Spire Nottingham Hospital

Quality Report

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

Ratings

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

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

Letter from the Chief Inspector of Hospitals

Spire Nottingham Hospital is operated by Spire Healthcare Limited. The hospital opened on 29 April 2017. It is a new purpose built independent healthcare hospital in Nottingham, Nottinghamshire. The hospital has 42 beds. Facilities include four operating theatres, one of which is a hybrid theatre, a day case theatre suite, a five-bed level three intensive care unit (currently this is not operational), chemotherapy suite and X-ray, outpatient and diagnostic facilities.(A hybrid theatre is equipped with advanced medical imaging devices. These devices enable minimally-invasive surgery.)

The hospital currently provides surgery, and outpatients and diagnostic imaging. We inspected surgery, and outpatient and diagnostic facilities.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 5 and 6 February 2018.

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

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

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

Services we rate

We rated this hospital as outstanding overall, and we rated safe, effective and caring as good. We rated responsive and well-led as outstanding, this was because:

- People were respected as individuals and supported to be involved in their care. There was a strong focus on maintaining the privacy and dignity of patients. Patients' feedback about the quality of care and their experience was overwhelmingly positive.
- Patients could access care and treatment promptly at a time that suited them.
- Complaints were taken seriously and were investigated and responded to within agreed timescales. Changes to the service were made as a result of complaints.
- The hospital management team worked collaboratively to ensure the needs of the local population were met. The management team were proactive in developing services, such as the progression of introducing new services when it was safe to do so.
- The vision and values were understood and well embedded in staff's daily work. Staff felt supported by a leadership team that inspired them and who were credible and visible. Staff were proud to work at the hospital and there were high levels of satisfaction across all staff groups. Staff felt involved in the running of the hospital and were encouraged to suggest ideas for improvement.
- A safe and high quality service was assured through robust governance structures that proactively reviewed performance, identified areas of risk or emerging concern and made arrangements to mitigate these risks and drive improvement.
- There were innovative approaches to gather feedback from patients and actions to improve services were made as a result of such information.

Summary of findings

- Data demonstrated a good track record in safety. There were clearly defined systems to report, investigate and learn from incidents and when things went wrong, and the duty of candour was enacted.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. There was a programme of mandatory training in key safety areas, which all staff completed, and systems for checking staff competencies and for identifying and meeting staff's training needs.
- There were systems and process for recognising and reporting potential abuse, for preventing and controlling infection and for managing medicines which were consistently applied by staff.
- Care was planned and delivered in line with current standards and best practice. There were audit arrangements to provide assurance of this and systems to review new guidance and oversee its implementation.
- Patients had access to a full range of health care professionals who worked together as an integrated team to meet patients' needs. Staff could access patients' records and other clinical information when it was required. There were systems to follow up patients after discharge and to liaise with their GPs.
- Patients consented to their treatment in line with relevant legislation, including those who may lack capacity to make decisions for themselves.

Following this inspection, we told the provider it should make some improvements, even though a regulation had not been breached, to help improve the service.

Professor Edward Baker

Chief Inspector of Hospitals

Overall summary

Spire Nottingham Hospital is operated by Spire Healthcare Limited. The hospital opened on 29 April 2017. It is a new purpose built independent healthcare hospital in Nottingham, Nottinghamshire. Spire Nottingham Hospital is situated south of Nottingham city centre; it opened almost two years after work started on the project. A full project team including engineering, pharmacy, pathology, IT, logistics, purchasing, recruitment and training supported the Senior Management Team in getting the hospital ready for opening. A majority of the consultants who have practising privileges at the hospital are from the local NHS hospital trust. The hospital's main specialties are orthopaedics, spinal surgery, urology, gynaecology, general surgery, plastic surgery, ophthalmology, ENT, oral surgery, gastroenterology and breast surgery. Spire Nottingham Hospital is the only hospital in the region with a hybrid theatre.

The hospital primarily serves the communities of the Nottinghamshire, Lincoln and North Leicestershire areas. It also accepts patient referrals from outside these areas.

Services are provided to NHS patients, and self-funded patients who may be insured or who self-pay to cover the costs of their treatment.

The hospital currently provides services to adults only. It stopped providing children's and young people's services in October 2017.It offers outpatient, day case and inpatient services for a range of specialities including orthopaedics, ophthalmology, gynaecology, urology, ear, cosmetic and general surgery. Additional services offered on an outpatient basis include rheumatology, dermatology and cardiology. These services are supported by on-site physiotherapy and diagnostic imaging departments.

The hospital has been registered with the CQC to carry out the following regulated activities since April 2017:

- Surgical Procedures
- Treatment of disease, disorder or injury
- Diagnostic and screening services
- Services in slimming clinics

Summary of findings

- Family Planning Services

The hospital has had a registered manager and a designated controlled drugs accountable officer (CDAO) in post since registration in April 2017. Spire Healthcare Limited has a nominated individual.

This was the hospital's first inspection since opening. There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the nine months since opening.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Outstanding** ☆	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as outstanding because patients were protected from abuse and avoidable harm and received care and treatment that reflected best practice guidance from competent staff. Patients were treated as partners in their care, and valued as individuals which protected their dignity and privacy. Patients' feedback was overwhelmingly positive. Services were tailored to individual needs and there was flexibility to ensure patients' choices and preferences were respected. The management team were focused on the delivery of safe and effective care, and there were robust governance arrangements used to drive service improvement. All staff showed an appreciation of the hospital's values and this was demonstrated in their daily work.
Outpatients and diagnostic imaging	**Outstanding** ☆	We rated this service as outstanding because people were protected from avoidable harm and abuse and there were systems for reporting and learning from safety incidents. Patients received care and treatment that was based on current national guidelines from staff who were competent to do their jobs. Patients were valued as individuals and their dignity was truly respected. Feedback from patients was unfailingly positive. Patients could access care and treatment in a timely way and there was flexibility around timing of appointments. The individual needs of patients were recognised and arrangements made to meet them. The leadership was robust and visible, with a focus on providing a safe service that met the needs of the patients.

Summary of findings

There were robust governance arrangements that gave adequate assurance and which drove improvement. Staff demonstrated the organisation's values through their work.

Summary of findings

Contents

Outstanding ☆

Services we looked at

Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Spire Nottingham Hospital

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Our inspection team

The team that inspected the service comprised of Yin Naing inspection manager,three other CQC inspectors, and two specialist advisors with expertise in surgery and outpatient services. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about Spire Nottingham Hospital

The main service provided is inpatient surgery, and outpatient services. The hospital has two wards with 42 beds in total. However, currently only Hazel ward (20 beds) is in use. Patients are cared for in single, en-suite rooms which means there is no mixed gender accommodation. The ward treats both day case and

Summary of this inspection

overnight patients and can provide extended recovery care level one as required. There are four operating theatres, one of which is a hybrid theatre. All four theatres provide laminar flow (a system of circulating filtered air, this system reduces the risk of airborne contamination). Endoscopy services are also provided although these are not Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited currently due to not being open 12 months.

There is a separate outpatient department (20 rooms) including a plaster room, a gynaecology treatment room, ear, nose and throat treatment room, cardiology assessment room, pre-operative assessment room, three further treatment rooms, ophthalmic examination room, prayer room/quiet room, multiple large and small waiting areas with beverage facilities, GP room, clean and dirty utility rooms. The physiotherapy service has eight individual treatment rooms and a large gym with exercise and weight machines, free weights, Pilate's area and visual training feedback systems. An imaging department which provides 3 Tesla MRI (indicator of magnetic strength), 128 slice dual source CT(higher resolution and speed), fluoroscopy (an x-ray procedure that makes it possible to see internal organs in motion) and plain film X-ray, changing rooms, multiple reporting areas, ultra sound rooms and a digital mammography room. The hospital has its own pharmacy, pathology and sterile services unit. The hospital also has a six pod chemotherapy unit and a five bedded critical care unit which are not currently operational. Currently the hospital does not treat patients under the age of 18 years. However as patient numbers increase and the business develops it is envisaged that all areas will be used and patients under the age of 18 will be offered treatments.

We carried out an announced inspection visit on the 5 and 6 February 2017. During this inspection, we visited the ward, theatres, imaging and outpatients departments. We also visited the clinical support services. We spoke with 48 members of staff including; registered nurses, healthcare assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 14 patients and two relatives. We also received 52 'tell us about your care' comment cards which patients had completed prior to our inspection and 10 Spire comment cards. During our inspection, we reviewed 20 sets of patient records and 12 sets of personnel files.

Activity (April 2017- November 2017)

- In the reporting period April 2017- November 2017 there were 371 inpatient and day case episodes of care recorded at the hospital; of these 18% were NHS-funded and 82% other funded.
- Six percent of all NHS-funded patients and 35% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 2,524 outpatient total attendances in the reporting period; of these one percent were NHS-funded and 99% were other funded.

Staffing

There are 137 medical staff with practising privileges including surgeons, anaesthetists, and radiologists. Two regular resident medical officers (RMOs) are employed under a contract with an external agency working a seven days on duty, seven days off rota.

The hospital employed 36.4 full-time equivalent (FTE) registered nurses, 16.3 care assistants and operating department practitioners, and 80.7 FTE other staff as well as having its own bank staff.

Track record on safety (April 2017- November 2017)

- There were no reported never events.
- A total of 129 clinical incidents were reported. In surgery, 99 clinical incidents were reported of which 82 were graded as causing no harm, six as low harm, and 11 as moderate harm. In outpatients and diagnostic imaging 30 clinical incidents were reported.
- No serious injuries were reported.
- No reported deaths.
- No incidences of healthcare associated Meticillin-resistant Staphylococcus aureus (MRSA) reported.
- No incidences of healthcare associated Meticillin-sensitive staphylococcus aureus (MSSA) reported.
- No incidences of healthcare associated Clostridium difficile (C.difficile) reported.

Summary of this inspection

- No incidences of healthcare associated Escherichia coli (E-Coli) bacteraemia reported.
- One incident of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) reported. (This was reported to CQC by the provider in December 2017 as part of the providers' requirements to report incidents resulting in patient harm.)
- Eleven complaints were received by the hospital, but none were received by the CQC. No complaints were referred to the Parliamentary Health Services Ombudsman or the Independent Healthcare Sector Complaints adjudication service.

External Accreditation

Currently no accreditations are held as the hospital has not been open 12 months. However application for SGS Accreditation for Sterile Services Department and Joint Advisory Group on Gastrointestinal Endoscopy (JAG) are in progress.

Services provided at the hospital under service level agreement:

- Resident Medical Officer
- Critical Care Transfer
- Supply of Blood and Blood Components
- EIDO Healthcare LTD supply of patient information
- Medical Gases Provision
- Medical Equipment Servicing
- Laundry and Linen Services
- Pathology
- Translation/interpreting 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

We rated safe as good because:

- There was an open incident reporting culture within the hospital, and an embedded process for staff to learn from incidents. All staff demonstrated an understanding of the duty of candour and the principles behind this.
- The hospital monitored safety through a clinical scorecard with 47 clinical indicators. The scorecard was used for benchmarking against other Spire hospitals and to identify areas for improvement.
- Staff were knowledgeable about safeguarding processes and what constitutes abuse.
- There were processes in place to manage a deteriorating patient and staff spoke confidently on steps they would take to manage a patient. Staff used a national early warning scoring system to aid identification of a deteriorating patient.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. They were supported by a programme of mandatory training in key safety areas. There were simulation exercises that kept staff skills current.
- Equipment was serviced and visibly clean and processes were in place to ensure all items were well maintained.
- The environment was fit for purpose and visibly clean and tidy. We observed good levels of infection prevention and control practice throughout the department.

However, we also found the following issues that the service provider needs to improve:

- Documentation was not always completed in line with professional standards.

Are services effective?

Good

We rated effective as good because:

- Policies, procedures and guidelines were up to date and based on National Institute for Health and Care Excellence (NICE) guidelines, relevant regulations and legislation.
- Quality improvements were made as a result of audits and the hospital benchmarked its performance against other Spire hospitals.

Summary of this inspection

- Patients received appropriate pain control and food and drink that met their needs and preferences.
- Staff worked collaboratively as part of a multi-professional team to meet patients' needs. There were systems that demonstrated staff were competent to undertake their jobs and to develop their skills or to manage under-performance.
- There was effective multidisciplinary team working throughout the department and with other departments in the hospital.
- Staff had regular development meetings with their department manager, and were encouraged to develop their roles further. Information provided by the hospital showed 100% of staff had been appraised.
- Staff could access information they needed to provide care and treatment in a timely manner.
- The physiotherapy department had started to collate patient outcome data. This information was used locally to develop and improve treatment plans for patients.
- Staff demonstrated an effective knowledge of the consent process and we observed staff gaining consent in accordance with local policy and professional standards.

Are services caring?

Good

We rated caring as good because:

- Patients were always treated with dignity, respect and compassion. This was reflected in the feedback received from patients who told us staff were very caring.
- Patients received information in a way which they understood and felt involved in their care. Patients were always given the opportunity to ask staff questions, and patients felt comfortable doing so.
- Feedback from patients and relatives was consistently extremely positive, and patients told us they would recommend the department to their friends and family.
- Staff provided patients and those close to them with emotional support; all staff were sympathetic to anxious or distressed patients.

Are services responsive?

Outstanding

We rated responsive as outstanding because:

- Hospital managers had worked with the local community and local commissioning groups to plan and deliver services to meet the needs of local people.

Summary of this inspection

- There was a proactive approach to meeting the individual needs of patients. Staff in the outpatient department had worked hard to ensure the needs of patients living with dementia were taken into consideration.
- Staff on the ward had put together a dementia box. Relatives or carers could stay overnight to reduce anxiety for patients living with dementia.
- There were one-stop clinics available for some specialities including breast care and basal cell carcinoma to minimise the number of attendances to the department. Staff were looking to provide more one-stop clinics in other specialities.
- Staff were encouraged to resolve complaints and concerns locally, which was reflected in the low numbers of formal complaints made against the service.
- Patient complaints and concerns were managed according to the hospital policy. Complainants were kept informed of the progress and could discuss their complaint face to face if they wished.
- Complaints were investigated thoroughly, analysed for trends and themes. We saw learning identified and shared to improve service quality.
- The diagnostic imaging department ensured a quick turn around on the reporting of procedures. Time taken for reporting was between two and three days.
- Services were planned and delivered in a way that met the needs of the local population. On the day appointments could be provided for patients with the required referral paperwork, as well as a range of appointment times for those who worked during the week.
- Patients could access services easily; appointments were flexible and waiting times short. Appointments and procedures occurred on time and patients were kept informed of next steps throughout the care pathway.

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Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The hospital had a clear vision and strategy which was realistic and was reflected through team and individual staff member objectives.
- Staff understood the vision and strategy and their role in contributing towards it.

Summary of this inspection

- There was a clear governance structure, which all members of staff were aware of and involved in. There was evidence of information escalated from local level governance meetings and information cascaded from top-level governance meetings.
- Staff were extremely positive about their local leaders and felt they were supported and appreciated. This positivity also extended to the executive level of leadership, who were extremely visible and approachable.
- The morale amongst the departments was very high and staff felt proud to work within their departments and as part of the hospital.
- Departments had their own risk registers, which fed into the hospital risk register. Managers had clear visibility of their own risks and were knowledgeable about the mitigating actions taken.
- A reward and recognition scheme was in place for staff, staff could also be nominated for the annual Spire Healthcare award scheme.
- Staff from the outpatient and diagnostic imaging had received all three 'inspiring people' awards, which have so far been awarded by the hospital.
- Staff felt well informed and involved in the development of the departments, and within the development of the hospital.
- Up to date policies and procedures were in place to support staff in the delivery of safe and effective care.
- Robust procedures were in place for the granting of practising privileges to consultants.
- There was a culture of openness and honesty supported by a whistle blowing policy and freedom to speak up guardian.
- The hospital prioritised engagement with staff, patients and the public. Comments and suggestions were taken seriously and we saw evidence of resulting changes.
- Managers were open to innovative ideas and constantly strived for quality improvement. Plans were in place to increase patient numbers and ensure sustainability.
- Information was used to improve quality, we saw many examples of where this had taken place.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Surgery

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

Are surgery services safe?

Good

Incidents

- The hospital had systems in place to monitor safety, lessons were learned and improvements made when things went wrong. The hospital policy stated that incidents should be reported through the hospital electronic reporting system. All the staff we spoke with told us they were encouraged to report incidents.
- There were no reported never events related to surgery in the period from April 2017 to November 2017. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- During the reporting period,(April 2017- November 2017), 99 incidents were reported, 11 of moderate harm, six of low harm and 82 of no harm, this indicated that staff were following the reporting procedure described in the hospital incident reporting policy.
- The hospital used an electronic incident reporting system; staff we spoke with were able to describe the incident management process and told us that learning identified following incident investigation was feedback through team meetings, emails and the hospital safety bulletin. We saw safety bulletins displayed on notice boards throughout the hospital.
- We saw an example of learning from an incident. Following an incident of moderate harm related to a piece of equipment in theatre. A full investigation had been completed to identify how the error occurred and how to prevent a recurrence. Changes had been made to the storage of sterile and non-sterile equipment as a result of this incident. All theatre staff we spoke with were aware of the incident and the changes that had been made to prevent a recurrence.
- We saw that root cause analysis (RCA) investigations were completed as part of the investigation of incidents. The theatre incident was completed appropriately on a standard template. An action log showed all actions had been completed.
- The provider had achieved 82% of incident investigations completed within 45 days, which was better than the organisation's target of 80%.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The hospital had a duty of candour policy. We asked a number of staff, both clinical and non-clinical, about their understanding of duty of candour and all staff were able to give examples of how this would be applied. Their responses reflected an approach of openness and transparency.

- The policy contained a flow chart showing the escalation to candour and a record of notification. The hospital's electronic reporting system included prompts to ensure duty of candour obligations were undertaken, which we saw.
- We saw two examples of incidents when duty of candour had been exercised appropriately.

Clinical Quality Dashboard

- The hospital monitored safety through a quarterly clinical scorecard. The scorecard reported on 47 clinical indicators such as pain scores, complaints, infection control and pressure ulcer incidence.
- The scorecard was completed by all the hospitals in the Spire Healthcare organisation which meant that the hospitals could benchmark against each other.
- All staff we spoke with were aware of the score card and understood its benefits; we saw the 2017 quarter three score card displayed on notice boards. The provider monitored incidences of venous thromboembolism (VTE, which is a formation of blood clots in the vein), pressure ulcers and falls.
- The score card was red, amber, green (RAG) rated, green ratings meant the hospital was performing at or above target for the indicator. Spire Nottingham Hospital was green for 34 indicators, amber for six indicators, red for two indicators and no rating for three indicators.Overall, the hospital was performing at or above target level; the two red ratings were connected to patient reported outcome measures and were due to low patient numbers.
- The scorecard was discussed at head of department meetings and analysed for areas of improvement. This was then fed back to the local teams.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from healthcare associated infections.
- There was an infection prevention and control (IPC) lead in place supported by an IPC committee, which was responsible for ensuring services were delivered in accordance with the hospital control of infection manual.
- We reviewed the prevention and control of infection manual November 2015, which included procedures to follow covering all aspects of IPC and reference to other associated policies such as MRSA, management of waste and food hygiene.
- Infection prevention and control was included in mandatory training. Compliance with IPC training was 100% in the reporting period. Against a target of 95%.
- All areas we inspected were visibly clean and cleaning schedules were displayed, complete and up to date.
- Patient rooms were dust free and all fabrics in the rooms were wipeable in line with hospital building note (HBN) 00/09. The flooring was laminate with coved edges in line with HBN 00/10 part a (flooring).
- Cleaning materials and equipment were colour coded, which meant that staff knew which piece of equipment should be used in which area to prevent cross contamination.
- The service had not participated in the patient led assessment of the care environment (PLACE) audit in 2017, as the hospital had not been open for the minimum required period. However, they had already engaged with the process and were on the audit programme for 2018. PLACE audits look at a variety of areas, which patients feel are essential to maintain high standards, cleanliness of the environment is an element of these audits.
- Systems were in place for the segregation of waste, bins were colour coded and clearly marked so clinical and domestic waste was disposed of correctly. Staff could describe appropriate segregation of waste. This was in line with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations. The clinical waste unit was checked and seen to be secured.
- Special kits were available to clean spills of blood and blood stained fluid.
- We saw evidence of regular tap flushing within the departments, which was in line with the requirements of health technical memorandum (HTM) 04-01 the control

of Legionella, hygiene, safe hot water, cold water and drinking water: part A. These records were electronic and reviewed regularly by the responsible person for the water system as part of the water safety group.

- Pathology samples were sealed in plastic envelopes and transported to the pathology laboratory in bags specifically designed to carry samples, we observed samples being received in the pathology lab according to the infection control policy.
- We inspected 13 pieces of ward equipment including intravenous fluid pumps and blood pressure equipment, all were visibly clean and had 'I am clean' stickers attached to them so staff knew they had been cleaned and were ready for use.
- All staff were bare below the elbows and complied with the hospital uniform policy. We observed staff following best practice for hand washing; patients told us that staff washed their hands before and after care and treatments.
- Hand hygiene audits were performed and results included on the hospital clinical scorecard, the most recent audit result was 96% compliance against a target of 95%.
- As all patient rooms were single occupancy staff were able to isolate patients who were at increased risk of spreading infection and those who were at risk of developing an infection. Patient rooms were deep cleaned following occupation by patients carrying an infectious disease.
- Staff in theatres wore suitable clothing for the operating environment and we observed theatre staff preparing for a surgical procedure and noted the surgical scrub was performed according to the hospital infection control policy.
- Patients were prepared for theatre according to National Institute for Health and Care Excellence clinical guideline 74, surgical site infection prevention and treatment. Staff described how they would prepare patients and we saw the pre-theatre patient check list being completed in the operating theatre.
- Procedures for avoiding and monitoring a surgical site for infection were included in the IPC manual. We observed staff in theatres following hand decontamination procedures, putting on sterile gowns and gloves and using antiseptic skin preparation.
- There were no surgical site infections resulting from surgery in the reporting period April 2017 to November 2017.
- There had been no cases of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin- sensitive Staphylococcus aureus (MSSA) or Clostridium difficile in the reporting period April 2017 to November 2017.
- Surgical patients were routinely screened for Meticillin resistant staphylococcus aureus (MRSA) and Meticillin sensitive staphylococcus aureus (MSSA) prior to surgical procedures. We saw evidence of this in patient records we reviewed. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated.
- Disposable surgical instruments were available for patients carrying Creutzfeldt – Jakob disease (CJD). CJD can be transmitted through brain tissue and spinal cord fluid.
- We visited the endoscopy suite which was not joint advisory group (JAG) accredited as it had been open less than a year. We observed the decontamination process of endoscopes and saw leak tests performed on all scopes after cleaning. This was compliant with HTM 01/06 decontamination of flexible endoscopy. We saw a tracking process was in place and this was documented within the patients' notes. This made it possible to track which endoscope had been used for each patient. Disposable sheaths were available for endoscopes used on patients carrying infectious diseases.
- Disposable gloves and aprons were readily available in the areas we inspected as was hand sanitising gel. We observed staff using this equipment whilst caring for patients.
- A care pathway was in place for urinary catheterisation and venous cannulation. Staff told us that planned urinary catheterisation usually took place in the sterile operating theatre environment.
- An aseptic non-touch technique, (ANTT) was followed for urinary catheterisation and cannulation. We

observed this taking place in the operating theatre. (ANTT is a standardised approach to performing an aseptic technique for invasive procedures, reducing the risk of a healthcare acquired infection (HCAI).

Environment and equipment

- The building was locked at night and access was by an intercom system monitored by the security guard.
- The wards and theatre department were located on the first floor and clearly signposted for patients to find. The main hospital doors were open for patients to walk through and be greeted at reception, however all ward and treatment areas were only accessible to staff through a card system. All doors were accessible to staff through a card system. Additional safety measures were in place once in one of the procedure rooms as a locking system had been implemented to prevent patients going back into a procedure room once they had left.
- Staff told us they had ample equipment to care for and treat people and that all equipment was regularly serviced and well maintained. The theatre manager told us that they had been able to request additional equipment for the operating theatre and it had been granted.
- Servicing of large items of equipment in the hospital was under service level agreements with the company who provided the equipment. All items had details of service date on them and dated for next service. Staff told us if equipment failed, the processes in place allowed swift response and replacement if necessary whilst being repaired.
- Equipment in the areas we inspected had been purchased new for the hospital, we inspected 20 pieces of electrical equipment around the hospital and all were within their scheduled service date.
- All equipment in the department had evidence of in date electrical safety tests.
- We saw completed risk assessments of products under the Control of Substances Hazardous to Health (COSHH) Regulations 2002, and we found all items were stored appropriately.
- All patient rooms were single occupancy with an ensuite bathroom. Nurse call systems and emergency buzzers were by the bed and in the bathroom, patients told us staff encouraged them to use the call system and that staff responded quickly to the call.
- The emergency and resuscitation trolleys we inspected on the ward and in theatre had been checked regularly, we saw the equipment lists and daily check lists had been signed according to the hospital resuscitation policy and was in line with the Resuscitation Council guidelines.
- In theatres, we saw the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic related equipment' (2009) was being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate logbooks being kept and we saw evidence of these being completed.
- We saw that theatres and anaesthetic rooms were well organised, dust free and single use items such as syringes and needles were readily available.
- We saw that both theatres had difficult intubation trolleys that were compliant with the Association of Anaesthetist of Great Britain and Ireland (AAGBI) and difficult airway society standard. The trolleys were set up in line with those in the local NHS trust, as the majority of the anaesthetists worked at that hospital; this would ensure familiarity with equipment and improve safety for the patient.
- One of the operating theatres was a hybrid operating theatre. A is a surgical that is equipped with advanced medical imaging devices which enable minimally-invasive surgery.
- There was a recording system in place to allow the details of surgical implants such as hip and breast prosthesis to be provided to the implants registry. We saw staff recording the information in the operating theatre. The registers enable individuals to be traced in the event of product recall.
- Staff described to us the process they would follow to report faulty equipment to the Medicines and Healthcare Regulatory Agency (MHRA) and we saw how the hospital shared safety alerts with staff through the monthly safety update bulletin and team meetings.

- The hospital had a sterile services department on site; staff told us the turnaround time for sterilising equipment was about two hours, which meant that sterile surgical equipment was always available.

Medicines

- A comprehensive medicines management policy was in place, which covered obtaining, prescribing, recording, handling, storage, security, administration and disposal of medicines. Staff we spoke with were familiar with the policy and aware of their roles in managing medicines safely.
- There was an onsite pharmacy with a team of four staff. Pharmacy staff visited the wards daily and checked medicines stocks on the ward weekly. Pharmacy staff were on call in the out of hours period.
- The pharmacy team had produced a pharmacy communication folder for ward staff to support them with medicines management and keep them informed of any changes relating to pharmacy supplies or services.
- During their daily visit to the ward pharmacy staff checked individual patient medication for reconciliation. The aim of medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission.
- The medicines management policy also described the circumstances when patients could administer their own medication following safety checks and according to a set of criteria.
- We checked the medicines storage on the ward and in the operating theatre. Controlled drugs were stored correctly and checked every day; we checked 12 individual medicines and all were stored correctly and within their expiry dates. (Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are classified as controlled drugs.)
- We checked the medicines trolley on the ward, which was locked and secured to the wall. Staff told us and we observed that during the medicines rounds they wore red 'do not disturb' tabards so staff and other people knew not to distract them from medicines administration.
- The temperature of the medicines fridges and the blood fridges was monitored remotely and any variation in temperature outside of the recommended range was reported immediately to pharmacy staff to investigate. The pharmacist and pathologist also monitored the blood fridges daily. During our inspection we saw the signed daily check logs.
- Appropriate medicines were stored on the resuscitation and emergency trolley including anaphylactic shock medicines. Anaphylactic shock is an extreme and life threatening allergic reaction. In the patient records we reviewed, we saw that allergies were recorded.
- Medical gases were stored safely; oxygen was piped throughout the hospital including patient rooms. Oxygen cylinders on the emergency trolleys we checked had adequate levels of oxygen within them and were within the expiry date.
- In the event that antibiotics needed to be prescribed, microbiology protocols were accessible on the hospital intranet. The resident medical officer told us they would refer to the protocols if they needed to prescribe antibiotics.
- Only one cytotoxic medicine was stored in the pharmacy, we saw that a risk assessment had been completed for the safe handling of this medicine. Cytotoxic medicines contain chemicals, which are toxic.
- Medicines were discussed with patients on discharge. Patients requiring anticoagulant injections following surgery were shown how to administer the injections themselves and given an information leaflet and sharps bin to take home.
- The pharmacy team received drug alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) these were shared with staff through the monthly safety update bulletin.
- The pharmacy team were proactive in supporting nursing and medical staff with the correct use of medicines. In November 2017 we saw an advisory sheet produced by the pharmacy team on co prescribing of laxatives with opioid medications.

Records

- Patient records were managed in line with the hospital information lifecycle management and patients' records policy; staff attended annual information governance training. We saw staff managing patient records in accordance with the Data Protection Act 1998.
- Records were stored securely in locked areas and only accessible to nursing and medical staff. Patient record files contained all relevant care and treatment documentation in one place. All patient records were stored on site for easy accessibility.
- We reviewed 10 sets of patient records and saw that they were complete and up to date, most were easily legible. However, in two sets of records, doctors' signatures were unreadable and did not provide a contact number. 'Generic Medical Record Keeping Standards' Royal College of Physicians 2009 state that every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed. (Generic Medical Record Keeping Standards). As a result of this feedback during our inspection, the hospital senior team informed all medical staff of the need to adhere to the 2009 standards for documentation.
- All relevant sections of the pre-operative assessment documentation were completed including a range of pre-operative risk assessments such as the American Society of Anaesthesiologists (ASA) Grade (a system used for assessing the fitness of a patient before surgery) venous thromboembolism risk assessment and bleeding risk assessment.

Safeguarding

- Reliable systems, processes and practices were in place to keep people safe and safeguarded from harm.
- Information provided by the hospital prior to our inspection demonstrated 100% of all staff had completed safeguarding adults training and 98.9% of all staff had completed safeguarding children training against a target of 95%. Staff we spoke with all told us they had completed all aspects of their safeguarding training, including safeguarding children level three training.
- All staff were trained to level two safeguarding processes, heads of departments, including the Hospital Director, and a core of clinical staff were trained to level three. The Head of Clinical Services, who was the safeguarding lead, is trained to level four.
- We reviewed the safeguarding procedure for children and young people June 2017 which was based on current best practice guidance and the Intercollegiate (2014) Safeguarding children and young people: Roles and competences for healthcare.
- Staff we spoke with were able to describe a safeguarding concern and the process they would follow to ensure it was dealt with appropriately including referral to local safeguarding teams. Posters were displayed throughout the hospital with contact details and information for safeguarding concerns. There was a hospital wide process for documentation to flag if a patient was vulnerable or had different needs. However, staff we spoke with were unsure if there was a flagging system but at the time of the inspection the hospital had not provided care and treatment for any patient who was living with dementia, had a learning disabilities or other cognitive impairment.
- We did see the policy for safeguarding vulnerable adults which included information related to planning and assessing care for vulnerable adults with carers and family where independence is not possible.
- The safeguarding adults policy also contained information about the government's Prevent Strategy, part of the government's counter terrorism strategy which aims to stop people becoming terrorists or supporting terrorism. This was also included within the safeguarding training.
- We saw evidence, including a root cause analysis and action plan, of where administration staff had raised an adult safeguarding concern after contact from a member of the public. Action included positive feedback to the administration team on following safeguarding procedures appropriately.
- All staff involved in the care of patients had in date disclosure and barring service (DBS) certificates in place and we saw evidence of this in the staff records we reviewed.

Mandatory training

- Staff received effective mandatory training in safety systems. The target for mandatory training was 95%. Records showed 99% of staff had attended all required mandatory training in 2017. Records showed 89% of staff had attended mandatory training in the reporting period. There were eight topics; safeguarding adults, safeguarding children, fire safety, health and safety, infection control, manual handling, compassion in practice and equality and diversity.
- Specific training on sepsis recognition was included in the acute illness management training.
- We saw that staff compliance with mandatory training was discussed at departmental meetings. Compliance was also seen to be discussed when an appraisal was completed.
- Records for storing information on mandatory training were stored on an electronic system. We also saw optional role specific training was recorded for example; the nurses would complete safe transfusion depending on where they worked. All records for mandatory and optional training were stored electronically. We saw that reports were run monthly to check staff mandatory training completion rates.
- Staff told us mandatory training was a mixture of online training and face to face. Staff told us they were given time to complete the training at work and we saw the learning zone in the ward area which had computers available for the staff to do their online training.
- We saw evidence that the doctors employed by an external agency (resident medical officers), completed all required mandatory training.
- Mandatory training for practising privileges consultants was completed via their employing NHS trust and checked / updated by Spire Nottingham Hospital.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- We observed patients being assessed, monitored and cared for safely and were assured that systems were in place to remove and reduce the level of risk to patients.

  The American Society of Anaesthesiologists (ASA) used a grading system of one to six, which determines the fitness of patients. Grade one patients were normally healthy patients, and grade two patients had mild disease, for example well controlled mild asthma. Only patients that are ASA grade one or two had their operations undertaken at Spire Nottingham Hospital to ensure the hospital had the resources to meet their needs. ASA 3 graded patients could be considered for surgery at the hospital but only following a multidisciplinary team assessment where it was in the best interests of the patient.
- All patients underwent pre assessment and if there were any concerns about the patient's suitability this was discussed with the anaesthetist.
- Patients were accepted for treatment following a pre assessment consultation and according to the Spire Nottingham Adult Elective Surgical Admission Criteria. The hospital cared for level zero patients but was staffed and equipped to manage level one patients if required. Level zero patients are patients whose needs can be met through normal ward care in an acute hospital; level one patients are those at risk of their condition deteriorating and need additional advice and support from a critical care team.
- Most elective surgical procedures had a care pathway in place (92 in all). The pre assessment process was clearly described in each care pathway. We reviewed the care pathway for replacement of a hip joint. Clinical risk assessments included ASA score, vital signs, urinalysis, Waterlow score to assess the risk of pressure sores, thrombosis risk assessment, bleeding risk assessment and falls risk assessment.
- Female patients were informed that a pregnancy test may be required on admission to reduce any risk to an unborn foetus in the case of patients who were not aware they were pregnant.
- All patients over the age of 75 years completed an abbreviated mental test score for dementia screening. All patients screening positive for dementia then went on to be fully risk assessed to make sure they understood and had mental capacity to make an informed consent decision about their treatment.
- Cardiac patients were assessed by the cardiac nurse specialist in line with British Cardiovascular Society guidance. The resident medical officer and the

resuscitation lead were informed when cardiac patients were undertaking exercise tests to ensure that in the event of sudden patient deterioration resuscitation and life support procedures could be administered swiftly.

- All patients had a physiotherapy assessment following their surgery to make sure they were not developing a post-operative chest infection and to check they were able to mobilise.
- The World Health Organisation (WHO) 'five steps to safer surgery checklist' (WHO checklist) is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from theatre.
- The 'five steps to safer surgery checklist' was used in the operating theatre, and the cardiac catheter lab. We observed it being completed correctly in the operating theatre.
- The quarter three report of surgical safety checklist audit of the notes demonstrated a compliance with the WHO checklist of 100%. Senior managers told us that if any members of staff were not compliant with doing the appropriate checks that would be discussed with them and in the case of consultants not being compliant, this would be reported to the Medical Advisory Committee (MAC).
- Systems were in place to identify and manage patients whose condition was deteriorating.The frequency of routine observations, such as pulse and temperature, were dependant on what treatment the patient had undergone.
- All staff in the department had completed immediate life support (ILS) training and paediatric basic life support training. Registered staff had also completed an acute illness management (AIM) course to aid them in the recognition and treatment of a deteriorating patient. Unregistered staff were also undergoing specific AIM training for their role. This training included the management of sepsis.
- The national early warning score (NEWS) was used for deteriorating patients plus a sepsis-screening tool. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. This included patients experiencing signs of delirium during their stay in the hospital would be escalated as per the escalation procedure for deteriorating patients
- Staff showed us a folder containing information and instructions about what to do in the case of a deteriorating patient which included managing extreme blood loss and transferring the patient to another hospital. Documentation included an SBAR handover sheet and a checklist. SBAR stands for situation, background, assessment and recommendation and is a recognised briefing model used in clinical settings; it ensures all the relevant information is available to establish the best course of action for the patient.
- The hospital kept four units of O negative blood on site; O negative blood can be given to any patients in an emergency regardless of their blood group.
- A service level agreement was in place with a local NHS acute hospital for the transfer of patients who needed a higher level of care. We saw an incident report and staff told us of an example of a patient who was transferred successfully to an NHS hospital according to the agreement.
- The resident medical officer (RMO) was available to respond to any patient concerns. Guidance on when it was appropriate for nursing staff to call the RMO was outlined in the RMO handbook. The patient's consultant or nominated deputy could be contacted at any time if the RMO had any urgent concerns. Staff told us it was very easy to contact the anaesthetist or consultant if needed.
- When patients were discharged home ward staff contacted them by telephone the following day to check how they were feeling and to answer any queries. Patients were also supplied with contact numbers for use throughout a 24 hour period should they have any concerns or worries.

Nursing and support staffing

- Staffing and skill mix was planned and reviewed so that patients received safe care and treatment.
- Ward staffing was planned using an adapted version of the Shelford nursing care tool, which is a tool that calculates safe nurse staffing levels. Nursing staff told us the tool was updated daily and adjustments were made

to the nurse rota if necessary. We saw from the staffing rota and the staff on duty at the time of our inspection that actual staffing levels matched planned staffing levels.

- Two members of staff with intermediate life support skills were on duty at each shift, we saw this clearly marked on the staffing rota in line with the hospital's resuscitation policy.
- Staffing in the operating theatres followed the Association for Perioperative Practice recommendations and during our time in the operating theatre we observed the correct level of staff in attendance. The theatre manager told us that the theatre team was selected depending on the type of operation being performed, for example a member of staff with experience in spinal surgery would be selected for spinal operations.
- In the other areas of the hospital we visited we saw there were adequate numbers of support staff on duty including the pharmacy, physiotherapy department, pathology laboratory, domestic and catering staff.
- The provider did not use agency staff but did have a team of bank staff who worked regularly at the hospital; bank staff had the same training and induction as permanent staff.Bank staff had to work regularly at the hospital to maintain their position on the bank; this meant that bank staff were up to date and familiar with the policies, procedures and working practices at the hospital.
- Staff handovers took place between shifts, in the operating theatre and between the resident medical officers. We observed a multi-disciplinary handover on the ward during which each patient's care, treatment and progress was discussed. Staff told us the handovers were thorough and meant they had all the information they needed to care for patients.

Medical staffing

- Consultants retained 24 hour responsibility for their patients. Consultants with practising privileges were only appointed if they lived within 45 minutes of the hospital and we saw in the Medical Advisory Committee meeting minutes where some consultants had not been accepted because they lived too far away. This meant that consultants working at the hospital could attend quickly if needed.
- A resident medical officer (RMO) was on site throughout the 24-hour period. Two RMOs worked on a weekly rota. RMOs were allocated a bedroom on the ward and had access to the restaurant and food preparation areas. The RMOs were supplied through a private provider of medical services. In the event of an RMO being unable to attend, work arrangements were in place for another RMO to be in place within four hours. The patient's consultant or anaesthetist provided emergency cover until the replacement RMO was in place. This arrangement could also be activated if the on duty RMO had been working for a prolonged period without any sleep.
- Anaesthetists stayed at the hospital until all patients were fully conscious and had returned to the ward following surgery; this meant they were available to deal with any emergencies in the immediate post-operative period. All RMOs held a current advanced life support (ALS) certificate.
- The RMO attended the daily multi-disciplinary ward meeting and gave a detailed handover to the next RMO who was taking over the duty.
- We observed consultants discussing patient care and treatment with nursing staff and the RMO.

Emergency awareness and training

- The hospital had anticipated risks and made plans.
- We saw evidence of regular scenario training for clinical emergencies such as cardiac arrest, anaphylaxis and major haemorrhage. We saw evidence of these training exercises, feedback from them and learning for the staff. Staff told us that they found the scenario training valuable as it enabled them to keep their skills up to date.
- The hospital had practised a scenario where a patient required emergency admission to an acute hospital. They involved the local NHS ambulance service and NHS acute hospital so they would become familiar with the location and layout of the hospital.

- Fire drills were carried out monthly including use of the evacuation slide. Fire wardens were clearly identified by wearing a red badge. A fire warden was available on each shift on the ward and in theatre.
- Emergency generators were tested monthly, on average the emergency generator took 15 seconds to re-establish power to the hospital. Operating theatre equipment had uninterrupted power supply systems in place which were also tested monthly. This meant that in the event of total power failure systems were in place to make sure care and treatment was not affected.
- Pathology had practised retrieval of blood products from the local NHS hospital should more supplies be required in an emergency.
- Staff were aware of the business continuity plan which could be accessed on the hospital's internal computer system. This contained action cards, information on key holders and evidence of annual desktop exercises. A copy of this policy was also kept behind the reception desk in the outpatient department, which meant if required this was easily accessible by staff.

Are surgery services effective?

Good

Evidence-based care and treatment

- From the policies and procedures we reviewed we saw that care and treatment was delivered in line with legislation, standards and evidence based practice. Staff were familiar with policies and procedures and had to sign to say they had read, understood and would deliver care and treatment in line with them.
- Staff were informed about new guidance through the safety update bulletin and we saw in the December 2017 bulletin a list of the latest National Institute for Health and Care Excellence (NICE) guidance.
- From our observations of care and the patient records we reviewed we saw examples of NICE clinical guidelines (CG) being implemented such as CG50, care of the deteriorating patient and CG51, sepsis recognition. We also witnessed procedures in the cardiac catheter lab following British Cardiovascular Society and British Society of Echocardiography recommendations and guidance.
- The hospital had a comprehensive audit schedule in place with audits planned across a 12 month period covering all clinical areas, environmental issues and customer relations.
- The hospital had not reached the threshold for benchmarking against national and NHS audits due to low patient numbers and not yet being open for 12 months.
- Clinical indicators such as venous thromboembolism assessment compliance, national early warning score documentation, infection control, consent procedures, patient satisfaction and staff training were measured. Managers told us that when hospital heads of departments met they discussed the clinical scorecard and shared best practice with each other.
- We saw evidence of where practice had been changed as a result of audit. For example the pharmacy team had identified from an audit of their intervention log that laxatives were not being routinely prescribed with opioid medication, they subsequently produced an advisory sheet for nursing and medical staff on co prescribing of laxatives and opioid medications.
- Staff and managers were aware of the Royal College of Surgeons, standards for cosmetic surgery and we saw evidence of where the standards had been implemented. For instance in the patient records we reviewed the two week cooling off period had been explained and documented.
- The hospital submitted information to the breast and cosmetic implant registry and the national joint registry. We saw staff in the operating theatre logging implant details to be submitted to the registry.

Pain relief

- Pain was assessed and managed effectively. Patients were asked about pain in the pre assessment consultation. Anticipatory pain relief was prescribed and we saw this in the patient records we reviewed and being administered in the operating theatre.

- Pain was measured using a pain score of 0 – 4 where 0 is no pain and 4 is worst pain possible. The five patients we spoke with told us that nurses frequently checked and asked if they were comfortable and pain relieving medicines were administered quickly without any problem.
- Post-operative nausea was assessed using a nausea score, and anticipatory anti-emetics were also prescribed.
- Pain and medicines management was a standing agenda item on the medicine and pain management committee meeting and any issues were then passed through to the clinical governance committee.

Nutrition and hydration

- Food was prepared on site in the hospital kitchen by a team of chefs and met the nutritional requirements of patients, staff and visitors to the hospital.
- The hospital menu was compiled in consultation with a nutritional dietitian. Patients were able to choose from a variety of meals. The chef told us that they often responded to special requests from patients; Patients were complimentary about the food provided and one patient told us the food was 'equivalent to that of a five star hotel.'
- A member of the catering team attended the multi-disciplinary ward round which identified patients with special dietary requirements. This information was also displayed on a notice board in the kitchen.
- Patients requiring a general anaesthetic were fasted according to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. Fasting times were clearly communicated for each patient at the daily ward briefing and staff handovers.
- In the theatre department there was discussion about compliance to theatre starve times in line with national guidance and scorecard key performance indicators (KPIs). The most recent results showed the hospital had recorded 65% compliance against a target of 60%.
- Anticipatory medicines were prescribed to manage post-operative nausea and vomiting, we saw evidence in the patient records we reviewed.
- The hospital had dietetic services available two days per week but could contact a dietitian at other times if urgent dietary advice was needed.
- Patients' diet and nutritional status was covered in the pre assessment phase using the malnutrition universal screening tool (MUST). MUST is a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan and onward referral to a dietitian if necessary depending on the score.

Patient outcomes

- The provider monitored treatment outcomes and submitted information to the national audits, benchmarking and accreditation schemes. However because the hospital had not been operating for more than 12 months and patient numbers were low, there had been no return on the outcome information.
- Patients having hip replacements, knee replacements, hernia repairs and cataract operations were sent information about the patient reported outcome measures (PROMs) survey with their appointment letter. Patients happy to take part in the survey could complete it as part of their pre assessment consultation or on line at home via 'My Clinical Outcomes.' Patients were reminded through 'My Clinical Outcomes' three to six months following their operation to update the PROMs survey.
- The Head of Clinical Services told us that preparation for various national accreditation schemes was on going, for example, the endoscopy suite was working towards being Joint Advisory Group on Gastrointestinal Endoscopy (JAG) compliant.
- The hospital had begun the process for submitting information to the Private Healthcare Information Network (PHIN). PHIN publishes independent information to help patients make better treatment choices.
- Plans were in place for benchmarking consultants' performance but at the time of our inspection patient numbers were too low for the information to be meaningful.
- The hospital was collecting Quality-PROMS for patients having cosmetic surgery. Quality PROMS measure

patient satisfaction with the outcomes of some cosmetic surgery procedures for example, eye lid surgery, breast surgery and nasal surgery. However due to low numbers of patients meaningful data was unavailable.

- Out of 68 inpatient attendances there were three (4.4%) unplanned transfers to other hospitals, one readmission within 28 days of discharge and one unplanned return to the operating theatre.

Competent staff

- Staff maintained their skills and competencies in a variety of ways in order to deliver effective care and treatment. Robust recruitment processes were in place, which meant that staff with the right qualifications and experience were appointed. Staff told us that the provider arranged additional training in a variety of topics and they could request specific training through their line managers.
- We saw new training and development opportunities advertised in the December 2017 safety update bulletin and instructions for staff on how to access the training, this included information governance training and British Oxygen Company (BOC) training for medical gases.
- The human resource department monitored professional registrations and when registrations were nearing renewal reminders were sent to head of departments to follow up with individual staff.
- All qualified nursing staff had attended training for intermediate life support and national early warning scores. Other training courses were being provided by the hospital such as acute illness management and blood transfusions. Acute illness management training also included recognition and management of sepsis and was refreshed every two years.
- Catering staff we spoke with told us they completed food hygiene standards training and had attended training events delivered by a dietitian.
- The majority of consultants working at the hospital practised in NHS hospitals; effective processes were in place to grant practising privileges to those consultants applying to practise at the hospital. A few consultants did not practice in NHS hospitals, Spire Healthcare provided a responsible officer to these consultants to make sure they were fulfilling the requirements for revalidation.
- In all six consultant personnel files we reviewed details of the individual's scope of practice, CV and training record were complete and up to date. We saw evidence of monthly checks being run on the electronic HR system which showed any lapses with indemnity cover, General Medical Council (GMC) registration and appraisal information. Consultants were alerted of any information that was out of date and consultant practising privileges would be suspended if not acted upon promptly. The chair of the MAC was informed of any such issues.
- We saw all consultants who worked at the hospital had the correct pre-employment checks completed in order to be granted practising privileges. All applications for practising privileges went to the hospital director and were discussed with the chair of the MAC and ratified by the MAC. Qualifications were checked for any consultants applying to work at the hospital and their scope of practice should be the same as their practice in their employing NHS trust. An example was given of turning down an application in relation to a surgeon's patient outcome figures.
- The practising privileges biennial review programme is now undertaken at 18 months rather than 24 months. These will be reviewed at the MAC meeting. This was a recommendation of an independent review of the governance arrangements at Spire Hospitals, completed in 2014.
- A consultant directory was available to patients, which gave the names of consultants working at the hospital and their speciality. The hospital had plans to publish consultant performance data once patient numbers had increased.
- Staff we spoke with told us that they had regular meetings with their line managers and an annual appraisal meeting. In the staff personnel files we reviewed we saw that annual appraisal meetings had taken place for all staff who had worked at the hospital for longer than six months. The hospital reported that all (100%) of ward and operating theatre staff had received an appraisal within the last 12 months.

- Case reviews of complex cases would take place at the medical advisory committee (MAC); however the hospital had not managed any patients in this category since it opened.

Multidisciplinary working

- We observed effective team working in all areas of the hospital, multi-disciplinary team meetings, handovers and briefings took place regularly to ensure effective care and treatment was delivered to the patient.
- We joined the ward multidisciplinary meeting, which involved nursing staff, the resident medical officer (RMO), pharmacy staff, physiotherapy staff and catering staff. A thorough update was given for all the patients on the ward including discharge plans, discharge medicines, special dietary requirements and allergies. The meeting was participatory and each member of the team was clear about their role in the care and treatment of the patient. Relatives and carers were also mentioned if relevant.
- We also observed the operating theatre briefing which took part at the beginning of the day. The briefing included staffing roles and the theatre cases for the day, ward staff also attended this briefing.
- We also joined the head of department daily briefing which received feedback from all of the hospital briefings to ensure there was a full overview of patient safety. An on call head of service would also be informed of any concerns at weekends and out of hours.
- Patients, staff and the RMO knew who was ultimately responsible for the care of the patient.We observed handovers between the consultants, anaesthetist and the resident medical officer.
- An escalation procedure was in place, which described clearly the action nursing, and medical staff should take in the case of a deteriorating patient or a patient showing signs of sepsis.
- Ward staff liaised with relatives and carers, with the consent of the patient, to keep them up to date with patient progress and discharge plans.
- Discharge planning began once the patient was admitted to hospital, plans were discussed with all members of the multidisciplinary team (MDT) so arrangements such as take home medicines, follow up appointments and physiotherapy sessions were in place on the day of discharge. Discharge information was documented in the GP discharge letter which was posted to the GP on the day of discharge.

Seven-day services

- Systems were in place to ensure that all services could be available in the out of hour's period.
- Radiology, theatre staff and pharmacy staff were on call during the out of hour's periods; these were weekends, evenings, nights and bank holidays.
- Physiotherapists provided a seven day service for patients requiring physiotherapy at the weekend and were on call at other times.
- Blood tests could be analysed out of hours if needed. Staff told us pathology staff could usually get to the hospital within 15 minutes. Microbiology tests were carried out at the Spire Healthcare hub in Manchester, specimens were collected twice a day from the Spire Nottingham Hospital.
- Contact information about out of hours, on call services was included in the registered medical officer handbook. The RMO was onsite and available 24 hours a day. For complex matters and further advice and support the RMO told us they could contact consultants and that when they had cause to do this they had found it very straightforward.
- We saw consultants provided details of cover arrangements for when they were not available when obtaining practising privileges. This was documented and kept on record on the ward as well as in their personnel files.

Access to information

- Staff had access to all the information they needed to deliver effective care and treatment.
- Patient records were predominantly paper based and stored on site at the hospital. This meant that it was easy to request patient records and they were quickly available. Consultants did not take patient records out of the hospital.
- Discharge letters for GPs were printed and posted on the day of discharge; patients told us that their GP had

received information from the hospital the day after they had been discharged. GP discharge letters included full details of medication and any further treatment the patient required, for example physiotherapy.

- GPs were able to contact the hospital through the hospital switchboard and if necessary could request to speak to the patient's consultant. Ward staff told us they had taken phone calls from GPs in the out of hour's period and had transferred calls to the RMO.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent and details on the Mental Capacity Act, 2005 (MCA) guidance.
- Staff were aware of their responsibilities under the MCA, 2005 and deprivation of liberty safeguards (DoLs) and were able to describe the arrangements that were in place should the legislation need to be applied. Training on DoLs and the MCA was part of the mandatory training.
- Staff were aware of the Mental Capacity Act 2005 and if any concerns about a patient's capacity to consent were identified in the pre assessment consultation these would be discussed with the patient's consultant and the clinical lead.
- We found that patient's consent to care and treatment was sought in line with legislation and staff understood the relevant consent and decision making requirements including the Mental Health Act.
- Detailed information was given to patients to enable them to make an informed decision about care and treatments. The Spire Healthcare website contained detailed information on all procedures carried out by their hospitals.Information packs were given to patients prior to their first appointment. Risks and complications were explained during the consultation phase and we saw where these conversations had been documented in the patient records we reviewed. Patients told us that doctors and nurses spent time explaining procedures and answering questions.
- Patients undergoing cosmetic surgery were given a two week cooling off period. This meant that they had time to reflect on the information they had been given and change their minds if they wished. It also meant they were able to give an informed consent on the day of the operation.
- Patients undergoing breast augmentation requiring prosthetic implants also gave documented consent to be included in the breast implant registry. We saw evidence of this in two of the patient records we reviewed

Are surgery services caring?

Good

Compassionate care

- From the interactions we observed between staff, patients and their relatives, care and treatment was delivered with kindness, dignity, respect and compassion. Staff understood the importance of maintaining patient confidentiality.
- The October 2017 score for the Friends and Family Test (FFT) was 98%, this meant that 98% of the patients who completed the friends and family test survey answered yes to the question 'Would you recommend this service to friends and family?'
- Patients were nursed in single rooms; we observed staff knocking before they entered. In the operating theatre, we saw staff taking care to maintain a patient's privacy during surgical procedures. There were separate areas for males and females in the endoscopy suite.
- We saw notices displayed about the availability of chaperones, one patient told us they had requested a chaperone and someone was available straight away.
- From the November 2017 inpatient satisfaction report, 100% of respondents said they were satisfied with the care and attention they received from nurses and 100% of respondents said they were treated with compassion and respect at all times.
- Staff understood and respected patient's personal, cultural, social and religious needs. Social and home circumstances were discussed at the pre assessment

consultation. The hospital had a multi faith prayer room and a designated hospital chaplain. All patients were asked about their faith, culture and beliefs as part of the pre assessment process.

- Patients told us they were encouraged to wear day clothes the day after their treatment and sit out of bed at meal times. The physiotherapist told us that patients were supported to become mobile as soon as possible following surgery.
- Staff told us they spent time with patients and their relatives to understand their concerns and answer questions. Patients told us that staff were 'wonderful.' One member of staff told us they had recognised that a patient's relative was looking anxious and took time to talk with them and put them at ease.
- We saw staff responding promptly when patients were experiencing pain or discomfort and patients told us nurse always responded quickly to the call bell.

Understanding and involvement of patients and those close to them

- During our inspection we saw that staff involved patients, and if appropriate relatives and carers, in their care and treatment planning.
- Patients told us that staff introduced themselves, explained what care they were going to give and always checked they understood all aspects of their care during their experience at the hospital.
- All the patients we spoke with told us they had plenty of information about the procedures they were going to undertake and about the cost. Patients said there were no hidden costs and that final payments had been what they expected.
- Visiting times were fully flexible which made it easy for relatives and friends to visit. With the consent of the patient relatives and carers were involved in care planning and kept up to date with the patient's progress. There were facilities for relatives or carers to stay overnight if necessary. At the time of our inspection, the husband of an overseas patient had been allowed to stay in the room next to his wife. We saw at the multi-disciplinary meeting relatives were involved in discharge planning.
- From the November 2017 inpatient satisfaction report, patients scored between 94% - 100% to the question 'Were you involved as much as you wanted to be in decisions about your care and treatment?'
- We were told the hospital provided free meals to partners who wanted to come and eat with their friend or loved one whilst in hospital. This has been as a result of a patient who had expressed anxiety about their relative while they were in hospital. As a result of this feedback, they provided their relative with free meals so they could eat together.

Emotional support

- The hospital had adequate services in place to ensure that patients and those close to them received emotional support if needed.
- Patients told us that staff were always there to offer 'an arm around the shoulder' if needed and staff told us they were would always spend extra time with patients or relatives if they appeared upset at any time.
- The hospital had introduced clinical nurse specialists in some areas for example in cancer care and breast care. Clinical nurse specialists were able to offer additional emotional support or refer on to psychological services if necessary.
- There was a designated hospital chaplain; staff could arrange a visit by the chaplain at the patient's request. We saw posters displayed with details of the chaplain and contact information.
- Staff attended 'Breaking bad news' training which covered the emotional aspects of patient care in sensitive situations.

  The hospital supports the emotional and social needs of patients and allows, on occasions, a relative to stay in the Hospital, providing a bedroom and meals for this purpose.

Are surgery services responsive?

Outstanding ☆

Service planning and delivery to meet the needs of local people

Outstanding ☆

Surgery

- Spire Hospital Nottingham is an independent healthcare facility treating mainly self-funded and self-referred patients offering a wide range of specialties and consultants.Hospital managers have pro-actively engaged with the local population, including GP'sto increase understanding and awareness of the hospital and in order to work in partnership to deliver locally identified services. For example, the hospital was developing falls prevention classes at the request of the local community.
- The hospital also worked with local commissioning groups to support the NHS with waiting list initiatives, for example in 2017, the provider carried out tonsillectomy operations via an NHS service level agreement.
- GP training events were delivered at the hospital; this also gave local GPs an opportunity to discuss the services available at the hospital.
- Services at the hospital were provided flexibly in a purpose built environment to suit the needs of the patient and using high specification, sophisticated equipment. Pre assessment consultations were also available in the evening and at weekends.
- Patient wellbeing was integral to the planning of the new hospital and an extensive outdoor area has been developed to allow patients to spend time outside in a protected environment with their families.This included an outdoor play area, water features and ample comfortable seating.
- The hospital had a dedicated coffee and sandwich shop for patients and relatives which was designed to be in a central location of the hospital . When procuring theatre surgical instruments prior to opening, the hospital arranged meetings between consultants and suppliers to ensure that the equipment provided at Spire Nottingham was hand-picked by the surgeons to match their preferences and wherever possible the equipment they were familiar with in their NHS Trust employer to ensure continuity of care.
- A yoga class was developed in the physiotherapy department which is available to patients and staff. This was developed as a direct result of patient feedback that this service would benefit patient's recovery.

Access and flow

- Patients could access care and treatment in a timely way. Patients were referred to the hospital by their GP, consultant or could refer themselves. Patients we spoke with told us that appointments were flexible, quick and could be changed easily.
- The provider sent appointment reminders by text message, patients who did not attend for their appointment were contacted by the bookings team to find out why and book another appointment if necessary.
- Three NHS patients waited on average eight weeks from referral to treatment; the NHS waiting list target is 18 weeks.
- During our inspection, we observed that procedures were carried out on time and patients were kept informed of next steps throughout their stay in hospital.
- Once patients had seen their consultant and the pre assessment nurse, a date was agreed for admission to the hospital for treatment. There were clear exclusion criteria for patient with complex medical conditions. Patients completed a health questionnaire in which they were asked to declare any medical conditions and the pre assessment nurse also recorded the patient's past medical history.
- This meant that patients who were at risk of complications or deteriorating medical conditions were not accepted for treatment at the hospital.
- The hospital only accepted patients for planned surgical operations. In the reporting period April 2017 to November 2017 three patients had unplanned returns to theatre for further treatment.
- Discharge letters were posted to the patient's GP on the day of discharge.
- One patient's procedure was cancelled for non-clinical reasons in the reporting period April 2017 to November 2017 but this patient was offered another appointment within 28 days of the cancelled appointment, which was within recommended timescales.

Meeting people's individual needs

- Staff had access to a translation and interpretation service for patients whose first language was not English. This process had access to translation service on the telephone or could invite interpreters to attend appointments in person.
- All departments also had access to British Sign Language (BSL) interpreters for patients who used sign language to communicate with others.
- The hospital was a new building with free parking and easy access for people who use wheelchairs or were less able bodied. Signs were in the car park reminding patients and visitors that should they need assistance getting from their car into the hospital they should call the number provided.
- Throughout the hospital we observed that services had taken account of the needs of different people including vulnerable persons.
- Access to all areas of the hospital were wheelchair accessible, we saw hearing loops at reception areas. A hearing loop is a special type of sound system for use by people with hearing aids
- We saw hospital information and leaflets written in different languages. Interpreting services were available and staff were discouraged from using friends and family to interpret.
- Staff told us that if patients needed information in different languages this could be arranged, we saw patient notices displayed in different languages.
- Information was available on the Spire Healthcare web site, patients were sent an information pack prior to their first visit to the hospital and additional more specific information leaflets were given at the pre assessment consultation. Patients were also given further information on discharge including post-operative instructions.
- Staff on the ward had completed dementia training and there was a nominated dementia champion for the ward.
- A dementia pathway was in place, patients over 75 years of age were screened for dementia using the Abbreviated Mental Test Score. If the test indicated the patient may be living with dementia their GP was informed and ward staff if they were admitted to the hospital.
- Ward staff showed us a dementia box they had created for patients living with dementia. It contained items that would make the patient's stay in hospital easier such as simple signs and a calendar clock.
- Carers or relatives were encouraged to stay in hospital to reduce anxiety in patients living with dementia or learning disability.The ward had a folding bed that could be made up in the patient's bedroom.
- Free Wi-Fi was provided for patients, visitors and staff.
- The Spire Nottingham Hospital's adult elective surgical admission criteria meant it was unlikely that patients with complex medical needs were treated at the hospital due to the increased risk of complications during and after surgery. However, all patients were assessed individually including those living with dementia.
- The hospital had specialised bariatric equipment to care for and treat bariatric patients (who have a BMI (Body Mass Index) exceeding a healthy range) and we saw electronic hoists ready for use.

Learning from complaints and concerns

- Patient's concerns and complaints were taken seriously, complainants were informed of the progress of the complaint investigation and learning identified was shared widely.
- In the reporting period April 2017 to November 2017, there were 11 complaints. Complaints were managed by the complaints co coordinator and reviewed by the hospital director and head of clinical services. We saw that complaints had been managed in line with the hospital complaints policy, all but one had been responded to within the correct timescales. Complainants had access to the hospital director and head of clinical services if they wished to discuss their complaint in a face-to-face setting.
- The provider monitored complaints for trends and themes and learning from complaints was shared with staff through the safety update bulletin and with the wider Spire Healthcare community.
- We saw where actions and shared learning contributed to the improvement of care quality for the patient such as promptness in answering telephone calls from patients and practice around anti embolism stockings.

- Patients told us they would feel comfortable raising concerns or making a complaint. We saw 'Please talk to us' leaflets which described the complaints process to patients and action the patient could take if they were not satisfied with the response, such as contacting the Parliamentary Health Services Ombudsman or the Independent Healthcare Sector Complaints adjudication service.

Are surgery services well-led?

Outstanding ☆

Vision and strategy for this core service

- The provider had a clear vision 'to be the first choice for independent healthcare in the Nottinghamshire and surrounding community' and five strategic objectives for 2018. The five strategic objectives for 2018 were: to receive outstanding from the CQC, get it right first time, believe in our people, celebrate patient satisfaction and be innovative to enhance the patient experience and finally deliver revenue and regrowth in line with their annual operational plan.
- The strategic objectives were developed by the senior management team and heads of department whilst taking in to account responses from the hospital staff and consultant satisfaction surveys.
- Quality and safety was a top priority for the hospital and this was reflected in the objectives. One objective was to 'get it right first time- ensure processes are ingrained to deliver efficient services.' For example in theatres and on the ward 'ensure patient safety is at the forefront of everything we do by adhering to national guidelines, policies and clinical best practice.'
- We saw the objectives reflected in department team strategies and in individual staff appraisals. Objectives were realistic and contributed to the overall strategy.
- The senior management team told us they had engaged and listened to staff to ensure their voice was heard throughout the development of the strategy.
- All staff we spoke with were aware of and felt involved in the vision and strategic objectives and understood how these related to their individual performance.
- All staff we spoke with told us they were proud of working at Spire Nottingham Hospital and the visions and values were displayed in clinical areas.
- New staff told us they were made aware of the provider's vision and values at induction and this was reinforced through the appraisal programme. Staff were encouraged to demonstrate the values through their behaviours.
- Staff spoke with overwhelming pride in how they provided care for patients. Staff talked about their dedication and commitment of teams to provide the best patient experience.
- There was a clear action plan towards the strategic objectives and a planned review to monitor progress during 2018.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was an effective governance framework in the hospital, which gave robust assurance about the quality and safety of services. The provider held meetings through which governance issues were addressed. The meetings included the Medical Advisory Committee (MAC), Heads of Department (HOD), Clinical Audit and Effectiveness and Clinical Governance Committee. We saw the hospital committee structure organisation chart for 2018 and it was clear which committees were active and who chaired each meeting.
- The hospital had a clinical scorecard that had keyperformance indicators (KPIs) that were reportedquarterly. Results were benchmarked and trackedagainst group performance targets. Staff told usthis was used for quality improvement. We sawevidence at Clinical Governance and departmentalmeetings that results were discussed.
- All staff were aware of the clinical scorecard which had a number of key performance indicators related to patient safety. The scorecard was seen to be displayed in all clinical areas visible to staff.
- There was strong engagement with consultants workingat the hospital. As this was a new hospital, the MAC had to start from the beginning, which was a first for Spire Healthcare. A core team were approached prior to the hospital opening and an interim MAC was

developed. This became a full MAC in November 2017 and was seen to haverepresentation from different clinical specialties. The senior team and the MAC chair were very proud of how this team had evolved over the months leading up to the development of a full MAC.

- Mostconsultants worked at the local NHS hospital. The MAC chair and the Hospital Director had close links to the local NHS hospital medical director to ensure open lines of communication. were reviews of consultant practice to ensure thatthe consultants were working within their own scope ofexpertise.
- Effective systems were in place for granting practising privileges to consultants. All applications to practice at the hospital were reviewed by the hospital medical advisory committee (MAC). We saw evidence of this in the minutes of the MAC meetings we reviewed. We reviewed six sets of consultant personnel files, all contained evidence of the appropriate checks required by regulation including medical indemnity insurance and appraisals. Practising privileges were suspended if the consultant did not practise regularly at the hospital.
- There was a nominated consultant (MAC chair) whosupported the Clinical Governance Committee and alsosat on the MAC, the minutes showed they supported thefeedback of any governance issues to the MAC. This person also had direct access to all hospital policy and process documents in order that if any communication or changes were made they would be immediately informed.
- The Clinical Governance Committee met quarterly.Regular agenda items included incidents, keyperformance indicators, clinical audit plan, patientsafety, patients' experience and the risk register.
- Reviewing incidents was a standard agenda item on the quarterly clinical governance committee meeting and we saw evidence of this from meeting minutes. The senior team explained to us and we saw evidence of discussion concerning trends of incidents and planned action to be taken. We saw all incidents were reviewed by committee members monthly and summarised quarterly at the meeting.
- Learning wasshared across the other hospitals in the organisation, an organisation wide incident review working group reviewed all incidents to identify shared learning.
- All incidents were categorised by location and type and this was reviewed by the senior management team and reported onto the governance committee and medical advisory committee (MAC). Near miss incidents were also reviewed and discussed.
- The children's and young person's service was suspendedin October 2017 in order to ensure all staff had therequired training to enable this service to continue. Wesaw this was discussed and minuted at the ClinicalGovernance and MAC committee demonstrating a goodgovernance process. This demonstrated the hospitalleadership team made decisions based on the need toprovide safe services of good quality, even if they mayhave negative commercial consequences. This was also demonstrated in the slow build up and introduction of other services within the hospital for example intensive care utilisation and chemotherapy treatments.
- There was a wide range of audits carried out in thehospital and these were seen to be reviewed at theClinical Audit and Effectiveness Group, which in turn fedthrough to the Clinical Governance Committee andHODs meeting. Patient safety was seen to be an agendaitem for all committees. There was a regular audit planat the hospital and we saw they were up to date with theplan.
- Information was two way and key points were included in the safety update bulletin for staff. This meant that staff at all levels had a clear picture of quality and performance across the hospital.
- We reviewed the hospital governance report for quarter three 2017. The report was based on the Care Quality Commission five domains of safe, effective, caring, responsive and well led. It was a comprehensive document highlighting to all members of staff for example, the levels of activity, any changes in activity, new consultants, safety information including trends of incidentsand safety alerts.
- Policies and procedures were in place to support staff to carry out their duties safely and effectively and new policy information was included in the monthly safety update bulletin.
- The hospital maintained a risk register, risks were red, amber, green (RAG) rated, mitigating actions and controls were described in the risk register. There were

no risks rated red – the highest risk rating. We discussed risks with the department heads, the risks they described for their departments were commensurate with the risks identified on the risk register.

- All staff we spoke with were aware of the risk register. We saw that all incidents, risks and complaints were logged and managed on the hospital's electronic reporting system.
- Managers told us they were compliant with national safety standards for invasive procedures as the hospital fully adhered to the national Spire standards for surgical safety known as LocSSIP's.
- The hospital had a named infection control and prevention lead in post and an annual programme of Infection Prevention for 2018, which outlined actions required to reduce the risk of health care associated infection.

Leadership / culture of service related to this core service

- The senior team and heads of department at this hospital were mostly recruited prior to the hospital opening. They were able to develop as a new team and work collaboratively together to develop the foundations of the hospital since its inception.
- As a group, they had recruited teams and developed the services to provide quality safe care for patients. We saw evidence throughout our inspection of how the team had used their skills and knowledge to capably lead this hospital from the planning stage to a functioning hospital.
- The senior team had identified that they were continuing that growth and development through sharing and learning between teams across the hospital.
- The MAC had a new but stable membership and our discussions showed there was open communication with the hospital senior management team. This demonstrated a shared focus on delivering good governance and quality patient care.
- Staff were full of praise for the senior management team. Staff told us they regularly saw the hospital director and head of clinical services in their departments. All members of the senior team were seen to be approachable. Many members of staff told us 'that the fact that the hospital director and clinical leads knew their names meant a lot to them.'
- There was clear leadership, and staff knew their reporting responsibilities and took ownership of their own working areas. Staff were seen to be sharing ideas and between teams and working together to gain an understanding of each other's roles as the services developed. This was evident in relation to staff on the ward understanding of booking procedures and administration protocols in order to answer patient's questions or access the right person for them to speak to.
- During our inspection, leaders were visible in all departments we inspected; staff knew the senior managers, referred to them by name and told us they were very friendly and approachable. We observed staff and leaders interacting, leaders' mannerisms toward staff were appreciative and supportive.
- From the conversations we had with staff and senior managers, the data we reviewed and the action plans and learning identified, it was clear that leaders could recognise challenges to good quality care and identify actions to address them.
- There was a culture of openness and honesty, this was evident from the incident reporting process, complaints process and the way the hospital marketed its services.
- A whistle blowing policy, duty of candour policy and appointment of two freedom to speak up guardians supported staff to be open and honest. Staff told us they attended duty of candour training and described to us the principles of duty of candour.
- Staff told us they felt respected and valued. All staff were given a Spire Healthcare welcome handbook on appointment which contained all the information they needed to carry out their roles effectively including uniform policy and details of the employee assistance programme.
- Local managers we spoke with told us there was a procedure in place for the management of poor performance but to date they had not needed to use it.

- The senior team had identified and addressed some areas of poor performance and staff problems .They were dealt with and we were assured by how this was resolved to ensure staff did not feel intimidated and that patients were kept safe.
- There was an overall emphasis on safety and quality throughout the hospital from the quality of the food provided to the procedures and checks in place to ensure patient safety.

Public and staff engagement

- The hospital actively engaged with staff and the public by a variety of communication methods. They took on board comments and suggestions and acted accordingly to address issues. We saw minutes from a monthly 'believe in our people meeting'; representatives of all staff grades attended these meetings in order to review new ideas for development across the hospital. For example as the teams were all new it was discussed how to ensure staff developed an insight into other departments of the hospital.
- An annual staff survey took place which translated in to an action plan which was shared with staff. We saw the 'You said/we did' action plan displayed on notice boards. Staff had asked for more information on hospital performance and other key issues so in response, managers had implemented additional communication methods.They also held a 'Believe in our people' group made up of representatives from each department who could raise concerns or make suggestions on behalf of other members of staff.
- Staff told us they could raise concerns with senior staff or line managers, or the freedom to speak guardian. Posters were displayed in prominent areas with details of the freedom to speak guardian. Staff were also aware of the hospital whistle blowing policy; 94% of staff answered positively to 'I am aware of Spire HealthCare's policy on whistleblowing.'
- In the hospital consultant survey, 79% of consultants rated the service as excellent or good. This placed the hospital fourth out of 39 hospitals in the Spire Healthcare group.
- Feedback from the most recent patient survey showed that patients felt they had 'information overload' at the time of discharge. In response, ward staff introduced a follow up phone call with the patient the day after discharge to check if the patient was happy with discharge instructions.
- The hospital also took part in the net promoter score. The net promoter score is a management tool used to gauge the loyalty of an organisation's customer relationships. During 2017, patients gave the hospital a 90% net promoter score.
- In June 2017, the hospital held a public open day, which was well attended by the local community.Feedback was collected and as a result, the physiotherapy department planned a weekly Pilate's class and were developing falls prevention classes. The hospital had also welcomed visits from the local U3A (University of the third age) and Rotary club groups.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- One of the five strategic objectives was to deliver revenue growth and ensure sustainability. Senior managers had plans in place to increase patient numbers and make services more attractive to the public by re opening paediatric services, offering appointments in 24 hours, providing one stop shop services, providing one total cost for all procedures and supporting NHS waiting list initiatives.
- Staff and managers looked for continuous improvement by learning from incidents and complaints, implementing new evidence based practice and responding to feedback from patients and other stakeholders.
- Staff used information to proactively improve patient care. For example, a pain management group had started to meet to review pain management throughout the patient journey, including audit of patient records and analysing patient feedback. One result of this meeting was to identify a pain specialist for Spire Nottingham Hospital and arrange pain management training.
- The provider ran a staff reward scheme called 'Inspiring People.' Nominations were received from all hospital

staff and each month one member of staff was selected to receive a gift voucher in appreciation of what they had achieved.Staff could also nominate colleagues to the annual Spire Healthcare award scheme.

Outstanding ☆

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- There were no never events reported for the service from April 2017 to November 2017. 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.
- There were no serious incidents reported for the service from April 2017 to November 2017. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- The service recorded 40 incidents from April 2017 to November 2017. Thirty of these incidents were defined as clinical incidents and 10 were recorded as non-clinical incidents. Staff told us the main themes behind the incidents reported in the department were administration errors and errors in labelling specimens. Learning from the incidents had taken place and measures implemented to prevent further incidents.
- All staff we spoke with had a good understanding of the incident reporting process. All staff had completed and submitted an incident form and had feedback following incidents they had submitted.
- There was a good learning from incidents culture within the service. Staff were not only aware of incidents reported locally in their own department, but also within the hospital and provider wide incidents. Staff discussed relevant incidents at team meetings and identified any potential learning for their department.
- Under the Ionising Radiation (Medical Exposures) Regulations (IR (ME) R) 2017, providers are required to submit notifications of exposures 'much greater than intended' to the CQC. We received no notifications from April 2017 to November 2017. Staff in the diagnostic imaging department had a clear understanding of what a reportable incident was.
- Senior staff had recently completed root cause analysis (RCA) training to develop their skills when it came to incident investigation. At the time of our inspection, they had not been required to complete a RCA of any incidents, which happened in their department.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.
- Staff we spoke with had an understanding of the duty of candour process and the need for being open and honest with patients when errors occur. Senior staff members were able to confidently explain the process they would undertake if they needed to implement the

duty of candour following an incident, which met the requirements, however at the time of our inspection, they had not needed to do this. Staff did however discuss an incident, which occurred in a different service where the duty of candour was implemented.

For our detailed findings on incidents, please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

- All areas of the outpatient and diagnostic imaging departments we visited were visibly clean and tidy. Environmental audits were conducted by the infection prevention and control (IPC) lead. Results from the audits conducted in November 2017 showed an average 94% compliance with requirements for nine areas audited. All areas audited where clinical care and treatment was provided demonstrated 100% compliance. Areas which demonstrated the lowest compliance (82-93%) were administration areas, waiting areas and the dirty utility room. Staff told us actions had been taken in response to these results and compliance had now improved.
- The service had not participated in the patient led assessment of the care environment (PLACE) audit in 2017, as the hospital had not been open for the minimum required period. However, they had already engaged with the process and were on the audit programme for 2018. PLACE audits look at a variety of areas, which patients feel are essential to maintain high standards, cleanliness of the environment is an element of these audits.
- Housekeeping staff understood their responsibilities, cleaning frequency and standards. There were cleaning schedules in all areas and staff had signed when areas had been cleaned. Housekeeping staff were responsible for cleaning all areas in the outpatient and diagnostic imaging department, except the MRI scanning room. The lead radiographer for MRI was responsible for the cleaning of this room and had access to the appropriate resources to enable them to do this.
- There were handwashing facilities within the clinical environment and staff had access to hand sanitiser at point of care. We observed staff performing hand decontamination in accordance with the World Health Organisation (WHO) five moments for hand hygiene. We also observed hand hygiene promotional posters to support compliance with hand hygiene. All sinks observed in the department were compliant with Health Building Note (HBN) 00-09: infection control in the built environment.
- Patients and relatives were also encouraged to decontaminate their hands when entering the department. Hand sanitiser was available in public areas and waiting rooms for patients and relatives to use as required. We also observed hand sanitiser dispensers, which were aimed at children who visited the department. These were decorated in a way to encourage them to use them, as well as being at a height, which made it easy for them to use.
- The department regularly conducted hand hygiene audits. Information provided before the inspection demonstrated 100% compliance. These audits also included whether staff were bare below the elbow in accordance with national and local policy. All staff we observed during our inspection were bare below the elbow.
- Staff had access to personal protective equipment (PPE) in all areas of the outpatient and diagnostic imaging department to protect themselves and patients during care and treatment. We saw evidence of this in use throughout the clinic.
- We saw evidence of regular tap flushing within the departments, which was in line with the requirements of health technical memorandum (HTM) 04-01 the control of Legionella, hygiene, safe hot water, cold water and drinking water: part A. These records were electronic and reviewed regularly by the responsible person for the water system as part of the water safety group.
- There were wipes available for decontaminating equipment after use in all areas of outpatients and diagnostic imaging. There was also a well-embedded process in place using the green 'I am clean' stickers to identify when items of equipment were decontaminated and ready to be used on another patient. We observed staff decontaminating equipment after patient use with the wipes provided.
- The outpatient department used endoscopes (an instrument used to examine organs or body cavities) during some procedures. The decontamination processes used for these endoscopes was in line with Health Technical Memorandum (HTM) 01-06:

decontamination of flexible endoscopes. Staff immediately wiped equipment post procedure with specific wipes before being placed in a container with a cover to identify it had been used and sent to the endoscopy department for more in-depth decontamination and specific tests for functionality. An audit of these endoscopes was completed in January 2018; this demonstrated 100% compliance with the cleaning process.

- The departments mainly used single use items for procedures. On the rare occasions equipment used required sterilisation, staff placed items back into their containers (trays) and transported them to the onsite sterile services department for reprocessing.
- Staff told us all areas of the outpatient and diagnostic imaging departments had received a deep clean as part of the hospital deep clean programme. We saw a certificate in one area, which provided details of the deep clean, which had been completed.
- Staff were aware of additional precautions to take in the event of an infectious patient arriving in the department; however, we were informed it was unlikely that a patient with an infectious disease such as tuberculosis (TB) or influenza would attend appointments at the hospital. Staff from the outpatient department were involved in the peer vaccination programme (influenza vaccination) for the entire hospital. Staff told us uptake at the hospital was over 70%.
- Information provided before the inspection showed 100% of all the staff at this hospital had completed their IPC mandatory training. Staff from the outpatients and diagnostic imaging departments told us all the staff, except a new member of staff and a regular bank member of staff, had completed their IPC training.
- All areas in the outpatient and diagnostic imaging department had disposable curtains. These were intact and dated and staff knew the process for replacing them.
- In the event of a body fluid spillage in the departments, all areas had immediate access to body fluid spill kits.
- There was an IPC link practitioner within both the outpatients and diagnostic imaging departments. They liaised regularly with the lead IPC nurse for the hospital and facilitated audits and additional training as required.

Environment and equipment

- The outpatient and diagnostic imaging department was located on the ground floor and clearly signposted for patients to find. The main outpatient doors were open for patients to walk through, however all consulting and treatment rooms were only accessible to staff through a card system. The diagnostic imaging department required patients to use a call bell to gain entry. All doors were accessible to staff through a card system. Additional safety measures were in place once in one of the procedure rooms as a locking system had been implemented to prevent patients going back into a procedure room once they had left, preventing accidental exposures to radiation.
- At the time of our inspection there were three resuscitation trolleys in the department. One was located in the diagnostic imaging department, one in main outpatients and one in the cardiology room where a higher risk of cardiac arrest was perceived due to the nature of procedures and tests conducted in this room. All trolleys had regular checks when the department was open and items were in date. All trolleys were clean and free of additional items and had standardised equipment on them. All trolleys had tamper proof seals on them.
- Within the diagnostic imaging department, there was a magnetic resonance imaging (MRI) scanner, computerised tomography (CT) scanner, plain x-ray equipment, fluoroscopy, ultrasound scanning equipment and mammography equipment.
- Servicing of large items of equipment in the department was under service level agreements with the company who provided the equipment. All items had details of service date on them and dated for next service. Staff told us if equipment failed, the processes in place allowed swift response and replacement if necessary whilst being repaired.
- All equipment in the department had evidence of in date electrical safety tests.

Outpatients and diagnostic imaging

- Lead aprons were available in the diagnostic imaging department. They were stored correctly on hangers and there was evidence of regular checks of these. We reviewed these aprons and found them to be in a good state of repair. Staff had monitoring devices on them to monitor their exposure to radiation.
- The diagnostic imaging department displayed appropriate signs to indicate the risks from x-rays in accordance with the ionising radiation (medical exposure) regulations (IR (ME) R) 2017 and the Health and Safety (Safety Signs and Signals) Regulations 1996. We also observed signs in the department to indicate the additional risk to women who were pregnant. In the area where the magnetic resonance imaging (MRI) equipment was located, there were signs to indicate the dangers associated with this and prohibition signs. The strength of the MRI scanner was clearly displayed on the signs. This practice was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) safety guidelines for magnetic resonance imaging equipment in clinical use 2015.
- Within the room where the MRI scanner was located, we observed equipment such as waste bins with labels on them to show they were 'MR safe'. This meant these items were safe to remain in the room when the magnet was operational as they were safe and not at risk of becoming a projectile (an item pulled at force across a room due to the magnet). Items in the department, which could not be in the room with the MRI scanner when in use, were labelled 'MR unsafe'. The MRI lead told us they inspected the room at the beginning of the day to ensure no MRI unsafe items had been left in the room accidentally. If staff were unsure about equipment and could not assure themselves they could safely be in the room with the MRI, these were considered as MR unsafe. This was in line with MHRA safety guidelines for magnetic resonance imaging equipment in clinical use 2015.
- All areas of the department had completed assessments of products under the Control of Substances Hazardous to Health (COSHH) Regulations 2002, and we found all items were stored appropriately.
- Staff regularly conducted quality assurance checks of all equipment and recorded this. During a morning huddle in the diagnostic imaging department, the staff member leading the huddle informed the rest of the team about an item of equipment that had failed the quality assurance checks that morning and the action taken.
- We reviewed a random selection of consumable products including blood-sampling bottles, clinical swabs, dressings, intravenous fluids and airway supporting products. All items were in date and the outside packaging intact.
- In the outpatient department, there was bariatric equipment available including therapy couches and chairs. Staff were aware of the safe loads for these items and they were in a good state of repair. Bariatric patients have a BMI (Body Mass Index) exceeding a healthy range.
- There was an anti-gravity treadmill available in the physiotherapy department for patient treatment and rehabilitation. Patients using this piece of equipment were required to put on a special running suit. Staff told us the company that provided the equipment regularly replaced these and provided a comprehensive decontamination service, as well as servicing the equipment.
- We observed staff correctly segregated clinical and domestic waste. Waste bins provided for the department were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with policy.

Medicines

- Both outpatients and the diagnostic imaging department had safe systems in place for ordering, storing and administering medicines and contrast mediums in compliance with the hospital policy management of medicines in Spire Healthcare, dated 2016.
- No controlled drugs (CDs) or cytotoxic medicines were kept or administered in the outpatient department. CDs are medicines liable for misuse that require special management and cytotoxic medicines are medicines which contain chemicals which are toxic to cells, preventing replication and growth and may be used to treat cancer.
- Medicines in outpatients were stored in locked cupboards and refrigerators, within locked rooms. The

rooms were only accessible to staff through a card system, and only registered staff held the keys to the cupboards and refrigerators. We reviewed a selection of medicines in the department and found all items were in date.

- We found all medicine refrigerators were locked at the time of our inspection. The staff in the pharmacy department monitored refrigerator temperatures remotely. If there were any concerns, they would inform staff in the outpatients department immediately.
- Contrast medium was securely stored in the CT designated room within the diagnostic imaging department. When required, contrast was prescribed for patients and administered in accordance to hospital policy.
- The outpatient service used their own provider specific prescriptions for patients. Staff kept these in locked cupboards, within a locked room and had a recording system in place, which indicated when a prescription had been issued. This was in line with best practice guidance from NHS Protect: security of prescription forms 2013. The pharmacy department completed regular audits on prescriptions and the traceability of the used prescriptions. The department scored 100% compliance in the most recent audit.
- There was an anaphylaxis kit in the outpatient department. This was provided by the pharmacy department and in a tamper proof container. All staff were aware of the kit's location; however, we did not observe any evidence of staff checking this piece of equipment.
- There was a corporate antimicrobial policy in place at this hospital, which all departments followed. Staff also told us the consultant microbiologist who provided advice was from a local NHS acute hospital, it was therefore acceptable for staff to follow advice from the consultant microbiologist on antimicrobial prescribing which would be based on the local NHS acute policy.
- We had concerns that this could lead to conflicting decisions about antimicrobial prescribing and raised this with the hospital management. An example discussed with them was around antimicrobial prescribing and administration for sepsis. The Spire Healthcare corporate policy advised to administer an alternative antimicrobial from what the local NHS acute hospital administered. On review, of the policy section 10 stated 'that for guidance on antibiotic choice each hospital should follow local guidance'. We were assured this was not a significant risk for the provider.

Records

- The hospital had an on-site medical records store, which was located at the end of the hospital administration corridor. Only staff who worked in medical records had access to the department, other staff members would be allowed in by medical records staff. This ensured the security of the records held in the department. At the time of our inspection, all records of patients seen at the hospital were stored in this department. There were plans in place to eventually store old files in off-site storage, but this was not a priority at the time of our inspection.
- From April 2017 to November 2017 there were no patients seen in the outpatient department without their full patient records being available. This was down to strict policies in place over the security of patient records. Staff were not permitted to take records off-site.
- During our inspection, we did not observe any patient records left unattended. However, the medical records staff did inform us there had been one incident where this had happened. An incident form was completed following this and lessons had since been learnt.
- Hospital policy in place ensured all members of staff placed patient records in sealable wallets when transporting notes, even if this was from one room to the next room. This ensured confidentiality was maintained and no items could accidentally be separated from the notes. All staff members took records security very seriously, the medical records supervisor ensured staff adhered to correct policies, which were in line with the Data Protection Act 1998.
- We reviewed 10 sets of patient records and found they contained referral letters, results of any diagnostic tests, appropriate pre-operative assessment checks including venous thromboembolism (VTE) assessment and contemporaneous notes. However, in all of the records reviewed, we found documentation was not always completed in line with professional standards, as the

clinician did not always sign at the end of notes, and did not print their name or enter their professional registration number. In 50% of the notes we reviewed, we also found the notes were not legible.

- A documentation audit conducted by the provider showed 90% compliance with the standards audited against. Areas that received a negative response were in relation to clinicians not signing their entry.
- We raised this with the hospital director at the time of our inspection and a daily spot check audit of consultant documentation was implemented. A letter was sent to all medical staff outlining what was required.
- All images from scans and x-rays were stored on a patient archiving communication system (PACS). Only authorised staff could access these through a password system.

Assessing and responding to risk

- Local policies in the diagnostic imaging department followed the national guidance and standards in relation to the identification and prevention of contrast related acute kidney injury. Staff told us they had not experienced any cases of this since the hospital opened.
- All staff in the diagnostic imaging department had completed basic life support and paediatric basic life support training. Staff were knowledgeable about the steps to take in the event of a patient deteriorating in the department.
- Until recently, the diagnostic imaging department had two resuscitation trolleys, but one had recently been removed. Staff were aware of this decision, however at the time of our inspection had not assessed the impact this would have as the department was divided into two main areas with many card-operated doors in between. During our time on-site, the lead for the department risk assessed this and provided results to the inspection team to demonstrate there was no risk associated with this.
- All staff in the outpatients department had completed immediate life support training and paediatric basic life support training. Registered staff had also completed an acute illness management (AIM) course to assist them in the recognition and treatment of a deteriorating patient. The lead for the department had also sourced an AIM course for the unregistered member of staff.
- All patients had a set of baseline observations performed during pre-assessment appointments. Nursing staff used the national early warning scoring system (NEWS), to record routine physiological observations such as blood pressure, temperature, and heart rate. NEWS was used to monitor patients and to prompt support from medical staff when required. If staff had concerns about a patient's status, further observations and NEWS calculations would be conducted. If staff had concerns, they would contact the resident medical officer (RMO) to come and review the patient.
- In the event of a cardiac arrest, there was a hospital arrest team on site, which would be bleeped to attend. Staff knew the process to summon this support by dialling '2222.' Within the department, there was a visual and audible emergency buzzer system to identify where the emergency was located. Staff told us for the areas, which were not immediately visible, the bleep system used for the cardiac arrest team also showed the location of the emergency to help direct the team.
- The hospital arrest team regularly practised arrest scenarios. Staff from the diagnostic imaging department told us about an arrest scenario involving the MRI scanner. Staff told us this had gone well and ensured staff and patient safety at all times. The first step to an arrest in an MRI scanner was to safely remove the patient from the scanner to an area that was safe to resuscitate a patient.
- There was an embedded process in place to transfer deteriorating patients to the local acute NHS trust. Staff told us about an incident where a patient was transferred out from the outpatient department and required immediate treatment at the local NHS hospital. Although the patient had not deteriorated during their time in the department, during their appointment staff had identified a serious life threatening condition. Staff told us this process had gone smoothly at the time, although a review of the incident had identified areas for improvement.

- Staff told us they had not undergone any specific sepsis training to assist them to identify and treat patients suffering from sepsis. However, staff told us they would treat any deteriorating patient in the same way and would request the RMO to assist in the emergency. The provider confirmed sepsis training was included in the acute illness management (AIM) course which all staff completed. Records showed all staff had undertaken this training.
- Staff completed WHO 'Five Steps to Safer Surgery' surgical checklists in the outpatient department for patients who underwent a minor procedure. The National Patient Safety Agency (NPSA) issued a patient safety alert recommending that all providers of surgical care use the WHO surgical safety checklist. This was incorporated into the 'Five Steps to Safer Surgery', which included pre-list briefings, the steps of the WHO surgical safety checklist and post-list debriefings in one framework. The checklist focused the whole team on the safety of practices before, during and after a procedure. Staff had started to audit the use of these checklists, however there were only seven to audit at the time of our inspection, which did not give the lead for the department enough information about whether this process was embedded.
- Staff in the diagnostic imaging department used the WHO surgical safety checklists during some procedures they conducted. Information received showed the compliance with the checklists were improving from 91% in January 2018 to 100% so far for the month of February 2018.
- There was a radiation protection advisor (RPA) available to the diagnostic imaging department, contactable by phone or email. Onsite there was a team of three radiation protection supervisors (RPS) to ensure all staff were adhering to local rules.

Safeguarding

- Staff in the outpatient and diagnostic imaging departments demonstrated a good awareness of the safeguarding policy, and what actions to take if they suspect a vulnerable adult or child required safeguarding.
- All staff were able to identify who the lead for safeguarding was at the hospital. The outpatient manager was one of the safeguarding leads for the hospital. The diagnostic imaging manager had allocated a member of staff as the lead for safeguarding within the department.
- Information provided by the hospital prior to our inspection demonstrated 100% of all staff had completed safeguarding adults training and 98.9% of all staff had completed safeguarding children training against a target of 95%. Staff we spoke with all told us they had completed all aspects of their safeguarding training, including safeguarding children level three training.
- There had been no reported safeguarding concerns from outpatients or diagnostic imaging departments. Staff were however aware of a safeguarding which had recently occurred at the hospital.
- Staff within the outpatients department had completed female genital mutilation (FGM) training as part of their safeguarding training. Although the hospital did not provide a paediatric service, staff were aware of their responsibilities to report concerns. One area of risk staff had identified was through gynaecology clinics where a discovery of an adult female having undergone FGM who may have female children themselves. At the time of our inspection, there had been no requirements to report concerns.
- We saw information regarding domestic abuse and other safeguarding concerns displayed in the outpatients department waiting area, which was clearly visible to patients using the department. Within this information displayed was a range of confidential telephone numbers for patients to take away if they required this.

Mandatory training

- All staff in the department were required to complete fire safety, health and safety, infection control, safeguarding children and adult training, manual handling, compassion in practice, equality and diversity, Mental Capacity Act training and controlled drugs training. Mandatory training mainly consisted of electronic training, with some face-to-face training.

Outpatients and diagnostic imaging

- Information submitted by the provider showed 100% compliance with most modules. The only modules not to have 100% compliance were health and safety (99.4% compliance) and safeguarding children (98.9% compliance).

For our detailed findings on mandatory training please, see the safe section in the surgery report.

Nursing staffing

- There was sufficient staff with the qualifications, skills and experience to meet the needs of the patients in the outpatient and diagnostic imaging department.
- The outpatient department had one manager, one outpatient sister, one pre-assessment sister, three registered nurses and one healthcare assistant. There was currently one registered nurse on the bank staff and one in the recruitment process.
- Information provided before the inspection showed agency and bank usage was minimal. From April 2017 to November 2017 all months apart from September 2017 recorded a zero bank and agency usage. In September 2017, there was a 2% agency and bank usage.
- The outpatient department had not used agency cover since they opened and the diagnostic imaging department had only used agency once. Both departments had access to an agency, but preferred to use regular bank staff where they could to cover duties.
- The diagnostic imaging department had one manager, eight radiographers and one healthcare assistant. There were an additional three radiographers on the bank system who could cover cardiac cases, mammography clinics and general radiographer duties.
- When a cardiology clinic was running, staffing for this included a lead cardiology nurse and cardiac physiologist. These were additional staffing to the outpatient and diagnostics imaging department staffing.
- Staffing for the outpatient department was calculated using a tool adapted from the Shelford Staffing tool. This determined requirement against activity. During our inspection, one day had one outpatient sister, one registered nurse and one healthcare assistant on duty. The next day had one outpatient sister, three registered nurses (staggered through the day) and one healthcare assistant on duty. The outpatient manager worked Monday to Friday, 9am to 5pm and covered any additional requirements.
- There were no staff members on long-term sickness in the outpatient or diagnostic imaging department. In the eventuality of short notice sickness, cover through regular staff or bank staff was usually found.

Medical staffing

- The hospital employed over 137 consultants on practising privileges, most of whom were employed at the local NHS acute trust. There was a group of consultants who regularly provided clinics in the outpatient department.
- The hospital employed 14 radiologists on practising privileges. These radiologists worked on a rota for the diagnostic imaging department.
- Consultants provided their availability well in advance to the administration department so clinics could be scheduled.
- There was a resident medical officer (RMO) employed at the hospital. Their main duties expected them to cover the ward setting; however staff told us they could request the RMO to assist them if required.
- There were no medical staff on long-term sickness in the outpatient or diagnostic imaging department.

Emergency awareness and training

- All staff in the outpatient and diagnostic imaging department had completed fire safety training which included practical fire evacuation scenarios.
- Staff were aware of backup generators being installed at this hospital and the engineering team were responsible for testing these every month.Staff were aware of a major incident and business continuity plan, which contained details of what all departments, should do in the event of an emergency.
- For our detailed findings on emergency awareness and training please see the safe section in the surgery report.

Are outpatients and diagnostic imaging services effective?

Outstanding ☆

Outpatients and diagnostic imaging

Not sufficient evidence to rate

Evidence-based care and treatment

- The department followed corporate policies and procedures, which were accessible on the hospital's intranet. We saw these referenced the National Institute for Health and Care Excellence (NICE), relevant regulations and legislation and evidence-based best practice guidance.
- Staff in the diagnostic imaging department had recently reviewed the corporate policy in light of the new ionising radiation (medical exposure) regulations (IR (ME) R) 2017 regulations. The lead for the department, who was a member of the national Spire Diagnostic Imaging steering Group, told us this work had been shared with the Spire Healthcare corporate team who review policies and was being implemented into this policy.
- Staff provided evidence-based care and treatment in line with standards from the Society of Cardiological Science and Technology (SCST). We observed staff using the Bruce protocol (also known as an exercise tolerance test or stress test) for assessing patients with suspected heart disease.
- All departments conducted a planned programme of clinical and non-clinical audits. These results were discussed locally at individual department meetings as well as hospital wide governance meetings. Results of these audits were published on the internal dashboard. Results of these audits showed they were mainly meeting the targets within the outpatient and diagnostic imaging departments.

For our detailed findings on evidence-based care and treatment, please see the effective section in the surgery report.

Pain relief

- Staff in the physiotherapy department provided patients with chronic pain management classes. These classes were provided with oversight of a pain management specialist consultant and pain specialist nurse.
- Patients undergoing any minor procedure in the outpatients and diagnostic imaging department rarely required analgesia (pain relief) during their procedure. Procedures were usually conducted under local anaesthetic. If patients did require analgesia, the consultant in charge of their care could prescribe this.

Nutrition and hydration

- All patients attending the outpatient department had access to a tea and coffee machine, which was free of charge. There was also a coffee shop in the immediate vicinity of the department.

Patient outcomes

- Staff in the physiotherapy department completed patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) for patients receiving care and treatment. This involved patients completing assessments of their health outcomes and their functional level, as well as their experience of receiving healthcare. Ultimately the results from these assessments helped staff to look at care and treatment they provided and where necessary, alter treatment plans to improve patients' experiences.
- At the time of our inspection, the hospital had not collated enough data on PROMs and PREMs to enable them to benchmark their clinical performance against other providers, therefore staff used these results locally to improve patient experience.
- A patient dose audit had not yet been undertaken at this location, as the hospital has not been open for 12 months. However, a recent radiation protection advisor audit was completed and identified staff from the diagnostic imaging department were using the National Diagnostic Reference Levels (NDRLs) and recording the dose area product. A full patient dose audit was scheduled for later in 2018.
- At the time of our inspection, there were no accreditation schemes in place in any of the departments. The hospital had plans in place to participate in accreditation schemes once they met the threshold for how long they had been operating.

For our detailed findings on patient outcomes, please see the effective section in the surgery report.

Competent staff

- All staff had completed an induction programme when they joined the hospital. We saw evidence of completed

induction competencies in staff competency files. Staff told us since they had completed the induction programme, they had fedback to the hospital management on how this could be improved and this had resulted in a new document for new starters.

- All staff who worked at Spire Nottingham Hospital completed the same induction programme. This included employed staff, staff on practising privileges and bank staff.
- Information provided before our inspection showed 100% of staff within the outpatient and diagnostic imaging department had received an appraisal. Staff told us these had been meaningful and helped to identify a personal plan for development for the year ahead. Staff also had regular one-to-one meetings with their department leads, which also gave them the opportunity to discuss areas for development.
- Staff told us they felt supported to develop their roles further by accessing external training. We heard about several examples where staff had or were in the process of attending further training, supported by the hospital to develop and enhance their current roles.
- We observed examples where staff had been supported to complete additional training and had evidence of assessed competency in both the outpatient department, where staff had been trained to use the plaster cast removal equipment, and in diagnostic imaging where staff had undergone a cannulation course.
- When the hospital first opened, staff in all departments were required to complete competency training on all equipment within their departments. The company who supplied the equipment mainly provided this and we saw evidence to demonstrate staff competency. Department leads told us, for future staff joining the departments, this competency training would be provided by staff members who were equipment champions for the departments. If there was a large increase in staff in the departments, they would consider requesting the companies to return to provide competency training.
- Staff from the diagnostic imaging department regularly organised 'in house training' for staff to increase knowledge and awareness on imaging related topics as well as clinical conditions. This training was opened up to staff from all departments and feedback from staff was that it was well received.
- Department leads reviewed and monitored professional registration for staff where this applied. Staff were supported to meet the registration renewal process and revalidation process required by relevant professional bodies.
- There was a corporate policy in place to manage staff with variable performance. At the time of our inspection, department leads told us they had not had to use this process with staff members currently employed, but were aware of the policy if they required this.

For our detailed findings on competent staff please see the effective section in the surgery report.

Multidisciplinary working

- All staff without exception told us there was good internal multidisciplinary team (MDT) working at this hospital. All staff told us this had developed during the initial phase of getting the hospital 'up and running' in the first place.
- The outpatient department had nurse specialists in oncology and cardiology. Although they had specific clinics, which they would participate in, they also worked as part of the larger outpatient team to ensure holistic patient care was provided.
- There was a one-stop breast care clinic provided by the diagnostic imaging department. This service was led by the radiography lead for mammography and a radiologist who specialised in breast care. Patients attended for a consultation with a consultant, mammography and ultrasound. Staff would take biopsies if there was a clinical indication and send to the Spire Healthcare hub laboratories in Manchester. Due to the success of this clinic, the lead for the department was looking into setting up a similar process for patients with testicular concerns.
- Staff from this hospital worked closely with a local consultant microbiologist who provided advice for patients displaying signs of infection or who had clinical results of colonisation from an organism. The lead nurse

for infection prevention and control had engaged with them to ensure a close working relationship and had communicated with them several times about tasks requiring a microbiologist input.

- Staff in medical records and administration/bookings department told us there was a good working relationship with all departments in the hospital. This ensured patients attending the hospital had a positive experience, which was timely and professional.

For our detailed findings on multidisciplinary working, please see the effective section in the surgery report.

Seven-day services

- There were no typical seven-day services available within the outpatient and diagnostic imaging department. Staff in the diagnostic imaging department was however, on an on-call rota to provide out of hours services to ward patients if required.
- The diagnostic imaging department did not offer open access for computerised tomography (CT) or magnetic resonance imaging (MRI) scans from GPs, however there was the ability for GPs to contact the department to arrange short notice appointments.

For our detailed findings on seven-day services please see the effective section in the surgery report.

Access to information

- Staff in the diagnostic imaging department had access to the electronic system (picture archiving and communication system) which stored all images and reports.
- The outpatient department had recently started to send out letters to patient's GPs through an electronic system. Information is sent immediately after the patient's appointment without delay. The lead for the department had monitored the implementation of this new system to ensure it was efficient.
- Only staff from medical records had the authority to establish a new set of patient records. This ensured there were no unnecessary duplications and security of the records.
- Pathology reported verbally if there were any results which were abnormal as well as providing a paper version of the results to keep in the patient's records.
- There was a process in place to request relevant clinical information from alternative hospitals for patients attending this hospital. Staff in medical records would ensure these were saved in the patient's records.
- Hospital policies, procedure and guidelines were stored electronically. All staff had access to these documents. Department leads also kept paper copies of some policies, which staff could access if required. An example of this was the major incident policy, which was kept in outpatient's reception.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had corporate policies for consent procedures as well as a deprivation of liberty safeguards policy. Both of these policies were in date and staff were aware of them.
- Staff had a good understanding on the requirements for consent. Information provided by the hospital showed on a recent audit, 86% of consent forms were compliant with audit requirements. This was below the hospitals target of 95% compliance.
- During our inspection, we observed some positive examples of staff gaining consent from patients before procedures. This also included asking a patient for consent for a member of the inspection team to be present during a procedure.
- Information received from the hospital showed 100% of staff that required Mental Capacity Act 2005 training, had completed it (46 staff). This had also been provided to all health care assistants. All staff we spoke with demonstrated good understanding of the Mental Capacity Act 2005 and what to do if they had concerns about a patient's capacity to provide consent to treatment. At the time of our inspection, staff told us they had not had concerns about a patient's capacity or provided care and treatment for a patient under a deprivation of liberty safeguard.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

Outstanding ☆

Outpatients and diagnostic imaging

- We reviewed nine CQC comment cards and ten Spire Healthcare patient satisfaction cards for the outpatient and diagnostic imaging departments, most of which were positive. Comments received included 'very prompt, efficient and professional care', 'staff were very caring and professional' and 'excellent care, I cannot find any fault.' There was one comment card, which highlighted that a patient was disappointed due to a lengthy wait with no explanation.
- We spoke with six patients and two relatives during our inspection. All feedback received was extremely positive and praised staff for the way they treated them. Comments made by patients and relatives included "wonderful staff", "very attentive", "fantastic treatment" and "five star care and treatment."
- The service had adapted their own patient satisfaction forms from the NHS Friends and Family Test (FTT), which asked patients if they would recommend the service to their close friends and family. Results provided by the service for December 2017 showed 97% of patients would recommend the service to their friends and family. Of the 3% who would not recommend the service, responses included additional information before appointments about directions to the hospital, layout of the hospital, parking arrangements at the hospital and information about bus routes was required.
- There was a Spire Healthcare corporate chaperone policy in place dated April 2016. We observed signs around all departments informing patients about their right to a chaperone during their consultation and treatment. In each consultation room, there was a stamp for staff to use in patient notes to formally record details of a chaperone if patients required one. Alternatively, staff documented if patients refused a chaperone.
- We observed all staff treating patients with dignity, respect and compassion. Staff ensured curtains were drawn when patients changed for any treatments or investigations, and any gowns used by patients were fastened appropriately.
- All investigation rooms in the diagnostic imaging department had individual, lockable changing rooms, which ensured privacy, and dignity was maintained. Staff knocked and waited to enter when collecting the patient for their investigation.
- Receptionists made a concerted effort to maintain confidentiality by lowering their voices when speaking with patients at the desk. Rooms where patient care was conducted were appropriately sound proof and conversations could not be overheard.
- We observed staff introducing themselves to patients and explaining their role during our inspection. This was in line with the recommendations in the National Institute for Health and Care Excellence (NICE) quality standards for patient experiences in healthcare.

Understanding and involvement of patients and those close to them

- We saw staff taking the time to explain all the details of their care and treatment to patients and encouraged them to be partners in their care. Staff communicated with patients in a manner they understood. We saw staff involving patients during a scanning procedure, ensuring they were comfortable, but also indicating how much longer they would be.
- Staff made sure patients had the opportunity to ask questions about their care and treatment during and after their consultation. Patients told us they felt comfortable and confident when asking staff for further information about their care and treatment.
- Patients told us they had received adequate amounts of information prior to their appointments, which prepared them for what to expect during their appointment. This was reflected in information provided by the hospital, which showed in December 2017, 95% of the patients said the information received prior to their appointments was 'excellent' or 'very good.'
- Patients were encouraged to contact the outpatient and diagnostic imaging departments following their appointments if they had any concerns about their care and treatment, or if they had further queries.

Outpatients and diagnostic imaging

- Staff encouraged relatives and those close to them to, to be involved in the patients care and treatment. They also ensured they understood the information given during their appointments and gave them the opportunity to ask questions.
- Information about costings was provided to patients during the booking process and confirmation sent out with appointment letters. We did not observe any discussions taking place between patients and staff about costs. However, staff told us if they were asked questions about costs, they would handle them factually, but respectfully and tactfully.

Emotional support

- Staff told us they had clinics, where difficult and life changing news could be provided to a patient. To enable them to deliver the highest standard of emotional support, all staff members had attended 'breaking bad news' training. Staff told us of cases where they had used this training to support patients and their relatives.
- There were clinical nurse specialists in oncology and cardiology who provided emotional support to patients with specific diagnoses. The specialist oncology nurse told us they liked to offer 'open appointments' to patients who required her service to ensure the emotional support was provided.
- There was a quiet room available in the outpatient department where staff would take patients if they had received concerning or difficult news at an appointment. This enabled them to comfort them if they required it, but also maintaining their privacy and dignity. We did not observe any patients requiring additional staff support during our inspection, however staff told us about an experience where the quiet room was used to comfort a patient.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

Service planning and delivery to meet the needs of local people

- The majority of patients who attended the outpatient and diagnostic imaging department were self-funded patients. Staff in the bookings and administration department had recently started to arrange appointments for NHS patients, although these were in very low numbers at the time of our inspection.
- The service offered patients appointments in the outpatient department in the evenings and weekends. Outpatient appointments were available Monday to Friday between 7.30am and 9pm. Appointments were also available on Saturday between 8am and 4pm. Clinical assessments were also offered to patients through a telephone consultation if deemed appropriate. These arrangements accommodated patients who had commitments during the working week.
- All departments were located on the ground floor and developed to meet the needs and demands of patients. The environments had been developed in line with relevant health building notes to ensure compliance with recommended standards. There were three main waiting areas in use in the outpatient department. Patients were directed to the waiting area, which was closest to the consulting room they required.
- In one of the waiting areas in the outpatient department, there was a small selection of children's toys for children who accompanied adult patients. These were wipeable and in good condition.
- The physiotherapy department was open Monday to Friday between 8am and 8pm. They also offered a drop in physiotherapy session between 6pm and 8pm every Monday. This service was aimed at ensuring patients (particularly sports patients who had picked up injuries at the weekend) could access a rapid access musculoskeletal physiotherapy appointment in a timely manner. The patient did not need to wait for a pre booked appointment enabling faster diagnosis and access to imaging on onward management.
- The diagnostic imaging department was open Monday to Friday between 8am and 8pm. A full range of services was available between these times, with the one stop breast clinic operating in the evenings. There was no routine provision of diagnostic imaging services available at the weekends.

Outpatients and diagnostic imaging

- Free car parking was available at the hospital, with a large number of spaces available to meet current and future needs. There was signage available directing patients to the main reception, and clear signage to all departments once in the hospital.
- Transport for patients was an important issue, which staff took into consideration. Staff in the outpatient department helped patients if they needed to arrange transport home, including arranging taxis for patients.
- When planning the hospital bus routes were taken into consideration and stops were added by the local council at the hospital entrance. Unfortunately since the opening of the hospital the route has been reduced by the council.
- The physiotherapy department had identified a requirement for classes, which included falls prevention education. This was in response to engaging with local communities and listening to patient feedback. These classes were combined with general keep fit and well-being classes.
- Staff from the physiotherapy department had also identified a local gap in 'high end functional' physiotherapy with elite athletes. Service level agreements (SLAs) had been arranged to provide a range of services to professional athletes at this location.
- The service identified there was a proportion of patients travelling significant distance to the hospital. In response to this, they developed 'one-stop clinics' for breast care and basal cell carcinoma. This ensured patients had consultations, investigations and procedures during one appointment at the hospital. These clinics were well received and the service was now looking at other one-stop clinics.
- At the time of out inspection, the majority of patients were self-funded or insured patients. Appointments were offered to meet the needs of the patient, where possible at times that met their needs. For the few NHS patients who had started to use the services at the hospital, they were able to access the 'choose and book' appointment system.

Access and flow

- Prior to our inspection, the service had not seen many NHS patients since they had been open. The service had recently started to have a small number of NHS patients referred for outpatient and diagnostic imaging appointments. Therefore, there was no data available for waiting times or referral to treatment times for this service.
- The service intended to see all patients within 15 minutes of their appointments. If there were unavoidable delays in the department, staff would inform patients on their arrival and keep them updated on any further delays. During our inspection, all clinics were running on time and patients were aware of this. We saw signs in all departments informing patients to speak with staff if they had been waiting for longer than 15 minutes.
- The outpatient department audited the time patients waited once they arrived in the department for appointments. When the department first opened, there had been reoccurring issues with delayed appointments; however, recent results showed all patients were called in for their appointments promptly.
- We asked staff about the 'did not attend' (DNA) appointment process. Not all clinical staff were aware of it or if there was a process in place, however they told us the administration staff would manage this process. Administration staff confirmed there was a DNA process in place for those who failed to turn up or cancelled their appointments at short notice. A courtesy call would be made to ensure the patient was safe, and an alternative appointment time offered. There was currently no maximum time patients could DNA before they were no longer offered an appointment at the hospital.
- The hospital also used text messages to remond patients of their appointment.At the time of our inspection, all departments commented on the low access and flow they currently experienced. However, it was acknowledged there had been a steady increase month by month since the hospital had opened. The outpatient manager told us the department was currently running at approximately 43% capacity, and the physiotherapy department were also currently running a similar capacity.
- On the day appointments could be accommodated for patients who contacted the hospital directly, as long as all referral paperwork had been completed. Staff in the

diagnostic imaging department could not complete any procedures without a copy of the request form. There was also a system in place in the outpatients department for patients to return for wound reviews if they had recently had surgery and had concerns.

- The diagnostic imaging department had provisions in place to ensure all procedures were reported on in a timely manner. The lead for the department told us the current reporting times were two days for patients under an insurance company and three days for all other patients. There was a policy in place for urgent reporting of unexpected and significant findings. All staff were aware of this policy and how to escalate concerns.

Meeting people's individual needs

- Staff had access to a translation and interpretation service for patients whose first language was not English. This process had access to translation service on the telephone or could invite interpreters to attend appointments in person.
- All departments also had access to British Sign Language (BSL) interpreters for patients who used sign language to communicate with others.
- A member of staff from the outpatient department had completed the required training to become a dementia champion. They had produced a box (forget me not box) for the department with items in them which were considered as 'dementia friendly.' This meant the items within them would reduce potential anxiety, stress and frustration in a patient who was living with dementia if they attended for an appointment. Items within the box were 'twiddlemuffs' (double-sided knitted muffs with various soft items attached both inside and out), a pictorial pain chart, pictorial reminiscence cards and adapted cutlery and crockery.
- As well as a forget me not box of useful items, there was also a resource folder available for staff members to use which also had the contact numbers and details of local services which could support patients living with dementia and their relatives.
- The dementia champion in the outpatient department had also tried to adapt the environment to make it more dementia friendly through the introduction of signs and wall mounted clocks, which had large faces and font on them to make it easier for patients living with dementia to read.
- The pictorial pain chart was also used to meet the needs of other patients including those with learning disabilities and other disabilities where communication was difficult. Staff told us it was important to be prepared to meet the needs of patients in all eventualities; however, at the time of our inspection, they had not provided care and treatment for patients with any learning disabilities, living with dementia or other cognitive impairments.
- At the time of our inspection, the department did not have a learning disabilities specialist who they could go to for advice on how to meet the needs of the individual. There was a resource file in the outpatients department, which contained useful national advice telephone lines and information for healthcare professionals on how to meet the needs of a patient with learning disabilities. Staff told us they would encourage any relatives, friends or carers to attend any appointments with the patient.
- There was a multi-faith room located in the outpatient department, which was available to all patients who used the hospital. The staff in the department had organised this room and had sourced the equipment within this. We saw religious texts from different religions located in this room, as well as bibles for children and religious texts in large print for those with visual impairments. There were washing facilities available for those who required them, and wipeable prayer mats.
- The outpatient department had a hearing loop system in place for patients who had hearing impairments. This could also be moved around the department to meet the needs of the patient with hearing impairments.
- We saw a large library of patient information leaflets in the outpatient department. These covered a range of different health needs from cancer related issues to women's health requirements and heart disease information. We also saw these leaflets in different languages and different font sizes. Staff told us leaflets in languages not currently provided could also be sourced if required.

Outstanding ☆

Outpatients and diagnostic imaging

- The outpatients department had basic bariatric equipment in place including a couch and treatment chair; however, they intended to improve the facilities available for bariatric patients as the needs of the hospital grew.
- Patient wellbeing was integral to the planning of the new hospital and an extensive outdoor area has been developed to allow patients to spend time outside in a protected environment with their families.This included an outdoor play area, water features and ample comfortable seating.
- The hospital had a dedicated coffee and sandwich shop for patients and relatives which was designed to be in a central location of the hospital .

Learning from complaints and concerns

- All staff we spoke with were aware of the complaints process at the hospital. Staff told us where possible; they would try to resolve any concerns and complaints at a local level before escalating this. As a result of this, no complaints had been forwarded to the Independent Sector Complaints Adjudication Service or Parliamentary and Health Service Ombudsmen.
- Department leads were knowledgeable about their complaints rate and had been involved in the handling of complaints. Complaints and incidents were a regular agenda items on all team meetings, and staff were keen to identify any potential learning from them. Leads also recorded compliments received from patients, and we saw examples of this in the outpatients department.
- Information received prior to the inspection showed there were 11 complaints received at the hospital between April 2017 and November 2017. Of these, four complaints included the outpatients and diagnostic imaging services provided at this location. There were two complaints, which identified lateness of appointments as the key theme, one that identified a follow up error, and the other complaint identified unhappiness with the outpatient department appointment booking process. All complaints were resolved at the first level.
- Staff in all areas demonstrated a positive attitude towards complaints, and welcomed feedback from patients as they had a genuine interest in improving the department. We observed one patient raise a minor concern with a member of staff at the end of an appointment. Staff encouraged the patient to raise this formally so action could be taken to rectify this.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

Vision and strategy for this core service

- The hospital vision was to be recognised as the first choice for independent healthcare in Nottinghamshire and the surrounding area. This vision was displayed everywhere and all staff identified this as being their own vision too.
- There was no separate vision or strategy for this core service; however, staff were committed to the overall vision of the hospital. Department leads were tasked with business targets by the Senior Management Team to raise the profile of the hospital.
- The Senior Management Team had engaged with members from all departments to develop five key objectives, which all staff will base their own personal objectives around. Staff were keen to help take these key objectives forward and had already volunteered to participate in working groups. One of the key objectives, which all staff discussed, was around growing the services they provided and maximising the capacity of clinics. Staff told us they had discussed ideas locally and had even been to staff forums to discuss ideas with the Senior Management Team.

For our detailed findings on vision and strategy for this core service please see the well-led section in the surgery report.

Governance, risk management and quality measurement

- Leads from the outpatient and diagnostic imaging departments contributed to the overarching governance of the hospital and attended regular governance meetings. This ensured information was escalated from the department level and information cascaded from the executive level. All staff commented on how they were well appraised of important governance issues.

Outstanding ☆

Outpatients and diagnostic imaging

- The outpatient and diagnostic imaging department both had a local risk register which department leads maintained. This was reviewed regularly at team meetings and new risks added if identified, or removed if no longer an issue. Staff told us they also discussed whether risks required escalating to the hospital risk register. We reviewed the hospital risk register and found two risks, which had been escalated from the local risk registers due to requiring executive oversight of these. These risks reflected the top concerns of the department leads.
- In response to the largest risk in the outpatient department (mislabelling of specimens), the lead had implemented a safety cross initiative which identified days which had passed where no further incidents had occurred. This was a local way of monitoring whether mitigating actions were effective in reducing the risk from reoccurring.
- The diagnostic imaging department had organised radiation protection committee meetings to take place on a regular basis. This was to ensure that all clinical procedures and supporting activities undertaken were in accordance with legislation and regulations. The radiation protection advisor and three local radiation protection supervisors regularly engaged about safety practices within the department and any important information from these engagements was cascaded to the rest of the department. Any areas of concern from any meetings or engagement activities were escalated to the hospital clinical governance meetings.
- The hospital had implemented a clinical scorecard to monitor performance and quality on key indicators. The outpatient and diagnostic imaging departments inputted into this scorecard and used the results to drive quality improvement. At the time of inspection, there were areas on the scorecard that required further development once the hospital had been opened for a longer duration and more information could be collated for this.
- The physiotherapy department had locally implemented patient reported outcome and experience measures for quality measurement and patient outcome measurement.
- Departments were engaged with local audits, however at the time of inspection there was little participation in national audits due to the low patient numbers and relatively new operational status of the hospital. Staff monitored quality internally at present and addressed areas of low compliance.
- Staff in the outpatients department were aware of the national safety standards for invasive procedures (NatSSIPs) and how these impacted on their department. Spire Healthcare had developed their own local safety standards for invasive procedures (LocSSIPs) which the hospital was using with no variation.There were clear policies in place to support these.

For our detailed findings on governance, risk management and quality measurement for this core service please see the well-led section in the surgery report.

Leadership and culture of service

- Staff from all departments spoke overwhelmingly positive about their clinical leads for the departments. Staff told us their managers were extremely visible, very knowledgeable about their roles and responsibilities and approachable. Staff also told us clinical leads were very encouraging of staff and wanted them to develop their own roles and responsibilities.
- The positivity extended beyond local leadership, and included the leadership of the Senior Management Team. Staff told us they regularly saw the hospital director and head of clinical services in their departments. They told us the Senior management team were visible, competent and enthusiastic leaders who strived to provide the best service for patients, whilst creating a positive working environment for staff. They regularly communicated updates about the hospital and all staff felt they would be welcome to approach them individually if they had concerns.
- All staff told us they felt valued and appreciated at this hospital. Local leaders would regularly thank them for their hard work and sent messages of their thanks to them. Executive staff also extended their appreciation to the staff and showed a genuine interest in staff well-being. One staff member told us this was the only hospital they had ever worked at where the hospital director knew their name. Other staff members agreed with this and told us things like that made them really feel valued.

Outstanding ☆

Outpatients and diagnostic imaging

- There was a positive culture in all departments. Staff enjoyed working at the hospital and in their respective departments. The majority of staff had been at the hospital since it had opened, and had worked hard to develop the departments into the functioning departments they were at the time of inspection. Staff felt immensely proud of what they, as individuals and teams, had achieved.
- We observed high standards of team working in all departments within this core service. Staff worked collaboratively, constructively and quickly to deliver a high standard of care for patients.
- There was an open and honest culture within all departments. Staff were open and honest with patients if issues occurred during their care and treatment. We observed staff implementing this during our inspection after a patient attended an appointment with the wrong consultant.
- The open and honest culture extended to beyond interactions with patients. Staff were encouraged to speak up about concerns if they had them without fear of reprisal. There was a policy in place to support staff who spoke up about concerns as well as two freedom to speak up guardians recently appointed.

Public and staff engagement

- The hospital had implemented the 'you said, we did' initiative, which demonstrated prompt responses to issues raised by patients. Examples from the most recent feedback received included not enough signage for the way out of departments and the environment on a whole appeared very cold and unwelcoming. Actions taken against these included additional way out signage ordered for the outpatients department and more patient information boards and local art to be installed in all areas.
- Staff in the outpatient and diagnostic imaging department had specific surveys in place to gather patient feedback about the quality of service provided. This was monitored on the clinical scorecard and quarterly reports produced. The most recent feedback was mainly positive; however, it was acknowledged that response rates were still relatively low.
- Staff from all departments related to this core service had participated in the hospital's staff survey. Although a full report had not been completed at the time of inspection, some headlines from findings included staff satisfaction in regards to whistleblowing and ability to raise concerns, good team working and prioritising high quality care. All these aspects scored 88% and above for staff satisfaction.
- Staff engagement was a key factor at this hospital. Members of staff from all departments in this core service had voluntarily joined the 'believing in our people' forum. This forum discusses staff feedback and works on potential solutions to any issues identified. Representatives provided feedback to their departments on actions taken, which we were told was useful and important to demonstrate their views and opinions were taken seriously.
- The hospital had an awards scheme in place called 'inspiring people awards.' At the end of 2017, three of these awards had been issued to staff for recognition in going the extra mile. All three of these awards had gone to staff form the outpatients and diagnostic imaging department. All staff within these departments were proud of the recognition their colleagues had received.

For our detailed findings on public and staff engagement for this core service please see the well-led section in the surgery report.

Innovation, improvement and sustainability

- At the time of our inspection, the hospital had not been open a full year. In this time, staff from the outpatient and diagnostic imaging departments had worked hard to improve the environments they were operating in. Staff told us they had taken the departments from 'empty shells' to the fully functioning departments we inspected. Staff continued to look for opportunities to improve the workings of their department as well as the quality of care they provided patients.
- Department leads for all areas covered in this core service had targets set to improve the business side of their services, which in turn the provider hopes will improve the hospital and sustainability of the services provided.

Outstanding practice and areas for improvement

Outstanding practice

- The provider monitored safety through a clinical scorecard with 47 clinical indicators. The scorecard was used for benchmarking against other Spire Healthcare hospitals and to identify areas for improvement.
- One of the operating theatres was a hybrid operating theatre. A hybrid operating theatre is a surgical theatre that is equipped with advanced medical imaging devices which enable minimally-invasive surgery.
- In June 2017, the provider held a public open day which was well attended by the local community. Feedback was collected and as a result, the physiotherapy department planned a weekly Pilate's class and were developing falls prevention classes. The hospital had also welcomed visits from the local U3A and Rotary club groups
- The provision of one-stop clinics for breast care and basal cell carcinoma had proved very successful and efficient. This prevents patients having to attend several appointments, which may inconvenience them and provides them with relevant information in a timely manner.
- Staff from the outpatient department had created the multi-faith room, which was accessible to all patients and staff who attend the hospital. There had been consideration into not only multiple faiths, but also the requirements of users (for example visually impaired and age of the user).
- The dementia champion in the outpatients department had proactively created a 'forget me not' box, which contained items useful for patients living with dementia. There had also been work completed within the environment to make it suitable for patients living with dementia.
- The provider had appointed two staff members to fulfil the freedom to speak up guardian role for the hospital staff.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure all documentation in patient records meets the required professional standards.