed by the RMO and monitored closely. If they were at significant risk of deterioration an ambulance would be called and the patient would be taken to the nearest NHS hospital emergency department. Staff we spoke to stated that this had happened once in the last two months, and the patient had been transferred and returned to hospital without harm.

There was an alarm system for the hospital for summoning the resuscitation team, with a button in all clinical areas and bleep alarms held by the resuscitation team. We saw evidence that this was drilled each week day. We also observed there was a section in the daily huddle which confirmed which staff were part of the resuscitation team each day.

Patients at a higher risk of deterioration could be cared for in a bay closest to the nursing station, allowing faster response and more observation, and allowed for additional monitoring from staff in communal areas. The extended recovery unit area was opposite the nursing station on the surgery ward.

Management of sepsis was in accordance to the hospital's policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis trust guidance on the initial management of septic patients. The 'Sepsis Six' approach was used, and there was a sepsis pathway for patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis. We observed a sepsis trolley in place on the ward which was regularly checked.

There were three reported incidents of venous thrombo-embolism (VTE) - a medical condition where blood clots develop in the veins - within the hospital between July 2018 and June 2019. A VTE risk assessment tool was included in the hospital prescription charts that were audited monthly. Data provided by the hospital showed compliance for patients being risk assessed for VTE was 100%. On inspection we viewed patient records and they demonstrated that all patients had undergone VTE assessments on admission.

As of October 2018, the hospital had been accredited as a VTE Exemplar Centre by the Kings College National Standards committee. VTE Exemplar centres was a network of 34 healthcare sites, established by the Department of Health, to exhibit best practice and leadership in reducing avoidable death, disability, and chronic ill-health from hospital associated VTE.

Patient risk was discussed each day in the morning huddles and twice daily nursing handovers. The morning huddle provided an overview of activity (including any alterations to theatre lists) and key risks each day, and included attendance from surgery staff, as well as the heads of department. Notes from each morning huddle were typed up and shared with staff by email.

Within the theatre, we observed that staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection.

Surgery patients had access to numerous diagnostic assessments at the point of pre-assessment and for outpatient appointments following surgery. This included computerised radiography, MRI, digital mammography, fluoroscopy, and ultrasound. Staff stated that diagnosis, surgery, and follow up appointments could all be delivered at the hospital.

The hospital used the World Health Organisation (WHO) Surgical Safety Checklist to minimise the risk of incidents during surgery. We observed multiple examples of the WHO checklist in use on inspections. In all cases they followed a standardised, accurate approach that were well led and had good staff engagement.

We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes post-operatively. Staff told us compliance with the checklist

was closely monitored and monthly audits took place. Staff stated that if the check list had not been completed correctly or recorded it would be discussed with the individual staff members and discussed in team meetings.

The hospital provided evidence of surgical safety checklist audit as part of the clinical scorecard between July and September 2019, which showed a compliance of 98% across all five steps.

Nurse staffing

The service had enough nursing 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 staffing levels and skill mix, and gave agency staff a full induction.

The hospital used a provider wide nursing tool to plan skill mix required against patient activity and complexity of need. Staffing allocation was arranged seven days in advance to provide an overview and allow rotas to be rearranged if needed. Theatres used the Association of Perioperative Practice (AFPP) staffing guidelines to ensure there were adequate numbers of appropriately trained staff available for each theatre. The service met the standards set out in the guidelines.

The hospital recognised that recruitment for nursing staff was an issue. Surgery wards had a significant number of vacancies, and the service stated that despite regular recruitment drives this was a persistent issue. Senior staff stated that the area the hospital was located in, transport links, and the competition from a number of other providers were significant factors in this issue. At the time of inspection there was 16.4 wholetime equivalent (WTE) register nurses in post.

The hospital had started a number initiatives to develop their nursing workforce. This included contacting retired and speciality nurses to see if they would join the bank staff, and encouraging regular agency staff to take on permanent contracts. The hospital had also started a preceptorship programme for newly qualified staff, with a view to developing the nurses through experience and training. This included providing opportunities for development staff to join post graduate modules and accredited courses.

The hospital also had a ward sister development programme being available to both clinical and non-clinical managers. Nurses we spoke with stated there were good opportunities for development with the hospital, and that they were encouraged to grow in the roles. Since the time of the last inspection the service had internally promoted four team leaders to managerial levels.

The hospital provided evidence for the use of bank and agency nursing staff between August 2018 and July 2019 for inpatients wards. For the 12-month period bank and agency usage was between 19% and 39%. Senior staff stated that surgery wards had a staff bank that filled most shifts, and where bank staff were not used they had agency staff on fixed term contracts. Senior staff informed us that only bank staff would be used in the theatres, and this was reflected in the data provided.

The hospital's induction policy included the induction of agency staff. Agency staff underwent an induction to the unit, and senior nurses told us that where possible they used agency staff familiar with surgery wards, as this helped to maintain consistency of care. All new starters received a checklist for completion, which included familiarisation with ward practice, mandatory training, signing off competencies, and orientation.

Prior to inspection, the hospital recognised that there had been changes to the theatre nursing management following a long period of stability. Theatre staff and leadership were positive about the new theatre manager that had come into post and stated they had brought in some ideas that had improved the flow through theatres.

Staff had telephone access to a registered children's nurse for advice and support when caring for children aged 16-18 being treated on an adult pathway.

At the time of our inspection, the hospital was supporting nine apprenticeship students working in the theatres, outpatients and diagnostic imaging. Six students had completed this and were being supported to move onto degree pathways through the provider's links with national universities. Three students had achieved the Care Standards and a Level 3 National Diploma linked to the clinical areas.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep

patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

Surgical treatment at the hospital was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the hospital for many years.

There were 269 doctors and dentists employed or practicing under rules or privileges.

The hospital employed two resident medical officer (RMO). There was an RMO on the hospital site 24 hours a day, seven days a week, who liaised with the consultant and nursing teams. Each RMO worked 12 hours on duty and 12 on-call. The RMOs worked for seven days and then had seven days off.

At the time of the last inspection RMOs were hired by a third-party on to contracts with the corporate provider. All RMOs were now appointed by the hospital. In the event of a hospital RMO being unavailable, or if the on-call RMO was called in, the hospital would contact the third-party organisation to find an agency replacement.

Staff were positive about the availability of the RMOs, stating they worked well with the nursing team and were responsive when needed. Consultants stated they were confident in the skills of the RMOs.

If needed, consultants were available to be contacted by the hospital throughout their patient's stay. Consultants provided a contact name and details from either a speciality colleague, or from their base hospital, to cover them during absence. Cover arrangements were regularly reviewed biennially and through the Medical Advisory Committee (MAC) if needed. Consultants were also required to reside within 45 mins of the hospital to facilitate swift attendance if needed. RMOs we spoke to also stated they could access consultant advice and support if they needed.

The Resident Medical Officer (RMO) provided continuous medical cover and were part of regular ward rounds to ensure that all patients were appropriately treated and safe. Any changes in a patient's condition were reported to their consultant, and their advice was followed in respect of further treatment.

Anaesthetists were contactable by telephone when not on site and it remained the responsibility of the admitting consultant to make arrangements for appropriate anaesthetic cover when admitting patients. If an anaesthetist was required unexpectedly the anaesthetist involved in the patient's care would be contacted and if unavailable their cover would be contacted. In the event that neither anaesthetist was available the hospital would contact anaesthetists with practicing privileges who are on-call for their local NHS Trust.

The Medical Advisory Committee (MAC) met quarterly and reviewed matters relating to the delivery of clinical care across the hospital and new practising privilege applications from consultants. The MAC was chaired by an assigned lead, and featured representation from all surgical specialities provided by the hospital. We reviewed minutes from the last three MAC meetings and found the meetings were well attended by consultants from each clinical area.

The role of the MAC included reviewing any new applications for practicing privileges and ensuring applicants met the requirements of the role were appropriately qualified. The MAC had representation from all surgical specialities, and was also attended by the hospital director and the director of clinical services.

If consultants did not provide information that they were meeting the requirements of the role (for example, evidence of mandatory training or of professional registration), they would be suspended until the necessary evidence of competence was provided. Between August 2018 and July 19, the hospital had suspended 22 consultants with practising privileges due to lack of up to date documentation to evidence their fitness to practice.

Records

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

Patient records we reviewed were in paper form. We reviewed four patient records and found them to comprehensively completed. All records had notes of the patient care from different disciplines, treatment plans, completed risk assessments, and results of any diagnostic tests the patient had received.

On the last inspection we identified that legibility of patient records was an area for improvement. On this inspection

we identified that this was still an issue. We identified that some areas of patient records for surgery were either not legible or not recorded at all, specifically in recording the name and GMC number of the consultant in the consultation visits. This meant that in the event of any concerns or incidents, it would be difficult to identify the relevant consultant involved.

Service leads stated that there had been work undertaken to improve legibility and that this issue had been discussed in departmental and speciality meetings. On inspection, we saw communication from the director of clinical services reminding all consultants working at the hospital of the need for their notes to be legible. Staff were encouraged to order name stamps to allow them to stamp their notes with their name and GMC number as well as signing in their name.

Staff who worked with NHS patients had access to their own NHS email accounts to allow for the secure transfer of records.

Information governance was part of mandatory training for all staff. The hospital also had a medical records policy detailing the process for managing and completing patient records. We observed staff adhering to best practice in relation to information governance and storing records securely**.**

Patients' observation charts were kept by the patient's bedside in locked cabinets, and staff would record observations at regular intervals in line with best practice. Records were made available to theatre staff as necessary and we saw this reflected in the patient record. Any records being transported hospital wide were done so in sealed bags.

The nursing notes we looked at were appropriately completed; patient history, consent, allergies, medicines history and pain management pathways were routinely recorded, signed and dated.

The hospital completed medical records audits on a quarterly basis which was reported on as part of the clinical scorecard and discussed in governance meetings. The audit included standards for recording consent, care pathways, a record of appointments, discharge summaries, and MDT input. The hospital provided the evidence of the most recent records audit for June 2019, which showed over 91% compliance against their standards.

Medicines

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

The hospital pharmacy was open from 9am to 5pm Monday to Friday, and also open on Saturdays between 9am and 1pm. Outside of these hours, staff could access an on-call pharmacist through the nurse in charge.

We reviewed five medication charts and found them to be consistently and legibly completed. Staff documented information on patient allergies and patient risks as necessary in the patient record. We found that prescription charts were legible.

Medicines were administered and secured securely in accordance with the medicines management policy of the hospital.

Controlled drugs were stored and managed appropriately. Drugs were kept in lockable wall units and staff performed daily checks of the controlled drugs to ensure they were accounted for.

Medicines requiring cool storage were appropriately stored in refrigerators. Fridge temperatures, as well as the temperature in the medication room, were recorded daily.

The pharmacy service for the hospital ran an annual audit schedule. This included controlled drugs audits, medicines storage in theatres, pharmacy interventions, missed doses, antimicrobial stewardship, and medicines reconciliation, as well as dispensing turnaround times for patients being discharged.

Patients were assessed for any potential allergies to clinical equipment or medications on admission. We observed allergy assessments completed in the patient record.

For patients being discharged, medicines to take out (TTO) were delivered to the patient. The TTO stock cupboard was checked weekly by the pharmacy team so that the RMO and senior nurse were able to discharge patients promptly out of hours.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong,

staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There had been two 'never events' reported at the hospital from June 2018 to July 2019, both relating to incorrect site injections. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

We reviewed action plans for the two never events and found them to be investigated, with action plans to reduce the risk of repeat occurrence. Following this most recent never event in June 2019 these actions included introduction of a "stop before you block" mechanical deterrent prior to injection for the specialism, back to basics, challenging conversations, and human factors training for all staff and relevant consultants, limiting the amount of cases on each consultants list per day, and a competency training day on managing sedated patients.

Between June 2018 and July 2019 there were 644 clinical incidents reported in the hospital, 566 of which (88%) caused no harm. This included three that were categorised as severe harm.

An incident reporting procedure was in place and staff knew how to report an incident. Staff told us they also received feedback from incidents reported that were investigated.

The service held a daily briefing of staff and service managers from all departments to share information on incidents, concerns around transfers of patients, staffing issues and any other issues that may impact the delivery of care.

Staff were aware of the principles of duty of candour and when it would be applied. Staff also stated they felt encouraged to report incidents if they identified concerns. The incident policy reflected the hospital's requirement to be open and transparent with patients when there had been an incident and the duty of candour policy outlined the procedure by which patients would be involved or informed in the investigation process.

The hospital incident policy described the process to be followed when investigating incidents. Incidents were investigated by a nominated individual and reviewed in governance meetings locally. We reviewed serious incident reports from the last 12 months and found them to be comprehensively investigated and reviewed.

Safety Thermometer

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

The safety thermometer is a collection of data submitted by all hospitals which shows a snapshot of inpatients suffering avoidable harm, reported on one day each month. The safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE), a blood clot which starts in a vein.

Safety thermometer data was displayed on a quality and safety performance noticeboard. This displayed safety information for each month between July 2019 and September 2019. Within the timeframe the hospital reported two serious incidents, no falls, no hospital acquired pressure ulcers, and no VTEs.

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 best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Care and treatment was delivered to patients in line with National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines. Staff followed national and local guidelines and standards to ensure effective and safe care. National best practice was reflected in the policies we reviewed.

Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice.

Staff had access to the service's policies and guidelines via an intranet. Paper copies of local protocols and policies were also available to staff. All protocols and guidelines we reviewed were in date. NICE guidelines were disseminated at monthly clinical effectiveness meetings and by email to staff

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.

Surgery wards had a process to ensure patients did not eat, as appropriate, prior to undergoing a general anaesthetic. Each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The service stated patients treated as nil by mouth prior to their operation was kept to a minimum, so that patients were allowed to drink fluids.

Staff made sure patients had support with nutrition and hydration to meet their needs. Any patients that had specific dietary needs would be identified at pre-assessment for surgery, and catering staff could then prepare accordingly. Staff told us although there was not a dedicated ward dietician, a dietician was available to provide advice and support if needed.

The hospital complied with national guidance that patient should receive clear fluids up to 2 hours before surgery and food up to 6 hours. Hydration scores were audited quarterly and the latest quarterly result (July to September 2019) showing this was achieved for 84% of patients.

We reviewed patient records on inspection and found that the nutritional needs of patients was monitored using the Malnutritional Screening Tool (MUST), or a paediatric screening tool for young people.

We observed patients and visitors to the wards being offered refreshments by staff. Patients were positive about the quality of the food provided, and the most recent monthly feedback (from July 2019) showed 87% positive feedback from patients. This was 15% above the average for other hospitals in the same group.

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 pain relief to ease pain.

We observed staff on the wards discussing pain management with patients. Patients stated that they felt their pain relief was discussed as part of their care, and we saw this reflected in the patient record.

Surgery wards used a pain management assessment pathway for staff to identify the correct action to assess the patients need for pain relief. The assessment pathway was accompanied by a pain scale, which used a picture assessment tool for patients with communication difficulties. The tool also reminded staff to check for pain that may be an indicator of clinical risk, such as neuropathic pain.

The hospital had a senior lead nurse with responsibility for pain management care for surgery patients. The pain nurse had completed specific pain management training (as part of a Florence Nightingale Scholarship) in Australia and was involved in research at the hospital relating to pain management. Staff we spoke with stated that the expertise was useful to have for advice and support, and that the pain management nurse also provided training to improve staff skills and awareness. If this nurse was not available, pain management could be provided and administered by the available RMO.

The hospital had a number of audits underway to ensure performance related to pain management was regularly reviewed. Pain scores were audited quarterly, and the patient survey asked patients how their pain was managed throughout their stay. Data provided by the provider from July 2019 showed that 96% of patients responded 'a great deal' to their pain being managed.

A recent review in 2018 looked at the current provision of anaesthetic practitioners undertaking the role of sedationist. It was established that further education and training was required for this role due to increased patients with complex co-morbidities. To support this, the hospital developed a training curriculum (underpinned by guidance from the Royal College of Anaesthetists, Nursing and Midwifery Council (NMC), The Health and Care Professions Council (HCPC), with a view to improving the skills of staff taking on the sedationist role.

Good

Surgery

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 hospital had recorded outcomes and processes in relation to hip and knee replacement procedures. Outcomes were benchmarked against nationally recognised programmes.

Patient Reported Outcome Measures (PROMs) are standardised validated question sets to measure patients' perception of health and functional status and their health-related quality of life. The hospital invited all patients (private and NHS) who had undergone hip or knee replacement surgery to complete a PROMs questionnaire. Data provided by the hospital showed that between 31% and 25% had completed a PROMs questionnaire in the last six months (this improved further to 43% in Q3 2019.). We were not provided the results of the questionnaires.

Information on comparative outcomes by clinicians for orthopaedic specialities was reviewed on the National Joint Registry (NJR) website (available through the NHS Choices website). We saw named consultants with practising privileges at Spire London East with indications of their outcomes as being within the expected range. The hospital was also part of the Private Healthcare Information Network (PHIN), which published information on independent health providers to help patients make treatment choices.

Patient outcomes and hospital performance were monitored through local clinical governance meetings as well as joint meetings for clinical leads from the corporate provider. Where issues of performance or areas for improvement were identified the hospital would put actions plans in place to improve. Performance in relation to actions plans was monitored by the service and speciality leads and reported on through the quality and safety meetings.

The Clinical Scorecard was used to review performance against externally and internally set quality standards. Compliance targets were set for each measure and this information was shared quarterly via the Quality report.

The service conducted a regular programme of audits to evaluate the quality of care being received by patients. The results were reviewed in regular quality and safety meetings, and changes to service delivery were planned as necessary. The audit programme included benchmarking against other sites within the corporate provider (39 sites nationally), and externally on national audit programmes. We were not provided with the outcomes of the audits, however, the leadership team told us they were generally positive. Where outcomes were not to the required standard, action plans were put in place and a further audit held to assess the impact of the action plans.

Information provided by the hospital showed that there had been eight cases of unplanned returns to theatre between July 2018 and June 2019, compared to nine at time of the last inspection. In addition, there had been six unplanned readmissions to the hospital within 28 days of discharge, compared to 16 at the time of the last inspection.

The hospital provided data on the cancelled procedures for the hospital within the reporting period. In the last 12 months, July 2018 to June 2019, there had been 25 cancelled procedures for a non-clinical reason. Of the above cancelled procedures, 100% of patients were offered another appointment within 28 days of the cancelled appointment.

Since the time of the last inspection, the hospital had begun participating in the North East London critical care network. The network brought together service leads from critical care services across the patch to look at areas of joint working and discuss performance. The hospital was involved with a view to expanding the enhanced recovery unit, while also to discuss how the surgery provision could alleviate system pressures across North East London.

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.

All staff received a local and corporate induction. Staff completed an induction and competency checklist when they first started which covered use of equipment, using

the service's systems, departmental understanding, and clinical competency skills relevant to their job role and experience. Competencies were then signed off by the clinical and nursing leads.

Staff were required to provide evidence of their registration with the regulated body of their profession. We saw evidence of staff registration with the Health and Care Professions Council (HCPC) and General Medical Council (GMC). Staff were required as part of their employment to ensure they retained their registration and revalidated when it came close to expiry. In the last twelve months 100% of consultants were required to provide this evidence, while 38% of nurses had completed their revalidation in the same time period, the reason for the lower number for nurses was on account of their revalidation taking place every three years.

Staff told us that they received an annual appraisal and found it useful discussing their development goals. Data submitted by the hospital showed that, as of September 2019, at least 95% of inpatient nursing staff and healthcare assistants, including surgical staff, had received an appraisal.

The service had a practice development lead nurse (PDN) in post with responsibility for monitoring mandatory training, ensuring staff competencies, and supporting staff development. The PDN ran regular training sessions for ward staff, often in collaboration with consultants on specific topics. Staff told us they were positive about the support and involvement of the PDN.

Multidisciplinary working

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

The surgical provision included the input of dedicated surgical consultants, RMOs, anaesthetists, nursing staff (ward and theatre), physiotherapy, as well as allied health professionals, such as dietitians, on referral. Staff stated they had good working relationship as a surgical team and across disciplines. Staff stated they worked well together collaboratively, and this was supported by effective and supportive management.

Care planning took place at pre-assessment with input from the multidisciplinary team, there was involvement from members of the team including doctors, nurses and allied healthcare professionals as needed.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. There was a daily MDT safety team meeting on the surgery ward at 8:30am, followed by a hospital wide daily huddle at 10am. While on inspection we attended a daily huddle for staff across the hospital and found it well attended by staff from all disciplines.

There was a service level agreement in place with a local NHS Trust for transfer arrangements should a patient's condition deteriorate, and they require additional care following a surgical procedure. The hospital resuscitation team on each shift was also multidisciplinary.

The hospital ran a multidisciplinary "joint school" on a fortnightly basis, which provided opportunity for patients to ask questions and learn more about the process prior to being admitted for surgery. The joint school included talks from surgeons, the surgery ward manager, and physiotherapists. Patients who had attended the joint school stated they found it to be reassuring and a good opportunity to ask questions of staff before being admitted.

Seven-day services

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

There was a resident medical officer (RMO) on the surgery ward 24 hours a day, seven days a week, who worked closely with the nursing teams and communicated with consultants if there were concerns.

Theatres were open for use between 7:30am and 8:30pm Monday to Friday, with an additional list every Saturday. The endoscopy suite operated the 8am to 6pm Monday to Saturdays. Staff we spoke with did not raise any concerns regarding the availability of theatre slots for patients.

Surgical wards had access to pharmacy input Monday to Friday 9am to 5pm, and Saturdays between 9am and 1pm. Staff could access support from an out of hours pharmacy if needed.

The ward had dedicated physiotherapy time between 9am and 5pm Monday to Friday. Additional support was available from the hospital physiotherapy department, which was open Monday to Fridays 7.30am to 9pm, and on Saturdays between 7.30am and 1pm.

Health promotion

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

On inspection we saw leaflets that included advice on health promotion for all patients. This included advice on diet and nutrition, smoking cessation, wound management, and warning signs of acute illness. Information leaflets on potential clinical risks such as sepsis and diabetes were also publicly displayed.

Hospital staff provided advice to patients on managing their care after discharge. We observed staff on the wards from different disciplines advising patients on how to maintain their recovery after they had left the hospital, and this was reflected in patient records. Staff also encouraged patients to contact the ward if they had any questions.

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 patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

The hospital had policies in place for the process to obtain informed consent, and for the management of patients under MCA and DoLS.

At the time of the last inspection, we found some consent forms were unsigned so could not clearly show confirmation of consent. On this inspection we found staff clearly recorded consent to surgery to treatment in the patients' records as necessary. Patient records that we reviewed clearly showed consent discussed and record at the surgery pre-assessment meetings, and on the day of the surgery.

Staff made sure patients consented to treatment based on all the information available. Staff told us that where patients did not speak English (for many international patients) they would not use family members to interpret on the patient's behalf and would instead arrange an interpreter.

Patients were provided with information leaflets by the hospital to read both from pre-assessment and on admission to hospital. The hospital had a number of information leaflets for each type of surgical intervention (or endoscopy) that they delivered, which was provided to the patient to help inform consent. Patients and family members stated that consent had formed part of the pre-surgery process.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of their responsibilities to patient consent, including in relation to the MCA and DoLS. All staff completed a mandatory training module regarding consent. The director of clinical services ran regular pop up sessions with staff to discuss MCA and DoLS.

Staff had a clear understanding of the consent process for children, including obtaining parental or legal guardian's consent and an understanding of Gillick competence, whereby children under the age of sixteen can be considered competent to consent independently to specific treatment.

Are surgery services caring?

Outstanding ☆

Our rating of caring improved. We rated it as **outstanding.**

Compassionate care

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

During the inspection we saw staff on the surgery ward treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles and any care they delivered to patients during their interactions. Care that we observed was patient centred.

We spoke with five patients on the surgical ward during the inspection, and three family members, including one parent of a patient under 18 (who was treated in the

paediatric area). Patients and family members spoke very positively about the care they received, and how they were treated by the staff on the wards. Patients told us staff were respectful of families and parents stated they were provided them with opportunities to ask questions about the care of their children.

The hospital provided evidence of thank you cards from patients who had stayed on the unit (including from children). Cards were normally displayed in some of the communal areas of surgery wards. Comments in these cards included: "I wanted to thank you for all the care you have given", "you were very kind and considerate, and it made a big difference to my stay" and "from the nurses to the porters to the chefs it was excellent".

We saw that patient's privacy and dignity was maintained whilst they were on the surgery ward and in theatres. Each patient had access to their own room, so follow-up care was delivered privately, and staff communicated with the patient well. Patients were taken to theatres discreetly and with a chaperone as appropriate.

Parents could accompany their child to the anaesthetics area before the patient proceeded to theatres. This was meant to alleviate some of the anxiety prior to surgery for both the child and their family. The paediatric area was in close proximity to the surgical theatres, meaning children did not have to pass through the adult surgery ward.

The hospital collected feedback from patients using a patient satisfaction survey. Survey results were reviewed monthly and benchmarked against other hospitals under the management of the overall provider. The survey asked people who use services whether they would recommend the services they have used. We saw feedback leaflets on the ward and also on the website, if they had any further comments.

The hospital provided patient satisfaction survey data, which showed that from February 2019 to July 2019, the average number of patients and family members who would recommend the service was 94%. The response rate for this period was between 16% and 20%.

The surgery ward we saw "you said we did" boards. These boards identified feedback that had been received from service users, and changes that the wards had made based on this information. Each patient room, including paediatrics, also had a "what matters to me" wipe boards, so patients could identify immediate feedback or preferences on the ward.

Emotional support

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

Staff understood the impact that patients' care, treatment and condition had on wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the interactions we observed. Patients we spoke with stated that care was patient centred and included time to assure the patient about any concerns they had.

Surgery wards had access to a patient concierge, who could provide patient centred and individual support as needed. Staff were able to provide numerous examples of input from the patient concierge that improved the experience of patients using the service. Cards advertising the availability and contact information of the patient concierge were visible in each room.

Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care. The hospital also had dignity champions appointed across the hospital to provide enhanced person-centred care.

Staff told us that they regularly assessed the patient's physical and emotional welfare and made referrals to the appropriate professionals when needed.

Understanding and involvement of patients and those close to them

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

Family members of patients were positive about the care the patients received and stated that staff members were professional and welcoming. Family members also stated they were kept well informed of treatment plans and were included in conversations about treatment as necessary.

There was evidence of discussions of patient care with those close to them in the patient records.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

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

The hospital provided surgical care to both private patients and to NHS patients within the local area. Staff and patients, we spoke to stated that the patient experience of private and NHS patients in regard to care was the same.

There was clear signage inside the main hospital building, which meant it was straightforward for visitors to locate the surgery wards.

The provider's website provided useful information about the service, procedures that were provided, payment options, and the referral process.

In communal areas and throughout the surgery ward there was a range of information for patients and family members to access specialist support and advice. This included for emotional and spiritual support, specialist health and social care input, and signposting to support charities. The surgery ward also had produced a comprehensive suite of public information leaflets, a pack of which was provided to patients (and family members) when they were admitted.

The service hosted a monthly bereavement support group on site, which was open to anyone who wished to attend. The group was hosted by a local bereavement support team to provide advice and peer support after the death of a loved one.

In the last twelve months the service had completed an independent review of the facilities for visitors with a disability. The report examined the hospital environment including communal areas, pre-assessment areas, imaging, wards, and theatres. The report identified areas for development including improving the accessibility of bathrooms, the layout of shower facilities, and hand rails in the imaging department. On inspection we observed that these changes had been implemented.

The hospital had nominated leads for areas of high clinical risk within healthcare, with a view to developing plans to mitigate the potential for incidents to occur. Nominated leads included a dementia lead, a diabetes champion, VTE lead, falls champion, pain lead, tissue viability lead, and a manual handling lead.

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 service visiting hours were 10am to 8:30pm every day of the week. Staff told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours. Visiting times were clearly displayed on the ward.

Surgery wards provided food that catered to dietary requirements and cultural preferences. Patients told us they were happy with the quality of the food that they received.

Staff were aware of how to access translation if patients or families were unable to communicate in English. Some staff stated they spoke other languages so could offer some translation, however also stated that they would use interpreters where appropriate, particularly for patients consenting to treatment. We saw information displayed around surgical wards in other languages, and patients were informed they could request information in their preferred language as needed.

Staff understood the information and communication needs of patients with a disability or sensory loss. A hearing loop was available for patients who were deaf or hearing impaired. Staff told us that patients with any communication difficulties would be provided with additional support, and that this had been facilitated for previous patients.

Some hospital staff had completed a qualification course in introductory British Sign Language, which allowed them to provide support for deaf patients and visitors. Staff stated

that this initiative allowed them to provide more individual care to patients that were deaf. The hospital was also producing a video in sign language to provide pre-appointment information to patients.

Information was provided in accessible ways for patients and their families, including for young children and adolescents. For example, information leaflets on anaesthetics was provided by the Royal College of Anaesthesiologists, with different levels for young children (including one to be read by parents), adolescent patients, parents, and adult patients.

Surgical wards took steps to ensure that young people and their families were supported during their visit. Families could visit the paediatric ward area prior to their surgery to ask any questions and alleviate anxiety, and a parent could accompany their child to the induction room until their anaesthesia was given.

Since the last inspection, the service had developed a specific paediatric waiting area for young patients to wait with their families. This space included activities and was available for follow up appointments as well as family members visiting surgical patients.

Surgical wards and theatres had a specific strategy in place to manage patients with a diagnosis of dementia. Surgical wards had dementia champions who provided support to patients, such as one to one nursing, as well as information to families. Any patients with a diagnosis of dementia was identified as such on the patient information board and in the rooms.

Since the time of the last inspection the service had improved the ward environment for patients with dementia. Bathrooms in each room were now clearly identified by colour coding and signage, in line with best practice. The ward had also improved the visibility of hand rails to improve the environmental support for patients with mobility issues.

There was a learning disabilities lead nurse within the hospital who provided support, advice and training for staff caring for patients with learning disabilities. At our last inspection, there was no clearly defined patient pathway for patients with a learning disability and staff told us that they often had little notice that a patient with a learning disability would be attending the service. At this inspection, we saw examples of patient pathways for this cohort. Staff told us how they would adapt their practice to meet the needs of these patients. They said that generally, where patients had learning disabilities, this would be identified in their notes which would be available to them prior to the start of a shift. In addition, this would be flagged at the morning safety huddle.

Access and flow

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

The hospital ran an appointment system which was supported by the booking team, and allowed patients to choose pre-assessment appointments and surgery times that suited them. Patients had the option of direct booking online if they were private patients. Patients also had full choice of consultant and were treated under the care of the same consultant throughout their full pathway to ensure continuity of care.

The hospital saw a mix of private and NHS patients. Staff we spoke with stated there was no difference in the clinical services or expertise available to either private or NHS patients. At the time of inspection the hospital activity was approximately 42% NHS and 58% private.

All patients attended a pre-assessment clinical to establish suitability for surgery at the hospital and identify any areas of complexity in their cases. Pre-assessment clinics were provided by the surgical consultant and any areas of concern were identified using the risk assessment proforma, and recorded for future use.

All children who attend pre-assessment prior to admission had a plan of action implemented to see if the child has any specific needs or requirements. Young people and parents were able to visit the paediatric areas to alleviate some of the anxiety of visiting the hospital. Patients aged 16 to 17 year were risk assessed for their relevant pathway to see if they were more suitable to be treated as children or in the adult environment.

The surgical provision consisted of 27 inpatient beds and 16 day case rooms ('pods') on a co-located ward. Surgical facilities also included four operating theatres (three were operational at the time of inspection and were laminar

flow) a level one extended recovery unit, and a separate paediatric area. 27 beds in total which are used for both inpatient and day case. This includes two extended recovery beds.

The recovery area had a designated recovery bed for young people, so that they were segregated from older patients. The paediatric recovery space had been decorated to accommodate young patients.

The patients were prepared for their operation or procedure in their private bedroom and waited there to be escorted to theatre, after their procedure they were transferred to the recovery room to recover and ensure they were stable and pain free. Then they were collected and taken to either the day surgery unit and discharged home or returned to a room on the ward for overnight stay.

The hospital provided data on the use of theatres during operational hours in the last twelve months. During the reporting period (July 2019 to October 2019), surgical theatres were in use between 40% and 48% of the time. Senior staff recognised that this was a lower level of activity than the hospital would like and that the clinical strategy was to increase the use of theatres in the coming years.

The hospital had a pathway in place for patients that had their surgery cancelled on the day, and had introduced steps to minimise the risk of this happening. These steps included daily discussions of lists in theatres and confirmation of what is needed ahead of time, ward safety briefings, and the safety huddle. Any cancellations, including on the day, were discussed as a regular agenda item at weekly operational senior leadership and speciality meetings, with the data also examined at the clinical governance meetings.

Surgeons and Anaesthetists reviewed patients on the day of surgery and also following surgery. This allowed consultants to inform the patients of how their surgery went, review their recovery, and prepare their discharge arrangements. Patients told us that they were required to confirm that they had somebody at home to support their care before they could be discharged.

Patients were seen by the RMO and consultant before discharge could be completed and signed off. Results of the treatment were communicated to the patients' GP and other healthcare providers as necessary. Discharge summaries also reflected input from other MDT staff as needed, such as physiotherapy.

There were adequate discharge arrangements in place with patients provided with contact details of who should be contacted should any problems occur. Patients stated that they would contact the ward if they had any concerns, and some patients who had done so stated they received a quick reply from their consultants.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Staff stated they would aim to resolve any patient complaints and concerns immediately. Staff were all aware of the complaints procedure and who had overall responsibility for managing the complaints process.

There was a complaint management policy in place. The complaints policy differentiated between formal and informal complaints, with defined timescales for the provider to acknowledge and respond to formal complaints (acknowledged within three working days, fully responded to within 20 working days). The complaints policy also included reference to the service's responsibilities to duty of candour.

Any patient making a complaint was invited as part of the complaint acknowledgement letter to come into the hospital and meet the senior management team, with a view to being involved in resolving their concern.

The hospital had a dedicated complaints handler in post who ensured complaints were investigated and closed in a timely manner, and who ensured complainants were kept updated at each stage of the process via phone or email

We observed signs on surgery wards advising patients and visitors how to make a complaint. Complaints posters were also displayed in different languages. Patients we spoke with were confident they would be supported to make a complaint if needed and knew how to make a complaint.

Any complaints were discussed as part of the daily morning huddle to inform staff. Complaints were further reviewed at the weekly senior management and departmental meetings, as well as in other governance meetings. There was also a weekly complaints resolution meeting, which monitored the progress of complaints responses in relation to deadlines. All final responses were reviewed and signed off by the Hospital Director.

Good

Surgery

Patients had access to a local complaints process, or could escalate the complaint with the overall corporate provider. The complaints process included information about external independent adjudication services such as the Independent Sector Complaints Adjudication Service (ISCAS).

From August 2018 to July 2019 the hospital received 77 complaints, which included for surgery. The service examined these complaints through the formal complaint's procedure, and they were resolved without need for referral to ISCAS, the PHSO, or other independent adjudication. These complaints were investigated by an assigned member of staff, and we saw evidence of complaints and outcomes discussed in team meetings.

The service was signed up to the ISCAS code and subscribed to the service which included provision of mediation between the hospital and the patient should this be required to help solve more complex complaints.

Are surgery services well-led?

Good

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

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Surgery at Spire London East had a clear management structure in place. Responsibility for surgery came under the director of clinical services, with local management provided by a pre-assessment lead, a paediatric services manager (also deputy matron), a surgery ward manager, and a theatre manager.

Staff we spoke with stated that the divisional leadership was visible on the wards and were approachable to all staff, operating an "open door" policy. We observed ward and theatre staff interacting well with the surgery leadership during the inspection.

Ward level nursing leadership was provided by a ward manager who managed the co-located areas of the surgery ward and day cases area. The surgery ward manager was also supported by a deputy manager. Staff stated that the manager was supportive to staff, and they felt they could bring any concerns to her if needed.

Staff knew the management arrangements and their specific roles and responsibilities. Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management. The nursing and medical leadership teams worked closely together to plan and deliver care. Staff from both disciplines were positive about the working relationship on the ward.

The daily medical presence on the ward was provided by a resident medical officer (RMO), who stated they were supported by the consultants surgeons and could access them if they needed to. Consultants we spoke with were also positive about the skills and experience of the RMOs.

Medical leadership was managed through the Medical Advisory Committee (MAC), which was chaired by the medical lead and attended by Hospital Director and director of clinical services, and had representation from consultants from each major surgical speciality.

Vision and strategy

The service had a vision for what it wanted to achieve or workable plans to turn it into action.

The Hospital had a clear vision and strategic goals, which was aligned to the Spire Healthcare corporate national strategy. The hospital had developed a clinical strategic plan started in 2017 and running until 2020 with defined goals for the development of the service. The strategy at the time of development also included input from staff.

The clinical strategy contained six main streams aligned to hospital business objectives and national clinical priorities. These were to develop strong clinical leadership, a focus on outcomes and key performance indicators (KPIs), enhancing the safety culture of the organisation, monitoring patient experience, developing hospital staff, and introducing a single patient record.

We reviewed the clinical strategy and found it reflected the goals of the surgery provision provided by the hospital. The service had also developed some short information leaflets for frontline staff to inform them of the strategic goals of the hospital.

The paediatric services delivered at the hospital had also introduced strategic goals for their service, which were currently in development. This included introducing speciality services for young people with a diagnosis of an autism spectrum disorders.

Staff told us that they were generally aware of the vision and strategy for the service, and that they would be kept informed on developments and consulted about any changes. We reviewed department and speciality meeting minutes on inspection and found they reflected discussion of future objectives.

As part of the hospital's clinical strategy it had commenced on a programme aligned to the American Association of Nurses, MAGNET which included components on Transformational Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge, Innovation, Improvements and Empirical Quality Results.

Culture

Managers across the service promoted a positive culture.

Staff we spoke with told us that there was a no blame culture, and that they felt valued and respected. We found that a positive working culture was embedded in the unit, and this was encouraged by supportive and available leadership.

There was evidence of staff and teams working collaboratively to deliver good quality of care. We observed one of the daily safety huddles during the inspection (which was minuted and shared with all staff each day), and found this to encourage contributions from all staff attending.

Staff were proud of the work they carried out. Staff stated they enjoyed working at the service and were enthusiastic about the care and services they provided for patients.

Staff demonstrated awareness of the corporate values and information on these values was displayed on the surgical ward and throughout the hospital. Staff stated that the Spire values were embedded well in the delivery of care.

Staff we spoke with felt they were encouraged to challenge any behaviours that did not meet the standards of practice set by the hospital. Staff stated that they felt they could challenge consultants on their practices, and were encouraged by management to do so.

The contribution of staff was recognised through an awards system for excellence in their roles. Staff could be nominated monthly to achieve an award from the hospital, which was then possible to go further to win a provider wide recognition award.

Governance

The service systemically improved service quality and safeguarded high standards creating an environment for excellent clinical care to flourish

Surgery wards had a clear governance structure in place. The director of clinical services led a team of speciality nurses and was supported by a clinical governance and risk manager. The director of clinical services reported into the Hospital Director.

There was a robust corporate governance framework in place which oversaw service delivery and quality of care. This included a monthly governance meetings which included attendance from key surgery staff, as well as senior management team meetings which also looked at risks and performance. Oversight of governance for the service was managed by a hospital wide quality and risk manager.

We saw records of the last four clinical governance committee minutes and saw they discussed safeguarding, regulatory updates, the clinical scorecard, incidents, audits, training, reports from subcommittees, and any other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the team meetings. The meetings were minuted for dissemination to other staff who were not able to attend.

Patient morbidity and mortality was also discussed as part of clinical governance committees. As the hospital did not have frequent deaths of patients using the service, staff stated that serious incidents would be discussed with a view to providing learning from them. We saw this reflected in the clinical governance minutes we viewed. The hospital participated in the National Confidential Enquiry Patient Outcome and Death (NCEPOD) audit process as part of the MAC.

The service had effective systems to monitor the quality and safety of surgery. The use of audits, risk assessments, quality indicators and recording of information related to the service performance was to a high standard. The service compiled this data along with Key Performance

Indicators (KPIs) into a quarterly clinical scorecard, which was discussed at clinical governance meetings and senior management team meetings. Action plans were developed to address areas of poor performance, and reports on the progress of action plans were fed back to the committees.

The provider disseminated information to staff in team meetings or through email. These included minutes of meetings, updated or new policies, changes in legislation or best practice, and service developments.

Staff were clear about the governance structure in the organisation and stated they were confident the systems in place supported the delivery of clinical care.

The Medical Advisory Committee (MAC) met quarterly and reviewed matters relating to the delivery of clinical care across the hospital and new practising privilege applications from consultants. The MAC was chaired by an appointed lead, and featured representation from all surgical specialities provided by the hospital. We reviewed minutes from the last three MAC meetings and found the meetings were well attended by consultants from each clinical area.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

The hospital had a local risk register which included risks relating to surgery. We reviewed this register and found consistent evidence of action plans put in place to control or eliminate the risks and saw that action plans and risks were reviewed regularly.

There were risks on the risk register that related to the provision of surgery at the hospital. The key risks were identified as the potential for incorrect recording of left/ right side for operation, adherence to the WHO checklist '5 steps to safer surgery' in theatres, risk of crime on the hospital grounds, risk caused by having multiple patient records, and risk to staffing. We reviewed the mitigating actions in place and found them to be sufficient to minimise the risk.

The hospital had a risk management policy which outlined the quality management system for managers across the hospital. The hospital had systems to monitor performance, including incidents reporting, clinical governance meetings, patient feedback, audits and staff appraisals. Performance was compared locally but also compared to other services owned by the corporate provider. These systems highlighted areas of good practice as well as opportunities for learning.

Staff we spoke with aware of the key risks to the hospital. The key risks were reinforced to staff through team meetings, in the daily briefing huddle, and was on displayed on noticeboards.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security systems.

The hospital produced a monthly newsletter for dissemination to staff on upcoming meetings and relevant dates, feedback from parents, performance issues, top risks for the wards, and recognition of staff contribution. The paediatric services manager also produced a newsletter for their services every two months.

All surgery staff demonstrated they could locate and access relevant information and patient records easily, which enabled them to carry out their roles.

Information on policies, news relating to the service, and access to e-learning and hospital guidelines, was available through the provider's intranet site. We observed that staff were able to navigate around the intranet and locate what information they needed.

Senior staff informed us they were General Data Protection Regulation (GDPR) compliant and that patient information was managed in line with data protection guidelines and legislation. On inspection we observed staff compliance with information governance guidance.

Senior staff monitored performance data to assess and improve performance within the service. The service was benchmarked against other similar services within the Spire group.

The service adhered to NHS England's Accessible Information Standard. This was a legal requirement for services to identify, record, flag, share and meet the information and communication needs of patients and other groups with disability, impairment or sensory loss.

Engagement

Good

Surgery

The service engaged with patients and staff to plan the delivery of services.

The hospital had a regular patient experience committee which discussed feedback from patients and how to improve the patient journey, which included discussions regarding surgery. The hospital also had input from patient ambassadors, who were patients that had used the service in the past and now provided feedback and advice to hospital leadership.

Patient satisfaction was measured by a hospital survey of patients and their family members. Results from the patient satisfaction survey were displayed in public areas and were discussed in local and hospital wide meetings. We saw leaflets in each patient room advertising the survey.

Surgery staff held daily team huddles, weekly team meetings, and both speciality and governance meetings on a monthly basis. Staff were informed in these meetings about changes to service delivery, areas of shared learning, and any quality or safety issues. These meetings were minuted for those unable to attend. Staff we spoke to were well informed on issues relating to the service.

Staff were engaged through the annual staff engagement survey, which provided an opportunity to discuss the experience of working at the hospital. Senior staff were positive about the feedback from the 2019 survey, which stated Spire London East was the 2nd highest performing hospital for staff satisfaction in the Spire group (39 hospitals total). Staff also had opportunities to provide direct feedback to the executive team through the leadership forums.

Staff we spoke with stated they were consulted on changes to service delivery. For example, staff stated that their input had been sought in relation to the development of the clinical strategy in 2017, and that the hospital had posters displayed and sent emails to remind staff of engagement meetings.

The corporate provider had introduced the Freedom to Speak Up Guardian roles across all hospital sites. The role here was provided by the paediatrics services manager and offered staff a confidential route to raising concerns. Staff we spoke with were aware of the role of the guardian and stated it was a useful resource to have in place.

The Freedom to Speak Up Guardian for the service had been proactive in advertising the role to staff when it was introduced. The guardian provided contact cards to staff, had posters displayed in communal areas, and ran events in October for Speak Up Month, led by the National Guardian's Office (NGO). The guardian also provided statistics to managers for the service on how many contacts they had each month and would raise any concerns in hospital meetings if needed.

The hospital was supporting local GP surgeries with basic life support training for staff free of charge after this key user group identified a training gap in the local area. Additional training, health promotion events and CPD events were also regularly delivered for GPs in response to their identified needs, supported by consultants.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

As of October 2018, the hospital had been accredited as a VTE Exemplar Centre by the Kings College National Standards committee. VTE Exemplar centres was a network of 34 healthcare sites, established by the Department of Health, to exhibit best practice and leadership in reducing avoidable death, disability, and chronic ill-health from hospital associated VTE. As part of this the hospital had also trained 60 VTE champions in preventative measures.

The hospital was an advanced life support (ALS) accredited training site, as awarded by the Resuscitation Council (UK).

The theatre equipment register programme had been recognised as a provider wide area of best practice, for which the responsible staff had won a Spire award. The programme allowed staff to better monitor the suitability of equipment and need for maintenance.

The hospital had a nurse with responsibility for pain management care for surgery patients. The pain nurse had completed specific pain management training (as part of a Florence Nightingale Scholarship) in Australia and was involved in research at the hospital relating to pain management. Staff we spoke with stated that the expertise was useful to have for advice and support, and that the pain management nurse also provided training to improve staff skills and awareness. If this nurse was not available, pain management could be provided and administered by the available RMO.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients 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.

Managers monitored mandatory training completion rates via an electronic system. Reminders were sent to individual staff members when training needed to be completed.

Mandatory training was provided in respect of anti-bribery, compassion in practice, equality and diversity, fire safety, health and safety, infection control, information governance, manual handling, safeguarding adults level 2 and safeguarding children level 2.

In outpatients, there was a compliance rate of 100% in all modules, except for manual handling, where the rate was 97%. In physiotherapy, the compliance rate was 96% in all modules except for information governance and safeguarding adults level 2 which were at 93%.

Bank and agency staff who worked in the department were required to produce certificates to demonstrate they had completed the mandatory training. Bank staff in physiotherapy had access to the same online mandatory training as permanent staff members.

Safeguarding

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

There were hospital-wide safeguarding leads for adults and children, who were identified on posters throughout the hospital. Staff told us that the safeguarding leads were readily accessible for advice and support.

Staff understood their responsibility to safeguard patients. They said that they could seek advice and guidance from the adult and children's safeguarding leads within the hospital. In the event that they identified a potential safeguarding issue, staff escalated this to the outpatients manager. Some of the staff we spoke with were able to describe safeguarding concerns they had raised. Where safeguarding concerns were raised, this was documented in the patient's notes via a sticker, so that future staff would be aware of the issue.

The service had safeguarding policies in place to keep both vulnerable children and adults safe from harm and abuse. If staff had safeguarding concerns these were communicated to the relevant staff.

The safeguarding leads said they had good working relationships with the local authority safeguarding teams in the area.

Cleanliness, infection control and hygiene

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

There was a provider-wide policy for infection prevention and control. Staff were aware of this policy and were able

to access it via the intranet and in a folder in the staff canteen. In addition, we had sight of the hospital's local Annual Infection Prevention and Control Plan 2019, which detailed training and audit plans for the year.

In the reporting period, there were no incidents of healthcare associated infections in outpatients.

All staff were bare below the elbows in clinical areas, in line with best practice. Staff used advanced personal protection equipment (PPE) such as disposable gloves and aprons where appropriate.

Alcohol hand gel hand sanitiser dispensers were in place throughout the department. These were accompanied by signs encouraging staff, patients and visitors to use them. There were hand-washing sinks in each of the clinic rooms and in the dirty utility room. At the last inspection, it was highlighted that the sink in the dirty utility room did not have hands-free taps. This had been addressed.

At the last inspection, we identified infection prevention and control risks including carpeted floors and visible dust and stains on floors. During this inspection, the carpets had been removed in all the clinical areas and the department appeared visibly clean. We observed housekeeping staff carrying out cleaning rounds. There were cleaning schedules in each of the clinical areas which were signed and dated. Staff used green "I am clean" stickers to indicate when a piece of equipment had been cleaned.

At our last inspection, the dirty utility area in outpatients was not clearly labelled, which created a risk of staff entering the room in error. This had been addressed and there was a sign and a coded lock on the door.

Surgical instruments used in minor procedures in the outpatients' treatment room were supplied and decontaminated by the hospital on site central sterile supply department. Staff told us they were satisfied with the instrument sterilisation service, in addition, they said that the surgical kits were always complete.

There were sharps bins in the clinical areas for the safe disposal of sharps. The bins were appropriately signed and dated and were not filled over the fill level. There were separate bins for clinical and non-clinical waste.

The hospital matron was the hospital-wide director of infection prevention and control. She was supported in this by an IPC lead and link nurses across the service. The link nurses carried out regular hand hygiene audits within the department. This was supported by a weekly hand hygiene questionnaire supported by staff as well as quarterly observations of hand hygiene practice by the IPC link nurses. Staff that were non-compliant were provided with individual feedback.

In addition, there were IPC annual audits in respect of uniform policy, asepsis, standard precautions, bi-annual housekeeping audits and a weekly audit of sharps disposal. Where the audits identified a gap, an action plan was put in place. We were not provided with the results of the audits, however, the leadership team reported that they were positive.

We had sight of the minutes of the quarterly hospital-wide IPC meeting minutes. The meeting was well attended and included action plans in response to previous audits and concerns.

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 department was uncluttered and well maintained. Patient waiting areas were visibly clean with sufficient seating for patients and their relatives. There was a specifically designed paediatric patient waiting room, which had been decorated appropriately and included toys and a soft-close door with non-trap hinges.

Large electronic equipment was maintained and serviced by the suppliers, and there were clear records of when this had been completed. We were shown evidence that the equipment maintained by the provider themselves was regularly maintained and replaced.

At our last inspection, there had been carpets in the waiting areas and consultation rooms, presenting an infection control risk. This had been addressed and all floors were appropriately surfaced and sealed.

Disposable curtains were used within the consultation rooms that were replaced in line with hospital policy. All curtains we checked were within date.

There were daily cleaning schedules in each of the consultation rooms which had been completed and signed.

There was a resuscitation trolley in the outpatients department. The trolley was appropriately stocked and staff were aware of its whereabouts. Staff checked the trolley stock daily and signed to say they had done so. The trolley was shared with the physiotherapy department, which was on the other side of the main hospital reception. Staff said that the location of the trolley and it's use across two departments was in line with Spire policy and therefore had not been risk assessed. However, the use of the trolley across both areas meant that, in the event of a crash in the physiotherapy department, the team would have to pass through the busy reception area with the trolley, creating the potential for a delay in the patient receiving resuscitation. We were told by the senior leadership, however, that they had undertaken recent scenarios in the physiotherapy department to ensure timely arrival of equipment and were confident that were no concerns with the current arrangement.

Assessing and responding to patient risk

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

There was a process in place within the outpatients for patients who were deteriorating. Staff contacted the resuscitation team that would include the residential medical officer, senior nurse, matron and outpatients manager, who would assess the patient.

The standard procedure was for the resuscitation team to stabilise the patient and contact the NHS ambulance to transfer the patient to the nearest appropriate NHS hospital for treatment. Staff we spoke with were aware of this procedure.

There was an alarm system for summoning the resuscitation team, with a button in all clinical areas. We saw evidence that this was tested weekly.

We observed physiotherapists taking patient histories before prescribing exercises in the gym for patients. They gave clear instructions and continuously asked patient to rate the level of effort required by each exercise.

Nurse staffing

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

Staff told us that staffing levels were sufficient to carry out their work effectively.

The department had a dedicated team of registered nurses, healthcare assistants, pharmacists, physiotherapists, receptionists and administration staff. Staffing levels were considered and agreed two days prior to clinics by which time managers were aware of clinic type and numbers attending. There was no specific acuity tool used to assess staffing levels. The department used staffing flexibly to address patient's needs.

At the time of our inspection the outpatients department employed one full time equivalent (FTE) clinical manager, 6.6 (FTE) registered nurses and 4.6 FTE health care assistants. There was one registered nurse vacancy.

Staff had access to a registered children's nurse at all times, via telephone, for advice and support when providing care to children.

There were nine full time physiotherapists and five bank physiotherapists as well as one physiotherapy assistant. There were two sports masseurs working within the service.

The service did not use any agency staff. Where additional staff were required, the service used bank staff, who were ordinarily employed elsewhere in the hospital. Bank staff were expected to demonstrate that they had successfully completed mandatory training and were provided with an induction programme. In the reporting period, the highest use of bank staff was in July 2019, when 20% of staff working were bank staff. There had been no unfilled shifts in the period May to July 2019.

There had been a downwards trend in staff sickness rates since September 2018, when the rate had reached 20%.

At the time of our inspection, the hospital was supporting nine apprenticeship students working in the theatres, outpatients and diagnostic imaging. Six students had completed this and were being supported to move onto

degree pathways through the provider's links with national universities. Three students had achieved the Care Standards and a Level 3 National Diploma linked to the clinical areas.

Medical staffing

Medical staff working within the service had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Consultants worked at the hospital under practising privileges. These were appropriately reviewed and recorded. Consultants who did not provide updates of the relevant evidence for their practising privileges had them revoked, these would be reinstated on the provision of the relevant evidence. During our inspection, there were three consultants who had had their practising privileges revoked for failure to provide updated evidence, and a further two were suspended on the second day of our inspection. This indicated that practising privileges were proactively managed.

In addition to medical staff, some allied health professionals, including optometrists, speech and language therapists and audiologists held outpatient clinics under practising privileges.

Records

Nursing staff kept detailed records of patients' care and treatment. Nursing records were clear, up-to-date, stored securely and easily available to all staff providing care. However, there remained significant issues with consultants' notes.

The department used paper records.

When not in use, records were stored in a hospital-wide records store on site. After six months, records were archived in Spire's central store. There was an electronic record tracking system to ensure that records could be found across the site. Records which were in use in the department were kept in locked cabinets.

The medical records team prepared paper based medical records the day before the patient's appointment, upon receipt of a list of patients from the choose and book team.

At our last inspection, we identified concerns with the legibility of consultant's notes. Whilst the leadership told us they had sought to remind consultants of the need for legible records, this issue had not been resolved at this inspection.

We checked eight patient records. In seven of the records we checked, consultants had not recorded their name or job title legibly, which was not in line with the GMC's professional standards of good record keeping. In addition, some consultant's notes were illegible. We escalated this to the senior leadership team. They took immediate action to address this, reminding all the consultants working at the hospital of the need for their notes to be legible and ordering stamps for each consultant to allow them to stamp their notes with their name and job title as well as signing in their name. They said they would continue to audit consultant's notes for legibility.

The nursing notes we looked at were appropriately completed; patient history, consent, allergies, medicines history and pain management pathways were routinely recorded, signed and dated.

Medicines

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

There was an on-site pharmacy open from 8am to 6pm Monday to Saturday. The pharmacy department was visibly clean. Access to the pharmacy was limited to pharmacy staff during open hours, with the resident medical officer and senior nurse in charge for the hospital able to gain access out of hours. As the service used private prescriptions, patients who were discharged after the pharmacy had closed had to return to the hospital the following day to collect their take home medicines or attend their GP to have their prescription transferred. This created a delay to patients receiving their medication. The hospital informed us, however, that where patients required medicines to be started immediately, these would be provided prior to the pharmacy closing.

Staff described the pharmacy team as supportive and approachable. They said that medicines were ready on time and were available when requested.

Arrangements were in place for the safe order, storage, and issue of prescription stationery to minimise the potential of prescription theft and consequent fraud.

Staff administered medicines only when prescribed by doctors.

Medicines were appropriately stored in locked cupboards. However, in one of the clinic rooms, to which the door was not locked, we found fluids stored in an unlocked cupboard. This presented a risk that the fluids could be accessed by patients or visitors. We escalated this to the leadership team on the first day of the inspection. On day two of the inspection, the cupboard was locked and a sign had been placed on the door reminding staff to keep it locked. Keys for the cupboards were kept in a safe with an electronic code. The code was changed twice a year and known only to pharmacy staff and senior nurses.

Controlled Drugs (CD)s were kept in a locked cupboard inside a locked cupboard, in line with the Controlled Drugs (Supervision of management and use) Regulations (2013). The CD book was appropriately completed with two signatures of qualified staff members for the dispensing, administration or destruction of all controlled drugs.

The hospital director was the accountable officer for controlled drugs. Managers told us that Spire required an audit of the controlled drugs every three months.

A list of signatories of staff authorised to order and administer controlled drugs was maintained by the pharmacy manager and located in the pharmacy to ensure safe ordering. Staff told us that CD destruction takes place at least quarterly and must be carried out and witnessed by the controlled drugs accountable officer (CDAO). We saw in the CD cupboard in the pharmacy department that medicines awaiting destruction were clearly labelled and segregated. The CD cupboard stocks were checked daily by two registered nurses and signed for.

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.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

There were no never events reported in the department within the reporting period.

There were no serious incidents in the department within the reporting period.

There were 171 clinical incidents reported within the outpatients and imaging departments between July 2018 and July 2019. In addition, there were 147 non-clinical incidents. This was a significant increase in the number of incidents reported at the time of the last inspection. However, senior staff ascribed this increase to increased reporting of incidents and near misses by staff. They said that staff were encouraged to report incidents, and that all incidents were treated as learning opportunities.

Staff confirmed that incidents were seen as learning opportunities. They said that they felt confident to report incidents and near misses and always received feedback when they did so.

Staff reported incidents via an electronic reporting system. They were able to show us how they would do so. A number of staff we spoke with were able to describe incidents and near misses they had reported and actions arising out of them.

Managers told us that when staff reported an incident they would investigate it by speaking to those involved. Managers provided feedback to individual staff members and shared learning from incidents with all staff during monthly departmental meetings and at daily safety briefings.

Serious incidents were investigated using a Root Cause Analysis (RCA) tool. We had sight of the completed RCAs for three incidents. These were fully and appropriately completed, learning had been identified and shared with the relevant staff.

Incidents relating to medicines were discussed at the quarterly medication management committee. We had sight of the minutes of the most recent meeting.

The duty of candour (DoC) is a regulatory duty which requires providers of health services to be open and transparent with patients and their families when things go wrong. Staff we spoke with had a clear understanding of the DoC and their responsibilities in relation to it. This was an improvement since the last inspection, where knowledge of the DoC was variable.

Are outpatients services effective?

We do not rate effective for outpatients.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983. However, a number of provider wide policies had not been reviewed in line with their stated review dates, meaning that these policies had expired.

Staff worked to local and national Spire policies. At a recent inspection of another Spire hospital site, it was identified that a significant number of the policies were out of date and had not been reviewed in time with their stated review dates. This was being dealt with by the central Spire team, however, it meant that several policies and procedures which staff relied on were out of date and had not been reviewed. At the time of our inspection of Spire London East hospital, half of the policies which were out of date had already been reviewed and updated.

To mitigate against this, the hospital leadership had taken local action. All of the policies which required review were marked as such in the local hard copies of the policies held in the staff canteen and other staff areas, as well as on the intranet. Staff had been advised that in the event they needed to refer to a policy, they should escalate this to the matron, who would contact the relevant member of staff at the head office who was assigned to review the policy to clarify what the corporate advice was in respect of that particular policy area, before feeding back to the member of staff.

Policies and procedures were based on relevant national guidance and best practice from relevant bodies such as the National Institute for health Care Excellence (NICE) the Royal college of physicians and others.

Nutrition and hydration

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

We reviewed eight patient medical records and saw that patient's nutrition and hydration needs were being assessed and met. Staff consistently completed the Malnutrition Universal Screening Tool (MUST) during assessment.

Patients were able to order hot and cold food from the catering team and there was restaurant on site. Tea and coffee were provided in waiting areas. The catering team provided food for a range of dietary requirements, including kosher, halal, vegetarian and vegan.

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 used a pain scoring system to assess patient's pain. There were separate systems for patients with learning disabilities or difficulty communicating. In the eight patient records we looked at, pain scores had been recorded.

We observed a member of staff discussing a patient's pain with them and advising about available options for medicines.

Within the physiotherapy department, complimentary therapies such as acupuncture and sports massage were available to patients to assist with pain management.

Patient outcomes

The service did not specifically record patient outcomes. However, in the last twelve months, there had been no

returns to the department following outpatient procedures. In addition, 97% of patients stated that their outcomes were "very good" or "excellent" when asked following their procedure.

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.

All nursing and healthcare assistants in the outpatients service had had their appraisal for 2019. In 2018, the appraisal rate was 98% for nurses and 97% for healthcare assistants. Staff told us their appraisals were meaningful and that their line managers supported them in seeking access to development opportunities.

We were told that all the physiotherapists had completed their appraisal for the year.

Staff starting in the department undertook an induction programme. They had competencies to complete relevant to their role and were paired with another member of staff until these were signed off. New staff we spoke with told us they felt very supported.

Nursing staff said that they were supported by the local leadership to provide evidence to the Nursing and Midwifery Council for the revalidation of their registration.

Physiotherapists undertook weekly supervision with their line manager, at which they discussed complex cases and learning needs. They had protected time each month to undertake training and continued professional development.

Staff across the department told us that their managers and the wider hospital leadership actively encouraged them to seek additional training and development.

Multidisciplinary working

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

We observed effective multidisciplinary team (MDT) working during our visit. In meetings and huddles staff's individual professional judgements were respected and listened to.

Staff told us that they felt supported by colleagues and that challenge was delivered in a fair and respectful way. There were daily huddles in the department attended by colleagues of all professions.

Seven-day services

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

The outpatients department was open Monday to Friday between 8am and 9pm, and on Saturdays between 8am and 7pm for specific clinics. The physiotherapy department was open Monday to Fridays 7.30am to 9pm, and on Saturdays between 7.30am and 1pm. No NHS patients were seen on Saturdays. The senior leadership team told us this was due to the contract with the local clinical commissioning groups.

The outpatients call centre for private patients had recently extended its working hours, to work earlier in the mornings and on Saturdays. This was in response to the number of calls that were being missed at these times and had increased convenience for these patients.

A resident medical officer was on site 24 hours a day, seven days a week.

Health promotion

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

Staff told us that they signposted patients to services for smoking cessation and alcohol reduction as well as promoting a healthy lifestyle.

There were leaflets and posters throughout the department promoting healthy lifestyles.

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. They used agreed personalised measures that limit patients' liberty.

Where minor procedures were undertaken in the department, patient consent was gained and appropriately documented in patient notes. Consent was

obtained prior to the procedure, at the booking in stage and again immediately before the procedure was carried out. Staff had a clear understanding of the need to gain consent from patients before carrying out procedures. We reviewed three patient consent forms for minor procedures which had been appropriately completed.

Staff had a clear understanding of the consent process for children, including obtaining parental or legal guardian's consent and an understanding of Gillick competence, whereby children under the age of sixteen can be considered competent to consent independently to specific treatment.

Are outpatients services caring?

Good

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

Compassionate care

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

Patients we spoke with told us that they were treated with care and compassion.

We observed caring interactions between staff and patients. In particular, we saw staff asking questions to returning patients based on information from their previous visit.

Staff respected patients' privacy and dignity. Individuals were provided care and treatment within individual consultation rooms where doors were closed. We observed staff knocking on doors before entering.

Emotional support

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

We observed staff taking time to speak with patients and demonstrating empathy in conversations with them. Staff took the time to check patients' wellbeing during interactions with 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.

Patients told us that their treatment options were discussed with them fully and they were given time to consider their options and to ask questions. There was a helpline which patients could contact following their appointment for medical advice.

We observed a physiotherapist tailoring the exercises to the personal needs of a patient, reflecting their lifestyle and physical goals.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

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

There was a service level agreement with the local clinical commissioning group (CCG), whereby NHS patients living in the local area could chose to undergo treatment within the service in the parameters of the agreement. We were told this excluded appointments on Saturdays. Evening appointments until 9pm were available to all patients, dependant on consultant availability. Patients were able to book an appointment at a time convenient to them through an electronic referral system.

The senior leadership team met with the CCG to plan for care provision. They said that they generally had a positive working relationship with the CCG.

There was free parking on the hospital site, which the senior leadership told us was a factor in patients deciding to undergo treatment at the hospital. Free parking was available to all patients.

Good

Outpatients

There was clear and adequate signposting throughout the department. At our last inspection, we raised concerns about the ease with which patients could navigate through the service once there. This had been addressed, and there were clear signs and pathways throughout the department.

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.

In 2018, the hospital had commissioned a review of accessibility by two people living with physical disabilities and had made amendments to the layout of the site in accordance with their recommendations. In 2019, the hospital focussed on invisible disabilities, and had worked with an individual living with an invisible disability to make changes to the site. This included signs on accessible toilet doors reminding staff and patients that disabilities are not always visible.

There was a learning disabilities lead nurse within the service who provided support, advice and training for staff caring for patients with learning disabilities. At our last inspection, there was no clearly defined patient pathway for patients with a learning disability and staff told us that they often had little notice that a patient with a learning disability would be attending the service. At this inspection, we saw examples of patient pathways for this cohort. Staff told us how they would adapt their practice to meet the needs of these patients. They said that generally, where patients had learning disabilities, this would be identified in their notes which would be available to them prior to the start of a shift. In addition, this would be flagged at the morning safety huddle.

The service had a dementia strategy and referred to Royal College Nursing guidelines when caring for people with dementia. Staff within outpatients told us they would seek advice from the patient's consultant so that a decision around care and treatment could be made. In addition, there were dementia champions within the service, who could support staff in providing care to patients living with dementia.

The hospital had formulated a mental health strategy. This involved referring patients between the ages of 18 to 65 who required mental health services to the acute NHS services. The service was provided 24 hours a day for seven days a week.

Where necessary, staff used a telephone translation service to discuss care options and gain consent from patients. All the staff we spoke with were clear that a professional translator was required for gaining consent to treatment, rather than a member of the patient's family. The information booklets provided by staff to patients were printable in different languages.

The hospital wide leadership team had undertaken British Sign Language training, to raise their awareness of patients with hearing difficulties. In 2019, the hospital held a deafness awareness day for all staff.

Patients had access to a chaperoning service. This was made clear on posters throughout the department. One of the HCAs told us that there was always an additional HCA or nurse chaperone available for gynaecological clinics. One of the HCAs we spoke with was reading a patients notes in anticipation of chaperoning them for an appointment.

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.

The service told us that they did not record referral to treatment time, as there were no issues with this. They said that as consultants booked their own clinics, there were no issues in ensuring patients were seen in a timely manner.

The department recorded the length of time patients said they waited for their appointment from their arrival clinic. This was reported to the hospital-wide leadership. The waiting periods were rated red (a wait of 30 minutes or over), amber (a wait of 15 minutes or over) and green (appointment on time). We had sight of the report for outpatients appointments for the period January to December 2018. The majority of patients reported that they were seen on time, with only 22 patients reporting a wait of 30 minutes or over. At our last inspection, we were

told that waiting times within clinics had been a significant issue. One of the primary causes for this was consultants being delayed or failing to attend. The hospital told us this had been addressed through the introduction of an electronic application which allowed consultants to manage their bookings in advance of their clinics and sent them real time reminders of their workload.

We were told, however, that where consultants were late this was raised with them by the hospital director.

Where consultants were unable to avoid cancelling a clinic, they were required to notify the hospital of this six weeks in advance, in order for them to be able to provide adequate notice to patients and to re-arrange the appointment.

Where children did not attend more than one appointment, this was treated as a safeguarding concern.

In response to patient feedback, clinic times for the GP and children's services had been extended to provide greater choice and flexibility of appointments

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.

We had sight of the hospital-wide complaints log. This recorded all complaints made to the hospital, the progress of the investigation into them and actions and learning arising. In the period March to September 2019, there were 24 complaints, of which seven remained open, all of the open complaints had actions against them and were being processed appropriately.

All complaints were acknowledged by letter within two days of receipt and received an initial formal response within 20 working days.

Any patient making a complaint was invited as part of the complaint acknowledgement letter to come into the hospital and meet the senior management team, with a view to being involved in resolving their concern.

The hospital had a dedicated complaints handler in post who ensured complaints were investigated and closed in a timely manner, and who ensured complainants were kept updated at each stage of the process via phone or email

We reviewed three complaints. All had been responded to within the appropriate timeframes. The staff investigating the complaints had contacted the complainant to agree terms of reference and the issues had been fully investigated and, where appropriate, actions put in place to prevent their recurrence. There was a weekly meeting at which learning from complaints was shared. In addition, this was shared with staff via an electronic bulletin and cascaded to them at handovers and safety huddles. Staff we spoke with were able to identify changes to practice that had arisen because of a complaint or concern.

There was a weekly complaints update meeting at which the progress of any open complaints was reviewed. Where investigators were struggling to meet the response timescale, they would be offered support to do so by the senior leadership team. Where the response timescale could not be met, due to the complexity of the investigation, or the need to contact relevant persons, this was formally communicated to the complainant.

Are outpatients services well-led?

Good

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

Leadership

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

Staff spoke highly of the local and hospital-wide leadership teams. They described the leadership as

visible, proactive and supportive. Staff were confident in the leadership and told us that they enabled them to deliver the best possible care to patients as well as encouraging them to develop in their own practice.

There were clear lines of responsibility and accountability within the service and within the wider hospital. The outpatients department was led by an outpatients manager and a physiotherapy manager, who reported to the hospital matron, who was also the head of clinical services. At the time of our previous inspection, this had been an interim position. However, the hospital leadership team had now stabilised. There were no gaps within the management structure.

The local management and senior leadership team described a non-hierarchical leadership culture, where staff were encouraged to share their concerns and suggestions. This was reflected in our conversations with staff, who told us they felt confident to challenge and raise issues to local and senior leaders.

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 had a strategy for 2019/20, which had five key aims including development of new services, streamlining their patient pathway to enhance patient's experience and being the hospital of choice for staff and consultants.

Staff we spoke with were aware of the vision and strategy particularly those areas relating directly to outpatients.

The hospital director said that the service was continually monitoring outpatient clinic utilisation to ensure that consultants and patients got the maximum use out of the service. He said that the service was seeking to expand its audiology provision to incorporate a dedicated paediatric audiology service, in response to the reduction of availability of such a service within the local area.

The service was benchmarked against the other locations in the Spire group. At the time of our inspection, the service was ranked second most chosen place to work for consultants, the senior leadership told us that they were aiming to be the first.

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.

We observed a positive, learning culture within the organisation. Many staff had worked within the service for a long time whilst others described it as "one of the best places they had ever worked". Staff demonstrated a passion for patient care and teamwork.

We had sight of a staff survey action plan, which set our clear actions designed to address any concerns or negative feedback identified by staff in the 2019 staff survey.

Positive contributions by staff were recognised at the morning huddle in the hospital director's office. In addition, at regular intervals, the hospital director "surprised" staff during their working day with a "shining star award", this was a trophy and a gift voucher to acknowledge the outstanding contribution of individual staff members. All staff could nominate colleagues for this award, and the photos of the most recent recipients were displayed in the main corridor.

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 eleven committees that reported into a central integrated governance committee. These included a clinical governance committee, a medical advisory committee and a clinical effectiveness and audit committee.

The hospital had appointed a clinical governance and risk manager in 2018, to manage the governance process across the hospital.

The clinical governance committee met monthly and was attended by relevant heads of department and the clinical governance and risk manager. At the meeting, all complaints, concerns, incidents and audits were discussed. A report from the meeting was fed into the quarterly integrated governance committee. Actions in response to risks or concerns were identified at the clinical governance committee and their progress monitored. At our last inspection, we identified that actions were not always promptly closed off. This was no longer the case. The clinical governance and risk lead kept a live register of actions, and their progress towards completion. Staff were reminded and supported to complete actions where necessary.

There were monthly outpatients and physiotherapy departmental meetings, which reported into the clinical governance committee. In addition, these were used as an opportunity to cascade learning to staff from previous incidents, complaints and concerns as well as sharing best practice from across the hospital and the wider Spire group.

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 clinical governance and risk manager told us that on joining the provider, she had reviewed the risk register and reduced the number of open risks from approximately 130 to 70, to reflect the core risks facing the service. She acknowledged that this remained a significant number but was able to demonstrate that the risk register was proactively managed. Risks were rated in terms of seriousness. There were mitigations recorded against each of the risks on the risk register. These had assigned action plans, with named individuals responsible for carrying them out. The clinical governance and risk manager proactively supported staff to ensure these mitigating actions were carried out in line with the appropriate timeframes.

All senior staff we spoke with were able to identify the top three risks on the risk register. These were: failure by consultants to adhere to the World Health Organisations five steps to safer surgery checklist (in outpatients as well as in surgery); wrong site surgery identified on the booking forms, and the safety and security of the hospital car park.

In addition, there was a hospital-wide daily huddle in the hospital director's office. This was attended by the senior leadership team and representatives from each of the departments. The meeting had a standing agenda designed to identify and immediately mitigate any risks that may arise during the day. Information from the meeting was updated in real time onto a form which was emailed to all staff and printed and displayed in the staff canteen throughout the day. This meant staff were appraised of any risks and their mitigations on each individual day.

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.

Performance data was displayed prominently in the main corridor. In addition, the service used information to drive improvement within the service. For example, the service was routinely benchmarked against others within the Spire group. Where a service was performing particularly well, best practice was shared with other services to encourage continuous development. The service submitted data to relevant external audits for accreditation and benchmarking.

Staff told us that relevant data was available when they needed it.

Good

Outpatients

The service adhered to NHS England's Accessible Information Standard. This was a legal requirement for services to identify, record, flag, share and meet the information and communication needs of patients and other groups with disability, impairment or sensory loss.

Engagement

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

The hospital engaged with the local community through an outreach programme with West Ham Football Club to encourage healthy lifestyles in schools. In 2018 the physiotherapy department organised sit-down exercise classes for the West Ham older supporters' network. Senior staff told us that they were currently planning a similar programme.

The hospital supported a local charity to raise awareness of testicular cancer by providing urology education for all academy players at West Ham United football club.

The hospital's conference room was available free of charge to local residents' groups.

The hospital also sought to engage the public by publishing "myth-busting" fact sheets on its website and social media. These were guides to the symptoms and treatment of health conditions written by experts from within the hospital. The guides were available free and were based on common medical search terms.

The hospital had recently held a lunch for all staff to mark its 21st anniversary.

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.

In the main corridor, there was a notice board where the senior leadership team provided brief summaries of learning and development from across the hospital. These were aligned to each of the CQC's domains.

One of the physiotherapists we spoke with told us that they were being supported to undertake additional research into sports injuries.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging 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.

See mandatory training for outpatients.

We had sight of sign-off forms for staff indicating that they were aware of the local rules. Local rules ensure that work is carried out in accordance with the Ionising Radiation Regulations 2017 within the department. These were accompanied by all relevant policies, which staff signed to say they had read.

Staff working in radiation had received appropriate training in the relevant regulations, radiation risks, and use of radiation. We saw that room risk assessments had taken place. Local policies were up to date and there were clear records of staff inductions.

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.

See safeguarding for outpatients.

Staff understood their responsibility to safeguard patients and their relatives. They demonstrated a clear knowledge of safeguarding procedures and described how they would escalate a safeguarding concern.

Staff undertook “pause and check” prior to procedures, to ensure that the right patient was undergoing the right procedure.

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.

See cleanliness infection control and hygiene for outpatients.

We had sight of the completed cleaning schedules for each of the scanners and the ultrasound room.

Staff used a triple-wipe system for decontaminating equipment. This was recorded in a log book and signed by staff to indicate they had done so. In addition, the most recent patient details were recorded in the decontamination logbook so that the source of infection could be identified in the event of cross contamination. Healthcare Assistants (HCA)s working within the department had received additional training in decontamination. The completion of the logbook was audited and where there were errors in completion, the relevant HCAs were given additional training and supervision.

There was a spill kit available in the CT scan room and in the storage room for dealing with radioactive spillages.

Environment and equipment

Good

Diagnostic imaging

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

See environment and equipment for outpatients.

The resuscitation trolley within the imaging department held both paediatric and adult equipment. Staff completed daily checks of the equipment and signed to say that they had done so. We saw that daily checklists were up to date and that all equipment was sealed and in date.

There were clear warning signs in areas where ionising radiation and magnetism were used.

Imaging equipment was serviced by the external providers from whom it was rented. We saw up to date service reports for the equipment. Staff told us they had positive working relationships with maintenance staff, whom they could contact when needed.

We had sight of the engineers' reports for all imaging equipment. These has been completed in line with the relevant review dates.

There was a back-up generator within the hospital to allow for the continuation of diagnostic imaging provision in the event of power failure.

There was a control area for the MRI scanners, which was also used for staff huddles and briefings.

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.

See assessing and responding to patient risk for outpatients.

Staff undertook a safety checklist prior to undertaking a scan. This included checking the patient's identification, confirming the procedure that they were booked for, a risk assessment for radiation and obtaining consent from the patient. We observed a checklist being carried out for a patient. This was fully documented in the patient notes.

We checked five patient records for imaging patients. These included risk assessments, the procedure undertaken, the names of the staff involved and the justification for X-ray and radiation dose. The use of and type of contrast dye was recorded in patient notes. Staff documented the pregnancy status for female patients. We saw evidence of patients' pregnancy status being recorded in the notes we checked. In addition, this was audited by the service.

There was a call bell inside the MRI scanner for patients to press in the event of an emergency.

We had sight of patient notes and scans. Scans for urgent review were marked as such and prioritised. Staff told us that if a scan highlighted a potentially urgent concern, they would escalate this to the on-call consultant radiologist to examine.

Staff had telephone access to a radiation protection advisor (RPA) for advice. The RPA was based at a different Spire location. However, staff said that they were always available via telephone and email. In addition, the RPA visited the site to attend meetings in the department and to carry out testing on equipment.

Staff told us they had access to previous images taken in advance of patient's appointments. The hospital had a secure electronic system for sharing images between providers. NHS patients' previous images were shared with the hospital under a service level agreement.

Staff told us that they carried out a twice-yearly resuscitation protocol, whereby the resuscitation lead staged an unannounced resuscitation drill within the department. This was also repeated whenever a new RMO started at the hospital.

Nurse staffing

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

There were two full time HCA's and two part time HCAs.

Medical staffing

Good

Diagnostic imaging

Medical staff working within the service had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

There were four full time cross-sectional radiographers. In addition, there were five general radiographers, three full time and two part time. Four of the radiographers had specialised in mammography.

The service also used two bank radiographers, one cross-sectional and one general.

There were 15 radiologists. Three were breast specialists; three were neuro-radiologists and head/neck; two specialised in interventional; two specialised in paediatrics; three specialised in gynaecology, urology and general; seven specialised in musculoskeletal. In addition, there was one female specialist ultrasonographer performing gynaecological scans.

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.

See records for outpatients.

We checked five patient records. These were fully and appropriately completed. They included appropriate risk assessments and patient consent forms. Electronic copies of images were appropriately and securely stored.

Medicines

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

See medicines for outpatients.

All nuclear medicine doctors held appropriate Administration of Radioactive Substances Advisory Committee licences which were seen.

Staff had appropriate training for the handling and storage of contrast dye. We saw that this was appropriately and securely stored, alongside equipment and instructions for dealing with spillages.

The hospital wide pharmacy team carried out regular medicine storage audits within the service. We had sight of the most recent audit, in which the department scored 100%.

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.

See incidents for outpatients.

We saw evidence of learning from incidents within the department. For example, there was a "Stop" sticker placed on every set of patient notes, reminding staff to check the patient's referral form, that the correct body part was being scanned, that they had the correct side, the correct patient and had completed an identity check. Staff told us that these stickers had been introduced in response to an incident whereby a scan had been carried out on the wrong body part.

There were no IR(ME)R incidents within the reviewing period.

Are diagnostic imaging services effective?

We do not rate effective for diagnostic imaging.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983. However, a number of provider wide policies had not been reviewed in line with their stated review dates, meaning that these policies had expired.

See evidence-based care and treatment for outpatients.

Good

Diagnostic imaging

The service audited adherence to national diagnostic reference levels (NDRL)s. In addition, there were regular audits to ensure compliance with local policies and procedures.

Nutrition and hydration

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

Patients had access to free water and hot drinks in the reception area of the unit. Patients attending for a CT scan were provided with water and encouraged to drink plenty while they were in the uptake rooms awaiting their procedure. Patients were not in the unit for a long enough period to require any food.

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.

See pain relief for outpatients.

Patient outcomes

The service did not record patient outcome data.

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.

All MRI radiographers and PET-CT technicians received a competency pack with modules to complete at the start of their employment. At the end of each module the assessor would review it. Final sign off was completed by the lead MRI Radiographer indicating the competencies had been completed.

All staff, including bank staff, completed a role and site-specific induction, which was recorded on the system. Staff competency records were up to date. All staff had had their appraisal for 2019.

Multidisciplinary working

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

See multidisciplinary working for outpatients.

There were regular multidisciplinary team meetings, these were attended by radiographers.

Seven-day services

Diagnostic imaging services were open Monday to Friday 8am to 9pm. The CT scanner was available from 9am to 5pm, except in emergencies. In addition, the department was open on Saturdays from 8am to 4pm for general x-ray and MRI scans; from 8.30am to 2pm for ultrasound with the CT scan only available for emergencies on weekends. MRI scans were available on Sundays from 8am to 1pm.

Health promotion

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

See health promotion for outpatients.

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. They used agreed personalised measures that limit patients' liberty.

See consent and Mental Capacity Act for outpatients.

Patients were provided with information leaflets by the hospital prior to their appointment. On arrival for their appointment, they had the opportunity to ask staff about their procedure. Patients were consented prior to their appointment and again immediately prior to their procedure.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of their responsibilities to patient consent, including in relation to the MCA and DoLS. All staff completed a mandatory training module regarding consent. The head of clinical services ran regular pop up sessions with staff to discuss MCA and DoLS.

Good

Diagnostic imaging

Are diagnostic imaging services caring?

Good

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

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke with five patients. They told us that staff took time to discuss their concerns with them and made them feel at ease. Staff demonstrated a caring attitude when speaking with and about patients.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients were provided with information prior to the scans in written format and shown the scanner prior to their examination. Patients were supported by the staff throughout the examination. This was done by explaining what was happening, how long was left and reassuring them that they were doing well.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Are diagnostic imaging services responsive?

Good

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

Service delivery to meet the needs of local people

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

See service delivery to meet the needs of local people for outpatients.

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.

See assessing meeting people's individual needs for outpatients.

On day one of our inspection, we observed that the waiting area for imaging was shared between adults and children. There was little in place for children in the waiting area, aside from some books. We raised this to the senior leadership team. On day two of our inspection, the policy had been changed for children to wait in the designated children's waiting area within the nearby outpatients department, before being called through at the start of their appointment. We saw signs informing patients and their families of this change. Staff had been made aware of this through internal communication.

There were single use soft-toys for children undergoing MRI scans. These toys were kept in sealed bags to prevent the risk of infection and children could keep them following their scan. In addition, there were bravery certificates following their treatment.

Whilst patients' relatives, friends and carers were not allowed in the MRI scanning room during a scan, there was a protocol in place to allow this for claustrophobic patients, and patients living with dementia. In these cases, a risk assessment was carried out for the individual accompanying the patient. If the person was not able to attend the scan, a member of staff was made available to act as a chaperone.

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.

Good

Diagnostic imaging

The administration team reviewed every referral and, depending on the urgency would schedule them accordingly. Scan dates would then be assigned to each patient.

Short notice appointments for patients with suspected cancer were booked in accordance with the relevant cancer wait times. Reports of all requested scans were run daily to ensure that all had been captured and scheduled according to the urgency.

The service told us that they did not record referral to treatment times, as they were not an issue in the service, with all patients being seen in a timely manner. We were told that the service met local targets for patient turnaround, in line with their service level agreements with the local clinical commissioning group.

Learning from complaints and concerns

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

See learning from complaints and concerns for outpatients.

Are diagnostic imaging services well-led?

Good

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

Leadership

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

Overall, the service had a shared leadership structure with the outpatients department. There were, however, specific local team leaders for each of the diagnostic imaging specialties, who reported to the main leadership team.

Staff spoke highly of the local leadership team. They described them as visible, approachable and supportive.

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.

See vision and strategy for outpatients.

There was no localised vision for the imaging service. However, staff were aware of the overall vision of the hospital and felt that they played a part in contributing to this.

Culture

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

See culture for outpatients.

Staff in outpatients told us that they enjoyed working within the service. The said that they felt supported by their leaders and by the wider hospital leadership.

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.

Overall there was a shared governance structure with the outpatient department. However, there was a specific radiation protection committee.

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.

See managing risks, issues and performance for outpatients.

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.

See managing information for outpatients.

Engagement

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

See engagement for outpatients.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

HCAs were supported to undertake NVQ Level 3 qualifications in Certificate for Imaging Support (level 3).

Outstanding practice and areas for improvement

Outstanding practice

As of October 2018, the hospital had been accredited as a VTE Exemplar Centre by the Kings College National Standards committee. VTE Exemplar centres was a network of 34 healthcare sites, established by the Department of Health, to exhibit best practice and leadership in reducing avoidable death, disability, and chronic ill-health from hospital associated VTE. As part of this the hospital had also trained 60 VTE champions in preventative measures.

The hospital had a nurse with responsibility for pain management care for surgery patients. The pain nurse had completed specific pain management training (as part of a Florence Nightingale Scholarship) in Australia and was involved in research at the hospital relating to pain management. Staff we spoke with stated that the expertise was useful to have for advice and support, and that the pain management nurse also provided training to improve staff skills and awareness. If this nurse was not available, pain management could be provided and administered by the available RMO

The hospital had joined the North East London Critical Care Network to enhance their resolve for transfer and emergency situations, and ensure advice and learning was shared locally.

In the last twelve months the service had completed an independent review of the facilities for visitors with a disability. The report examined the hospital environment including communal areas, pre-assessment areas, imagine, wards, and theatres. The report identified areas for development including improving the accessibility bathrooms, the layout of shower facilities, and hand rails in the imaging department. On inspection we observed that these changes had been implemented.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all records are fully and appropriately completed. In particular, records should be legible and should include the name and job titles of all consultants completing the records.