Spire Healthcare Limited

Spire Methley Park Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

Overall;

- The provider should ensure pharmacists receive either supervision to support them or undertake competency assessments from another pharmacy professional to ensure clinical effectiveness.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service stayed the same. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The

Summary of findings

service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff did not always complete medicines records accurately and keep them up to date.
- Evidence was not available to demonstrate that pharmacists receive supervision or competency assessments to ensure clinical effectiveness.

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

Diagnostic imaging

Good

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to meet patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of service users, took account of patients'

Summary of findings

individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

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

Diagnostic Imaging was a smaller proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.
We rated the Diagnostic Imaging service as good because it was safe, effective, caring, and responsive, and well-led.

Outpatients

Good

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 5 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Prescribing documents used within the outpatient department were not stored securely, and the service had not assessed the risk associated with where they were stored to prevent unauthorised access.

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

Medical care (Including older people's care)

Inspected but not rated

We inspected but did not rate this core service.

- The endoscopy service performed well for cleanliness. The design of the environment followed national guidance. The department had suitable facilities to meet the needs of patients.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. Staff monitored the effectiveness of care and treatment. Staff supported patients to make informed decisions about their care and treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity,

Summary of findings

took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Experienced and compassionate leaders ran services effectively using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and took pride in their work. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

The service only provided endoscopy under the medical care core service and therefore is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery report.

Summary of findings

Contents

Summary of this inspection

Background to Spire Methley Park Hospital

We undertook this inspection as part of our age of rating inspection programme. The hospital was last inspected on 1 to 2 and 17 November 2016.

Spire Methley Park is operated by Spire Healthcare Limited. The hospital has 29 individual bedrooms on one ward.

The hospital provides surgery, medical care, outpatients, and diagnostic imaging services.

The hospital had a registered manager in post at the time of inspection.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 21 November 2023. The inspection was unannounced.

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

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

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

How we carried out this inspection

During the inspection we spoke with 20 staff members, nine patients and reviewed 15 sets of patient records.

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

Outstanding practice

We found the following outstanding practice:

- The hospital had received a gold award for being a quality data provider from the National Joint Registry (NJR). This showed their commitment to patient safety, and accountability through data submission and results.
- Use of embedded X -ray images in an internal reference document for staff view for them to obtain consistent high-quality images.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Overall

- The provider should ensure pharmacists receive either supervision to support them or undertake competency assessments from another pharmacy professional to ensure clinical effectiveness.

Surgery

- The provider should ensure pharmacists receive either supervision to support them or carry out competency assessments from another pharmacy professional to ensure clinical effectiveness.
- The provider should ensure effective processes are completed for medicines management.

Outpatients

- The service should ensure that prescribing documents used within the outpatient department are stored securely.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Is the service safe?

Good

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

Mandatory training

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

The service had a mandatory training policy which was in date and version controlled.

The corporate target for mandatory training was 95% for all modules. Staff had until the 31 March each year to complete the training modules before the recording system was reset and commenced again in April each year.

Staff received and kept up to date with their mandatory training.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Managers monitored and recorded mandatory training and alerted staff when they needed to update their training through a computer-based system.

We checked the computer based mandatory training records which showed all staff were up to date with their mandatory training.

In addition to maintaining computer-based records, we saw in the 10 staff files that we checked, a record of which mandatory training the member of staff had completed accompanied by the training certificates.

Safeguarding

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

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Although the service had not made any safeguarding referrals in the last year, staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

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

Staff followed safe procedures for children visiting the ward. In addition, we saw evidence staff had completed safeguarding children and young people training.

The service had an adult's safeguarding policy and a children's safeguarding policy. Both were in date, version controlled and followed intercollegiate guidance.

The service had 3 staff members trained to safeguarding level 4. The Director of Clinical Services was the safeguarding lead. If they were not at work, one of the other level 4 trained staff would cover and provide advice for staff.

The Director of Clinical Services told us they would quality assure all safeguarding reports submitted by staff.

In the 10 staff files we checked we saw evidence of up-to-date disclosure and barring service checks (DBS).

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All ward and theatres we visited were clean and had suitable furnishings which were clean and well-maintained. Seamless easy-clean floor covering was used throughout all clinical areas, waiting rooms and toilets. Store areas were tidy and free from clutter.

The service performed well for cleanliness. There were regular infection prevention and control audits and the service consistently performed to a high standard throughout the audits we reviewed. The latest audits from October 2023 to November 2023 showed hand hygiene in theatre (98.7%) and ward (98.7%), aseptic non touch technique (ANTT) (100%), urinary catheter continuing care (100%), cleanliness audit for the ward (100%) and theatre (100%). The most recent patient-led assessments of the care environment (PLACE) audit results showed 98.73% for cleanliness against a national average of 98.01%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The hospital completed daily cleaning checklists for the ward and theatre. All public areas had cleaning schedules. We reviewed a sample of checklists which were up to date.

Staff used records to identify how well the service prevented infections.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand-washing and sanitising facilities were available for staff and visitors.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Items seen were visibly clean and dust-free and we saw a daily cleaning check list.

Staff worked effectively to prevent, identify and treat surgical site infections. Two of the theatres had a laminar flow system, which circulated filtered air to reduce the risk of airborne contamination of wounds and sterile equipment. We saw that the ventilation system within theatres had been regularly checked for bacteria.

The hospital had a specific policy for the monitoring of infections related to surgery, and we could see this was followed by the information we reviewed. We saw a robust screening process for monitoring of pre-operative infections such as MRSA, Carbapenemase Producing Enterobacteriaceae (CPE), Clostridium Difficile and Creutzfeldt-Jakob Disease (CJD). We also reviewed individual policies for 'Patient groups for MRSA screening' and 'Management of MRSA', both of which were in date and due for review in October 2026.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. Although during the inspection visit, we were able to access one theatre area and two additional staff only areas on the ward without needing a swipe pass or code to access these areas. We raised this at the time of inspection, and there had been a fault with some of the door access systems. The hospital director had this rectified immediately and was also looking to implement a new improved door access system in 2024 following this issue.

Staff carried out daily safety checks of specialist equipment. Environmental audits were conducted, and we saw a ward and theatre action plan following the November 2023 audit. The action plan clearly showed expected evidence, a responsible person, and a risk rating for each area. The most recent theatre environment audit showed 100% compliance.

The latest fire safety and evacuation test had been successfully carried out in October 2023 and this had been reviewed with an action note relating to the assembly point needing to be moved back from the roadside to the rear of the car park. There was a fire incident management plan in place, and this was version controlled and in date, with the next review due in August 2024.

There was an equipment maintenance schedule in place that was up to date and showed any faulty equipment and actions taken. This also included clear records of all equipment and the last and next service dates alongside the serial number for the equipment in each area.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

Good

Surgery

Staff ensured they had adequate knowledge of the patient's health, any relevant test results, and their medicines history. There was a comprehensive pre-operative assessment process that was used for all patients. The hospital had an effective process for assessing patients prior to admission. Patients had a pre-operative assessment to ensure they met the inclusion criteria for surgery and to allow any key risks, that may lead to complications during the anaesthetic, surgery, or post-operative period, to be identified.

Between 1 August 2023 and 31 October 2023 there had been one patient who was cancelled for surgery due to a failure in the pre-operative assessment process. The patient was then booked back in to undergo surgery once they had been optimised.

Patients with complex co-morbidities would not routinely be admitted for treatment. Admissions were only considered on the presentation of all relevant clinical evidence, a risk assessment, and the mitigation of risk and with the agreement from all parties involved in the care of the patient. If there were any risks identified these were discussed by the treating clinicians.

Staff completed risk assessments for each patient on commencement of their treatment, using a recognised tool, and reviewed this regularly, including after any incident. The service used a modified 'five steps to safer surgery' checklist based on guidelines from the WHO Surgical Safety Checklist. We observed the theatre team undertaking the 'five steps to safer surgery' procedures, including the use of the WHO checklist. From 1 January 2023 TO 30 September 2023 an audit of the WHO Surgical Safety Checklist in theatre found 99.7% compliance. From 1 October 2023 to 30 November 2023 an audit of the WHO Surgical Safety Checklist in theatre found 100% compliance.

Staff responded promptly to any sudden deterioration in a patient's health. The service had a deteriorating patient policy where patients would be referred to another nearby hospital for specialised care which the hospital did not provide. Staff participated in simulated emergency scenarios quarterly to ensure they maintained skills in responding to a patient collapse or cardiac arrest. Records showed that 95% of ward staff and 100% of theatre staff completed training in basic life support (BLS). 100% of theatre staff were trained in adult life support (ALS).

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score (NEWS2) tool to assess for patients at risk of deterioration. From October 2023 to December 2023 the NEWS2 audit found 95.1% compliance. There was a structured communication tool for handing on information to a clinical colleague about a deteriorating patient. Staff used the situation, background, assessment, recommendation, and decision (SBARD) communication tool.

The service transferred four deteriorating patients to an NHS hospital in the previous 12 months and records showed the service followed its policies and procedures. There was a service level agreement for patient transfers to the local NHS hospital.

The hospital had procedures for the recognition and management of sepsis and staff described how they would identify a deteriorating patient. Staff said they completed sepsis training as a part of mandatory training modules such as immediate life support.

Staff knew about and dealt with any specific risk issues. Each ward and theatre area had a meeting each morning to review any risks including patient safety risks and planned how to address these. We observed a service wide meeting which provided information on any risks and staffing requirements for each day.

Good

Surgery

Staff shared key information to keep patients safe when handing over their care to others. This ensured continuity of care when people moved between services or received care from different staff in this service. Clinicians wrote to the patient's general practitioner after gaining the patient's consent.

Following surgery, patients could access a 24-hour helpline for advice and help if needed.

Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. The surgical nursing team was made up of a theatre team, which consisted of a manager, scrub practitioners, anaesthetic team, recovery team and support team members; a ward team, which consisted of a manager, sisters, senior staff nurses, nurses and health care assistants and pre-assessment team, which consisted of a lead nurse, senior staff nurses and health care assistants. A senior member of staff was always on shift when the service was in operation. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants (HCAs) needed for each shift in accordance with national guidance.

The staff to patient ratio requirement was calculated in line with a national safer staffing guidance. The hospital calculated staffing levels in the morning, afternoon, and night. We observed the staff ratio for each day was displayed on the ward. Staff said there was always senior staff on shift and an on-call team in the unexpected event of readmission or returns to theatre. The service monitored staffing to ensure it provided safe and responsive care.

The manager could adjust staffing levels daily according to the needs of patients. All theatre lists were pre-planned so the number of staff required for each shift, on the ward and in theatres, could be pre-determined. Staffing levels reflected demand on the service and known treatment support needs.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The hospital had recently undertaken a recruitment drive to increase staffing and there were currently vacancies for 2 ward staff nurses and two healthcare assistants for the ward.

All staff had a period of induction, and supervision where required, on commencing work at the hospital. Nursing staff had completed their Nursing and Midwifery Council re-validation checks and updates to develop their competencies. The hospital reviewed staff absence and recruitment and retention information.

Medical staffing

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

The service had enough medical staff to keep patients safe. There were 161 consultants working under practicing privileges.

Good

Surgery

Assessments of applications for practising privileges, from doctors and allied health professionals, were carried out by the Medical Advisory Committee, which reviewed and approved the scope of practice submitted by an applicant. The service monitored compliance with the practicing privileges policy, and we saw evidence of this.

The medical staff on duty matched the planned number.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Records

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

Patient notes were comprehensive and all staff could access them easily. The hospital used paper and electronic records, to document patient information securely. Diagnostic images, reports and histopathology results could be viewed electronically. Records could be accessed across the departments, allowing continuity of record keeping. Bank staff could access the records they required.

We viewed 5 patient care records, which contained the patient's consent form, written theatre record, including observations and discharge information. Records we reviewed were completed appropriately.

Records were stored securely. Paper records were stored securely in a locked cabinet when not in use. Staff completed training in information governance and data protection.

The hospital completed audits such as a records audit which showed 100% compliance in the previous 12 months.

The hospital followed the providers clinical record keeping policy which outlined staff responsibilities and the standards that were expected to meet legal and regulatory requirements.

Medicines

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

Staff did not always follow systems and processes to prescribe and administer medicines safely. One person was given oxygen that had not been prescribed. Of the 5 prescription charts we reviewed, we found 3 people's Venous thromboembolism (VTE) risk assessments were not completed on the drug chart. Following the inspection, the provider told us, the risk assessments had been completed in the patients care pathway.

Staff were not always following the medicines policy. We found prescription charts were not always legible. In addition, we found prescribers were not following best practice guidance regarding prescription writing requirements as detailed in the British National Formulary. There was a risk that the patient could have been given their medicines incorrectly which might have caused harm.

Good

Surgery

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. However, we found documentation to support advice being given people around their discharge medicines was not always documented on the prescription chart. The pharmacy was open during the weekday and on Saturdays, and pharmacy staff provided advice and support to prescriber and clinical staff in addition to the dispensing of medicines. However, we found the week prior to the inspection due to staff shortages the pharmacy was not open during usual hours. Therefore, prescriptions were not able to be dispensed and specialist advice to support clinicians was not readily available. This might have caused a delay to people accessing their medicines. The provider told us that their review of reported incidents from January 2023 found there had been no incidents where patients had experienced a delay in accessing their medicines.

Staff stored and managed all medicines and prescribing documents safely. We found medicines were stored securely, and access to the medicines room was restricted. However, the door to the medicines room did not always close properly, this was highlighted on the day of inspection and staff took action to rectify this.

Staff did not always follow national practice to check patients had the correct medicines when they were admitted, or they moved between services. Documentation of each patients' medicines reconciliation was not always completed. Two prescription charts did not include all of the required information relating to the patient's own medicines to ensure safe prescribing. We also found 2 prescription charts did not detail the resources used for the medicine's reconciliation as identified by the services audits.

Staff did not always complete medicines records accurately and keep them up to date. We reviewed 5 peoples prescription charts. We found 2 people were prescribed medicines that had not been given and no reason had been documented on the prescription chart to explain the reason for the missed medicine.

The provider told us that 11 medicine related incidents had occurred between 1 August and 31 October 2023.

The provider completed audits of prescription charts with the last audit completed April to June 2023 and achieved 98% compliance. However, the audit template the service provided to us, did not identify the issues we found during the inspection. Since the inspection the service has developed further audit tools to drive improvement.

Incidents

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

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

Staff raised concerns and reported incidents and near misses in line with provider policy. We reviewed the incidents data for the previous 12 months and found they were reported and investigated in line with the service's procedure.

The service had no never events in the last 12 months.

Managers shared learning with their staff about never events that happened elsewhere. Learning was routinely shared from other Spire Hospitals.

Staff reported serious incidents clearly and in line with the provider's policy.

Good

Surgery

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff gave examples of incidents where the duty of candour requirements applied.

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

There was evidence that changes had been made as a result of feedback. Staff discussed learning from incidents at the clinical audit and effectiveness meetings. For example, we saw consistent shared learning with actions and timely follow up for these.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

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

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

The Director of Clinical Governance told us the service did ensure it identified and implemented relevant best practice and guidance, such as NICE guidance. The process for this was through the provider's corporate governance department. They provided quarterly bulletins with NICE guidance for all hospitals.

The Director of Clinical Governance then reviewed the information and implemented the NICE guidance relevant to the identified department. The implementation was carried out by the department head and signed off by the Director of Clinical Governance when completed.

The Director of Clinical Governance told us this process worked well and we could see this was the case through our review of guidance at the hospital. Staff also told us they felt this worked well as a process.

Compliance with clinical risk assessment audits (VTE) was at 100% for all parts of the audit in November 2023.

All Spire Hospitals in England and Wales submit data to the National Joint Registry (NJR). Spire Methley Park had 100% compliance on the NJR's annual data quality for 2022/2023.

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

At safety meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Policy and pathway documents were inclusive of patients with disabilities and people with protected characteristics. Staff made appropriate adjustments for patients with complex needs and planned individualised care to meet these needs in line with provider policy.

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

Nutrition and hydration

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

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

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We looked at four patient records which showed staff carried out an assessment of patients' nutritional requirements and used the malnutrition universal screening tool (MUST). We saw that patients' fluid and nutrition charts were completed accurately.

Specialist support from a dietitian was available for patients who needed it.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. Patient feedback confirmed this. Staff carried out an audit every 3 months to monitor compliance against pre-operative fluid fasting. The audit results showed a high level of compliance, with an average result of 90% between January and December 2023.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The ward manager told us that the hospital catering staff tailored menus to meet patient needs including responding to food allergies or to have something they liked when they were not feeling well.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff asked patients about their pain when taking vital observations and during medicines rounds.

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

Staff prescribed, administered and recorded pain relief accurately. Medicine prescriptions records showed staff prescribed appropriate pain-relieving medicines at regular intervals during the day as well as additional pain medication as required by the patient if they experienced increased pain.

Patient outcomes

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

The service participated in relevant national clinical audits. The service had a programme of local and national audits in place to benchmark the service against other hospitals in the provider group, local policy compliance and service improvements.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. Actions were required for any audits scoring less than 95% compliance. We saw examples of completed action plans from the pain trigger to action audit.

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw evidence of action plans from audit and saw that they were monitored and reviewed. Audits were repeated to improve compliance. Managers used information from the audits to improve care and treatment.

The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data from April 2021 to March 2022 did not identify any concerns and showed the service performed in line with national averages.

Performance reported outcomes measures (PROMs) data for 2021/22 reported to PHIN showed 100% of patients reported they had improved since their hip replacement and knee replacement surgery and the hospital performed better than the England average.

The hospital director told us that the PHIN and NJR data was compared with the provider's other hospitals and head office provided a snapshot of their performance.

Clinical effectiveness was overseen by the clinical audit and effectiveness committee and a corporate software system recorded all audits undertaken. These included but were not limited to audits on infection prevention and control (IPC), pre-op assessment, medicines management, records, pain, temperature, and hand hygiene. The director of clinical services told us that the audit information was entered into the system.

The system provided a hospital-wide summary of the audit data and since April 2022 the provider enhanced this process, so each department had their own dashboard. Each department dashboard included information such as complaints, incidents, investigations, quality improvement projects and risk register entries.

Good

Surgery

The governance manager created a quarterly governance report and provided a high-level summary of the data for each department. Managers shared and made sure staff understood information from the audits. Audit findings were reviewed as part of routine departmental staff meetings and as part of the clinical governance meeting and medical advisory committee meetings, held every three months.

The electronic system allowed the service to benchmark against the other provider hospitals. This was part of the patient safety scorecard that showed every hospital in the group and ranked them according to performance on each metric.

Competent staff

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

We checked 10 staff files which were held on a computer-based system. All the documentation complied with Regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014 set out in Schedule 3.

We saw evidence the service conducted monthly registration audits to confirm staff registrations and qualifications for various professional bodies were in date.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Ward and theatre staff received competency-based training and assessments covering a range of topics. During induction staff completed their core competencies. Staff then moved into their departments and continued their core clinical competency training which was monitored by the head of department.

Managers gave all new staff a full induction tailored to their role before they started work. We saw evidence of this ain the staff files we reviewed. We also spoke to new staff who shared this with us. Bank and agency staff also had inductions before starting work.

The hospital had a 'New Joiners – Skills and Learning Passport' in place to record and acknowledge new staffs learning and development during their 12-week induction. This was a comprehensive document including information on learning management system (LMS) – eLearning, role specific learning, policies, clinical colleague competencies and a completion area.

Staff we spoke with told us they received an annual appraisal including a mid-year review. The hospital provided data that showed 100% of ward staff and theatre staff had completed their appraisal.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Consultants had an induction programme, this included key information about the Hospital, the Hospital vision, mission, and values. It also included access to mental health first aiders, equality and inclusion strategy, and freedom to speak up contacts.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their main employer which was usually an NHS trust. This was reviewed as part of the practicing privileges process and during inspection we observed the database that monitored and recorded all appraisal information.

Good

Surgery

The service monitored the number of procedures that were carried out per year by each consultant and the medical advisory committee (MAC) discussed performance issues and competency regularly.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with had completed the appraisal process and had tailored individual development plans.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

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

We saw theatre staff work together to complete the safer surgery checklist and patient preparation prior to surgery. Staff displayed good communication skills and effective teamwork.

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

The ward manager told us that another multidisciplinary meeting took place every morning with catering, physiotherapy, ward staff and housekeeping. They discussed patients being admitted and discharged that day and which patients needed extra support.

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

Staff referred patients for mental health assessments when they showed signs of mental ill health such as depression.

Staff shared information about a patient's admission and treatment in a discharge letter which was sent to the patient's GP.

Good

Surgery

Seven-day services

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

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

Patients could access staff for support following discharge. This was available 24 hours a day seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The service had access to all key diagnostic services such as diagnostic imaging and laboratory services seven days a week to support clinical decision making.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on ward areas.

The service had information displayed on notice boards around the department for different illnesses or medical conditions accompanied by a quick-response code (QR code). The code when clicked on took the patient to advice as to how best to manage the illness or medical condition.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

We saw evidence in the patient notes we checked of patients being given diet and exercise advice as to how to best recover post operatively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The organisation had a consent policy that was within the date of review and included guidance for staff to follow. The policy included guidance for patients assessed as lacking capacity to consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice. Staff gained verbal consent before delivering routine daily care such as assistance with washing, dressing and repositioning. We observed staff gaining consent before delivering care and treatment. Staff gained written consent from patients for all surgical procedures.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Good

Surgery

Staff made sure patients consented to treatment based on all the information available. Theatre staff checked that patients understood the procedure they were having. This was included in the World Health Organisation five steps to surgical safety checklist.

Staff clearly recorded consent in the patients' records. We reviewed 5 patient records and they all contained correctly completed consent forms for their procedures. The hospital carried out an audit to monitor consent. We saw that an average of 99.25% of patients had a fully completed consent recorded in their notes for audit completed January to December 2023. Where audit results were less than 100% the findings related to legibility of the consent for and completeness of risks and benefits in one case and not to lack of consent process for patients.

There was an interpreter service available to support patients whose first language was not English during the consent process. Interpreters were pre-booked to provide either face to face or telephone support. Staff told us family members were not used for consent purposes.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw several positive, caring interventions by staff, who always took their time to ensure patients' needs were understood and met appropriately. Staff were very proud of the care they gave. From our observations, all staff were very pleasant and polite to patients, other colleagues and to all visitors.

Patients said staff treated them well and with kindness. Feedback from patients was positive about all of the staff. Visitors were very complimentary about the service provided.

Staff followed policy to keep patient care and treatment confidential. We saw staff respect and always maintained patients' privacy and dignity. Staff were able to give us a good summary of the patients under their care.

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Feedback from the inpatient and day case experience survey showed 96% of patients rated their overall experience as very good. 44% said Spire Methley Park exceeded their expectations, and 56% said it met their expectations in November 2023.

Good

Surgery

Patient feedback received on. NHS Review. has a current rating of 5 stars, 'Google review' has a current rating of 4.3 stars and 'Doctify Review' has a rating of 4.88 stars. Patients have said 'Absolutely top notch, caring, efficient staff, clear and utterly professional, would recommend to anyone' in relation to their experience at Methley Park.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We observed theatre staff communicating effectively with a patient and providing reassurance prior to surgery.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff gave an example of when a patient with anxiety had been accompanied by their family member and a healthcare assistant to have some pre-visits to the hospital in advance of their treatment to help with ensuring they were able to attend on the day.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed theatre staff communicating effectively with patients and providing reassurance prior to surgery.

The hospital had a 'patient care diary' in place, this included space for patients to record information such as who they were visited by on that day and how they feel their day went. We were told that patients use these diaries, and this can help with emotional support.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The hospital conducted patient surveys to obtain feedback on the service. These results were collated monthly and shared with the staff teams for learning and improvement.

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

Patients gave positive feedback about the service.

Good

Surgery

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. The hospital undertook some surgical procedures on behalf of the NHS.

Patients could choose their appointment dates and surgery dates to suit their needs. Weekend and evening appointments were available to ensure flexibility to meet individual patient needs.

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

Staff could access mental health support for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, patients with a learning difficulty who were coming in for surgery were identified during the pre-assessment process. They would be supported by the senior clinical team who would meet them during their pre-assessment and plan support they may need throughout their stay in hospital.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The hospital had a dementia champion and dementia friends to support patients living with dementia.

Wards were designed to meet the needs of patients living with dementia. The ward made reasonable adjustments for patients with complex needs. The hospital had information leaflets available in languages spoken by the patients and local community. Staff had access to print patient information in different languages where a patient's first language was not English. The hospital also had access to patient information in Braille to support visually impaired patients.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

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

There was a quiet room allocated every morning to be used as a prayer room. This could be accessed by either staff, patients, or visitors. On the day of inspection, this room had been allocated in a staff only access area, which made it difficult to access. We were told this did not usually happen and the room changed each day. We saw evidence of this through the daily meeting notes for previous dates.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We spoke to both the ward manager and catering staff who confirmed this.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patients could access the hospital either as privately funded patients or through NHS choose and book. All NHS procedures were prioritised by patient need following consultant review and agreement with the senior leadership team.

Managers and staff worked to make sure patients did not stay longer than they needed to. Managers and staff worked to make sure that they started discharge planning as early as possible. Ward rounds were conducted including to ensure timely discharges.

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

Managers worked to keep the number of cancelled operations to a minimum. Staff reported cancellations on the incident reporting system, and these were monitored by managers for themes.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers monitored patient transfers and followed national standards. There was a service level agreement with the local NHS trust in place for the transfer of patients requiring critical care transfer in the event of deterioration or an emergency.

Good

Surgery

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients confirmed they knew how to make a complaint. However, they told us that they had not had any reason to raise a complaint.

The service clearly displayed information about how to raise a concern in patient areas. We saw information on the ward that explained how to make a complaint. Information as to how to make a compliant was also available on the hospital website.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew how to deal with patient complaints and concerns. Initially staff attempted to resolve any issues at the time they were raised. In the event they were unable to resolve issues themselves they told us they would escalate the concerns to their manager.

Managers investigated complaints and identified themes. We saw monitoring of complaints by category between January 2023 and November 2023. This showed the highest category of complaint was clinical care. From January to November 2023 11 complaints had been received relating to clinical care. Following investigation only one complaint was upheld in relation to this category. Complaints were discussed weekly at the rapid response meeting, weekly to the audit and effectiveness meeting, quarterly to the clinical governance meeting and quarterly to the medical advisory committee.

The hospital director oversaw the management of all complaints. All complaints were reviewed by the director of clinical services. In the three months prior to our inspection, the hospital received two formal complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. This information was shared in staff meeting, daily huddles, on staff notice boards and newsletters.

Staff could give examples of how they used patient feedback to improve daily practice.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Where patients or their families raised concerns, staff took time to listen to the concerns and resolve any issues at the earliest opportunity. Staff felt able to act on concerns or escalate these to a senior member of the team to resolve where necessary.

Is the service well-led?

Good

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

Good

Surgery

Leadership

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

There was a dynamic, compassionate, inclusive, and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

There was a clear management structure with defined lines of responsibility and accountability. However, managers explained that the structure was also set up to enable whole team involvement. Staff worked together as one team to provide the best care for their patients and provide a supportive environment for their colleagues.

Staff told us that there was good departmental and hospital leadership. Leaders were very well respected, approachable, and supportive. All staff we spoke with were extremely positive about the leaders in the organisation describing them as open, professional, friendly, and supportive. They told us that that all leaders had an open-door policy and they felt comfortable approaching any of the hospital leaders with concerns.

Leaders understood and managed the priorities and issues the service faced. Daily meetings escalated concerns on the day. Leaders at all levels had clear oversight of capacity, patient acuity, staffing and risk.

Leaders were passionate about the service and worked well with staff to deliver the best possible outcome for their patients. Hospital leaders were visible in clinical areas and took time to meet with staff and patients.

Leaders held regular staff meetings and staff told us that they felt that their views were heard and valued.

Specialist leads such as the infection prevention lead and dementia lead were passionate and knowledgeable. They were accessible to staff and were empowered to carry out their role by the senior leadership team.

Vision and Strategy

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

The hospital's vision was 'to be recognised as a world class healthcare business' with the purpose to 'make a positive difference to people's lives through outstanding personalised care'. The hospital's mission statement was 'to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'.

The hospital had a comprehensive clinical strategy for 2023 with four strategic objectives. These included 'safety culture', 'quality improvement', 'regulatory compliance' and 'patient satisfaction'.

The vision, values and strategic objectives were clearly displayed on notice boards across the ward and theatre areas. The vision and values were saved on every desktop computer, covered in the induction programme for new staff and objectives were incorporated into individual staff appraisals. All staff we spoke with had a good understanding of the vision and values.

Good

Surgery

The strategic objectives were underpinned by key performance goals and measurable targets, including for clinical quality, patient safety and medical and clinical governance. The service had action plans in place for the strategy to continually monitor progress.

Culture

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

Leaders had an inspiring shared purpose and worked to deliver and motivate staff to succeed. This was apparent as we observed interactions between managers and staff.

Staff reported an open and honest culture and said they felt able to raise any concerns with their managers. Staff were extremely proud of the organisation as a place to work and spoke highly of the culture. All staff we spoke with confirmed that the needs and experience of their patients was at the centre of the service.

Staff told us they could raise concerns without the fear, and they were confident action would be taken as a result. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. The hospital leader demonstrated an openness to challenge, appropriate escalation and sharing of improvement.

Staff had access to independent freedom to speak up guardians to express any concerns outside of their immediate teams if they needed to. The hospital had a freedom to speak up guardian, who fed into the national corporate guardian.

We saw a poster on noticeboards highlighting who the freedom to speak up guardians and ambassadors were and the number for the 'raising concerns' helpline.

Managers supported staff's mental health and wellbeing. There was a room allocated every day as a safe space where staff could go if they needed to take some time out. The provider offered an employee assist line offering personal assistance and wellbeing support to all staff. Staff told us that managers were supportive of health and wellbeing, and they felt comfortable raising concerns about their own wellbeing. One member of staff told us that staff at the hospital had been a great support to them when they had experienced a personal challenge.

Processes and procedures were in place to meet the duty of candour. Where errors had been made or where a patients' experience fell short of what was expected, apologies were given, and action was taken to rectify concerns raised. When incidents had caused harm, the duty of candour was applied in accordance with the regulation.

Governance

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

There was a robust and effective governance structure, processes, and systems of accountability to support the delivery of good quality service and monitor and maintain high standards of care.

The service had effective data collection processes, which provided the management team with service level assurance. This included a variety of meetings and working groups that fed into committees for oversight. They hospital held three

monthly (quarterly) clinical governance meetings and monthly clinical effectiveness meetings. We reviewed 3 sets of meeting minutes and saw that they were well attended by the representatives from the senior leadership team, hospital managers and clinical leads. Agenda items included clinical governance, quality, risk, compliance, and audit. All levels of governance and management worked effectively together.

Heads of department shared information during staff handovers and team meetings. Managers told us that they communicated important information at team meetings with staff and by email or the staff notice boards, for when staff were unable to attend ward meetings or had been on leave. A monthly governance newsletter and monthly clinical dashboard was sent to all staff, so that everyone knew the key areas of focus for the month. The hospital produced a quarterly clinical governance report which outlined incidents.

There was a medical advisory committee (MAC) which met quarterly with responsibility for surgeon performance and surgery specific matters. The medical advisory committee (MAC) had oversight of audit results, complaints and incidents which were routine agenda items.

Incidents and themes were reported and discussed at the team meetings, clinical governance meetings and monthly clinical effectiveness meetings, medical advisory and health and safety committees.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits were completed monthly, quarterly, and annually as per the providers audit schedule. Results were monitored by the local, regional, and national management team. Results were shared at relevant meetings including the hospital team and clinical governance meetings.

The 10 at 10 daily meeting with all department heads was very detailed. Each department fed back their staffing situation including how many agency staff there were. There were updates including any returns to theatre, patient transfers, new incidents reported, safeguarding issues, IPC, complaints, consultant daily visit compliance and any issues from the resus huddle. Leaders on site were clarified and mental health first aiders identified. Any flash alerts were shared.

Management of risk, issues and performance

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

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

The key risks relating to the surgical services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member responsible for managing that risk.

Key risks and risk register entries were reviewed at monthly departmental meetings as well as clinical governance, medical advisory committee and senior management team meetings.

There was a clear and effective process for identifying, recording, and managing risk. Risks had been identified and recorded on the register. The hospital used a red, amber, green risk rating system, to indicate the high, medium, and low risk. Each risk had a rating on entry to the register and a rating once mitigations were in place. All risks had a review date, a named owner, and an action plan.

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

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

However, evidence was not available to demonstrate that pharmacists receive supervision to support them and or competency assessments from another pharmacy professional to ensure clinical effectiveness.

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

The hospital director had bi-weekly meetings with the chair of the MAC.

Information Management

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

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

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

Systems were in place to gather, analyse and share data and quality information with staff, key stakeholders, and the public. The hospital had access to local information and other Spire Hospital information to benchmark services.

The service had a website where people could access information about the surgical procedures available and which would be useful when visiting the hospital. Staff had access to the intranet to gain information relating to policies, procedures, professional guidance, and training.

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

Engagement

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

The service carried out an annual staff survey to gain feedback from staff about their experiences. The hospital-wide colleague survey (2022) had a response rate of 75% and 74% of staff said they were proud to work for the provider. This illustrated that the pride index had decreased by 13% from the previous year. The results showed that 79% of staff said that they would be happy with the standard of care if a friend or family member needed treatment. The staff survey showed the lowest score was 'receiving praise and recognition for their work in the last seven days' (57%). The hospital had developed an action plan for low scores in response to the staff survey.

Good

Surgery

We saw evidence a provisional 2023 staff survey had been completed between October and November 2023. This showed that 157 or 92% of staff out of 171 who could have taken part had responded. 88% of staff said they were proud to work for Spire which was an increase of 14% compared to 2022 results and 92% of staff would be happy with the standard of care if a friend or family member needed treatment. This was a 13% increase on the previous year. 76% of staff said they had received praise or recognition at work which was a 19% increase.

The hospital conducted a consultants satisfaction survey and the results for 2023 showed significant improvement from 2022. The response rate increased from 56% in 2022 up to 73% completion. Quality of care to patients rated as excellent or very good increased from 90% to 92%. Quality of service to consultants rated excellent and very good increased from 74% to 84%.

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

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

Learning, continuous improvement and innovation

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

The hospital had introduced 'Mako robot' assisted surgery in September 2023 for robotic hip and knee surgery.

Physiotherapy staffing levels have been increased to ensure that the department could open on evenings for patients to attend. Physiotherapy staff have delivered learning to nursing colleagues about the importance of early mobilisation of patients, from Day 0 following hip or knee surgery. This has improved the risk of post operative complications, reduced the length of hospital stay and has increased patients' confidence with discharge following surgery.

Leaders were committed to continually learning and improving the service. This was demonstrated on the day of the inspection in the response to our challenge relating to some issues with the magnetic door operating system which allowed our team into some areas that should have been protected to staff only. The hospital director had these issues immediately fixed and was able to provide a comprehensive update the next day with reassurance. This also included striving to improve and learn from the issues with a new and improved system looking to be implemented next year.

In October 2023, the ward team began a trial on improving ward handover processes, as part of this they have asked patients to feedback on their experience. Patients have been asked several questions, and these responses will be used to improve patient care.

Good

Diagnostic imaging

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

Is the service safe?

Good

Our rating of safe stayed the same. Following this inspection, we rated safe as good.

Mandatory training

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

The service had a mandatory training policy which was in date and version controlled.

The corporate target for mandatory training was 95% for all modules. Staff had until the 31 March each year to complete the training modules before the recording system was reset and commenced again in April each year.

Staff received and kept up to date with their mandatory training.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Managers monitored and recorded mandatory training and alerted staff when they needed to update their training through a computer-based system.

We checked the computer based mandatory training records which showed all staff were up to date with their mandatory training.

In addition to maintaining computer-based records, we saw in the 10 staff files we checked a record of which mandatory training the member of staff had completed accompanied by the training certificates.

Safeguarding

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

Good

Diagnostic imaging

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Although the service had not made any safeguarding referrals staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

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

The service did not treat children, however, staff followed safe procedures for children visiting the service.

We saw evidence staff had completed safeguarding children and young people training.

The service had an adult's safeguarding policy and a children's safeguarding policy. Both were in date, version controlled and followed intercollegiate guidance.

All staff had been trained to safeguarding level three. The service also had 3 staff members trained to safeguarding level 4. The Director of Clinical Services was the safeguarding lead. If they were not at work, one of the other level 4 trained staff would cover and provide advice for staff.

The Director of Clinical Services told us they would quality assure all safeguarding reports submitted by staff.

In the 10 staff files we checked we saw evidence of up-to-date disclosure and barring service checks (DBS).

Cleanliness, infection control and hygiene

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

The service had an infection prevention control policy which was in date and version controlled.

The IPC policy had recently incorporated the National Healthcare Cleanliness Standards. Heads of departments were held responsible for the cleanliness in their department.

The service had an Infection Prevention and Control guidance document for suspected or confirmed COVID-19 positive patients which was in date and version controlled.

Clinical areas, diagnostic imaging and patient changing areas were visibly clean and had suitable furnishings which were clean and well-maintained.

We inspected a room used for ultrasound procedures. It was spacious an appeared visibly clean.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

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

Good

Diagnostic imaging

We saw there were supplies of aprons, gloves and masks including standard and filter facepiece (FFP3) masks which gave protection from poisonous and deleterious kinds of dust, smoke, and aerosols.

There was specialised PPE which consisted of a lead apron with belts to support it. We saw evidence of the apron usage being subject to a quarterly audit.

On inspection, staff were observed to be bare below the elbow, used correct handwashing techniques, and PPE where appropriate, when in contact with patients.

We saw evidence the service carried out hand hygiene audits. The audit results from the last quarter did not identify any issues.

The service had disposable privacy curtains.

Staff cleaned equipment after patient contact.

On inspection staff were observed cleaning equipment then labelling it to show when it was last cleaned.

We saw evidence of ultrasound probe cleaning audits which record use of a three-part system for the decontamination of non-lumened invasive and non-invasive medical devices. It comprised 3 wipes and an activator foam that in sequence performed the steps of the decontamination procedure.

We saw evidence ultrasound guided injections were used. This is an aseptic technique which protects patients from healthcare-associated infections and protects healthcare workers from contact with blood, body fluid and body tissue.

The service had systems in place to ensure that cleaning of the department was appropriately monitored.

We saw evidence the service had conducted a gap analysis of the UK Health Security Agency (UKHSA) good infection prevention practice using Ultrasound Gel. The analysis identified 23 areas to be reviewed, 22 were RAG rated green and one RAG rated amber.

We saw evidence the service held quarterly infection prevention and control committee meetings which were attended by department heads. There was a set agenda covering 15 different areas to report upon.

Environment and equipment

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

Managers told us the service had a capital replacement programme in place.

The X-ray room used computed radiography which was due to be replaced by digital radiography.

The design of the environment followed national guidance.

Both the X-ray room and mammogram room were inspected. The rooms displayed effective clear signage on all doors referring to radiation.

There were emergency off buttons for the equipment. When equipment was not in use it was switched off, protocols and dose reference levels of radiation were available to view.

The local rules for each room were in date.

There were pause and check information prompts displayed for pregnancy, exposure by operators and by referrers.

Staff carried out daily safety checks of specialist equipment. The service used an external provider of technical and analytical services to determine occupational and environmental radiation exposure.

Data from those checks were kept in a folder for all staff to see. The folder was date stamped for documents checked and seen by staff.

The service had suitable facilities to meet the needs of patients' families. There were changing rooms available for private conversation with patients.

The service had enough suitable equipment to help them to safely care for patients. We saw there was a large supply of medical consumables available for ultrasound procedures.

The service used a spreadsheet to record the equipment it had. This included the make, installation, model and serial number, medical physics information and a servicing schedule. This was displayed on the office notice board.

Staff disposed of clinical waste safely.

The service had a fire incident management plan which was in date and version controlled. There was evidence had been tested on 3 October 2023. Three minor matters resulted from the test which culminated in the fire incident management plan being updated.

We saw fire extinguishers fixed securely on wall mounts, all had labels indicating they had been tested. The fire extinguishers were stored in accordance with the Fire Extinguisher regulations which form part of the Regulatory Reform (Fire Safety) Order 2005 which outlined to prevent fire extinguishers from being moved or damaged, they should be mounted on brackets or in wall cabinets with the carrying handle placed 3-1/2 to 5 feet above the floor.

We saw evidence a disposal of sharps audit for Diagnostics had been conducted between 1 October 2023 to 31 December 2023 which showed a 98.6% level of compliance.

The service held quarterly medical devices meetings attended by department heads. There was a set agenda which covered areas such as, incidents, safety alerts, servicing, and contracts.

Assessing and responding to patient risk

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

We saw evidence in the 10 staff files we checked and from speaking to staff they had received training in how to respond promptly to any sudden deterioration in a patient's health.

Good

Diagnostic imaging

The service conducted a daily crash bleep test to simulate a patient requiring urgent medical attention. A test was conducted during inspection and all the required staff responded to the bleep.

All referrals for outpatient appointments were reviewed by the Director of Clinical Services to identify any risks before the patient attend the hospital.

Staff we spoke with were aware of sepsis policy.

We saw evidence the service has a deteriorating patient's policy which was in date and version controlled.

Staff knew how to respond promptly to any sudden deterioration in a patient's health. There was a rapid response room where a patient would be taken if they were unwell. They would be reviewed by the resident doctor (RMO) and if necessary, the patient would be admitted to hospital.

If the patient was mildly unwell, they would be monitored in a room called a day pod until they were considered fit enough to go home.

Staff completed risk assessments for each patient on admission and/or arrival, using a recognised tool, and reviewed this regularly, including after any incident.

In the 10 sets of patients records we checked there was evidence of patient safety questionnaires being completed. The questionnaires included reference to Buscopan, contrast, and colonography air checklists if they were being used as part of a diagnostic procedure.

Staff knew about and dealt with any specific risk issues.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

Staff were aware of the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs).

The service gave patients, post procedure, after care leaflets explaining what action, they should take if they began to feel unwell.

The service followed the pregnancy status procedure as outlined by the Society of Radiographers which was a professional body for the diagnostic imaging and radiotherapy workforce which shaped policy and standards.

The service had a corporate contrast pathway policy which covered acute kidney failure linked to use of contrast. There was a flow chart which covered bloods and eGFR (estimated glomerular filtration rate) which is a measure of how well your kidneys are working. Once completed the checks would be signed off by a doctor.

The service would not take patients who had a known allergy to contrast.

We saw evidence ultrasound guided injections were used. They were a harmless way of imaging deep into the body's tissues which guides the injection directly to where it is required which reduces the risk of the injection being given in the wrong site.

The service had diagnostic reference level (DRL) protocols in place, which were an optimisation tool for medical imaging procedures using ionising radiation. They gave an indication of the expected radiation dose received by an average-sized patient undergoing a given imaging procedure. This was used to prevent too much radiation being given to patients.

We saw evidence staff had received training in how to deal with violence and aggression, conflict resolution and had received domestic violence and abuse training.

Staffing

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

The radiology manager worked 30 hours per week with additional flexible hours. There were two contracted radiographers one worked 37.5 hours per week, the other worked 22 hours per week. Managers told us they had sufficient staff. Staffing levels could be adjusted to meet the planned number of appointments.

The service used three regular bank staff radiographers who were available up to five days per week.

There was a vacancy for a radiographer.

There was 1 clinical support worker and three administrative assistants who worked part time.

There were 13 radiologists who ran clinics on site. There were 5 neurology radiologists who worked at a different Spire hospital, one of these attended the hospital to carry out pain injections in theatre when required.

There were 2 radiologists regularly undertook remote reporting from a different Spire hospital, one specialised in bowel and abdominal and the other musculoskeletal (MSK) conditions.

Six radiologist who attended the hospital had regular scanning sessions. Three were MSK specialists, one specialised in breast scans, one in renal and abdomen scans and the other gynaecology, vascular and abdominal scans.

They were engaged by the service through practicing privileges overseen by the corporate hospitals' directorate.

Managers we spoke with told us agency staff were used on occasion and there was a policy in place regarding use of bank staff which included the preferred supplier which was part of a corporate arrangement.

The service used a computer-based staffing tool to assess what the appropriate staffing levels should be to deal with demand. The radiology manager conducted regular waiting time audits to identify if additional staff we required so additional diagnostics clinics could be booked to reduce waiting times.

Data for September 2023 showed registered staff were 0.67 WTE below the establishment and Health Care Assistants were 0.28 above establishment.

Good

Diagnostic imaging

A review of staffing showed between August to October 2023 18% of staff used were bank or agency staff.

The service provided data which showed over a 12-month period from October 2022 the average clinical staff sickness was 7.3% and non-clinical staff was 8.4%. Mangers told us this was consistent with levels of sickness from previous years.

The service had a lone working policy which was in date and version controlled.

Records

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

During inspection we reviewed 10 patient records. They were comprehensive and all staff could access them easily.

We saw evidence that the records contained reference to the auditing of the picture archiving and communication system (PACS).

PACS is a computerised means of replacing the roles of conventional radiological film and the radiology information system (RIS) which was a networked software system for managing medical imagery and associated data.

There was evidence the patient records were subject to regular audit by the radiology manager.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

We saw evidence of audits termed, Accompanying Notes conducted between 1 October 2023 to 30 November 2023 and Single Patient Records conducted between 1 April 2023 to 30 June 2023, both showed 100% compliance.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

We saw evidence of audit checks for the use of iodinated contrast, a form of water-soluble, intravenous radiocontrast agent containing iodine, which enhances the visibility of vascular structures and organs during radiographic procedures.

We saw evidence of audit checks for the use of Gadolinium contrast media (sometimes called a MRI contrast media, agents, or 'dyes') which are chemical substances used in magnetic resonance imaging (MRI) scans.

The service had Patient Group Directions (PGDs) in place which were written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Good

Diagnostic imaging

We saw evidence that the highest radiation doses accruing acutely at a single site on a patient's skin, referred to as the “peak skin dose” (PSD), which is an important parameter in assessing risk of erythema (skin reddening) and epilation (hair loss), were signed off by radiologists prior to any treatment.

There was an anaphylaxis drugs box in the unit to support the mobile diagnostic services when they visited. The box was sealed and tagged which showed in was fully stocked and ready to use.

The service had no radiopharmaceuticals.

Staff reviewed each patient’s medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. The service used a code lockbox for medicines.

There was evidence of daily temperature checks were done in the drug storage cupboard.

There was a stock control process in place which ensured there enough medicines.

We saw evidence of medicines audits being carried out which linked to the hospital pharmacy audits.

There were oxygen and medical carbon dioxide available for use of the mobile CT and MRI team. There was evidence these were regularly checked.

The prescription pad was kept locked in the drugs cupboard.

There was a radiation protection poster displayed which explained safe dosages of radiation in an easy-to-understand format.

Staff learned from safety alerts and incidents to improve practice.

We saw evidence of a service level agreement (SLA) between pharmacy and the diagnostic imaging department for providing medicines.

The aim of this SLA was to define the level of medicines management support offered to the diagnostic imaging department by the pharmacy and to define the imaging role in medicines management. The SLA aimed to enhance relationships and working practices between the two departments.

Staff we spoke with told us it worked well.

Good

Diagnostic imaging

Incidents

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

The service had an incident reporting policy which was in date and version controlled.

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

Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service had not reported any never events.

The service had not made any reports under the ionising radiation medical exposure regulations (IRMER).

Staff we spoke with were aware of the Patient Safety Incident Response Framework (PSIRF) and how to report incidents through it.

Managers shared learning about never events with their staff and across the service.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with the service's policy. We saw examples of this in the services reporting systems.

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

We saw evidence of shared learning from an event at another Spire hospital. The information was displayed on notice boards for staff to read.

Staff met to discuss the feedback and look at improvements to patient care. We saw evidence of this during the rapid response meeting and safety huddle which we attended during inspection.

We saw on the Governance Matters newsletter covering 30 October to 5 November there was a section on what had been learned from incidents. There were 6 learning areas identified which were shared with staff.

The Governance and Quality Risk Manager we spoke with explained they had oversight of all incidents reported in the hospital.

They told us each incident reviewed by them and categorised depending on the level of harm and investigated accordingly.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Good

Diagnostic imaging

Managers debriefed and supported staff after any serious incident.

The service had an incident reporting policy which was in date and version controlled.

The service had a Duty of Candour policy which was in date and version controlled.

Staff we spoke with understood the principles of duty of candour. Managers we spoke with gave us examples when the principles of duty of candour had been applied.

No incidents of violence towards staff had been reported in the previous 12 months prior to the inspection.

Is the service effective?

Good

Effective was not rated during the last inspection. Following this inspection, we rated effective as good.

Evidence-based care and treatment

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

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

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice introduced in 2008 following substantial changes and updates in legislation, policy, case law, and professional practice.

The service had diagnostic reference levels (DRLs) in place. These were an optimisation tool for medical imaging procedures using ionising radiation. They gave an indication of the expected radiation dose received by an average-sized patient undergoing a given imaging procedure.

The service used a system which brought real-time tracking and management to clinical audit with dashboards and reporting which made it simple to deliver quality improvement.

We saw evidence radiologist protocols were based on NICE guidelines.

The service used evidence-based radiology (EBR) which is medical decision-making based on the combination of three main components: the best available medical imaging research evidence, clinical expertise, and patient's expectations.

We saw the service audited the following areas, Surgical Safety Checklist, Pause and Check Audit, Imaging Documentation Audit, Royal Pharmaceutical Society (RPS), Image Intensifier / Mini C/Arm Audit, Quality Assurance Overview, Post Examination Documentation and Mammo Peer Review.

The last 6 audits conducted for each area showed they had exceeded the 95% target on every occasion.

Good

Diagnostic imaging

Patient outcomes

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

Managers told us a corporate group had been set up to implement the Quality Standards for Imaging (QSI.) QSI was a collaboration between The Royal College of Radiologists (RCR) and The College of Radiographers (CoR), to improve the quality of care for people attending an imaging service.

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent, and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Improvement in patient outcomes were checked and monitored.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

The radiology manager was the service's Radiation Protection Supervisor (RPS). They were appointed by the service to ensure any work undertaken with ionising radiation was performed in compliance with the Ionising Radiation Regulations and the local rules required by the regulations.

We saw regular checks of staff qualifications and professional registrations through the Health and Care Professions Council (HCPC) were conducted by the HR administration staff.

The service only recruited qualified diagnostic radiographers.

Managers gave all new staff a full induction tailored to their role before they started work.

We saw evidence of skills and learning passport for new staff. The purpose of the passport was to record and acknowledge learning and development during the 12-week induction. Line managers and colleagues supported staff to work through the passport assisting in gathering all the information, skills and knowledge needed for the role.

Managers supported staff to develop through constructive appraisals of their work. We saw evidence all staff had received an appraisal which was termed, enabling excellence.

These were conducted halfway through and at the end of the appraisal year.

Managers supported staff to develop through regular, constructive clinical supervision of their work. All staff were assessed using a clinical competency framework.

We saw evidence of staff taking part in scenarios which tested their clinical skills. These were assessed by a manager as part of their clinical supervision.

The service had a 'driving clinical excellence in practice' programme for staff. The programme had been developed in collaboration with a local teaching hospitals NHS Trust and organisations in the Leeds Academic Health Partnership. The completion of this programme was designed to support continuing professional development and the collection of evidence in support of professional revalidation.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers told us support was available for staff to undertake post graduate education.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We saw evidence of staff building up evidence of their own personal professional development.

We saw evidence the service had adopted the British Institute of Radiology self-reflection for continuous personal development (CPD).

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. Managers we spoke with told us they would hold a one-to-one meeting with staff who were underperforming. The meetings were to support staff to improve.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We saw evidence the service was involved in multidisciplinary meetings. The radiology manager met regularly with department heads at the hospital including attending the clinical effectiveness and audit meeting and the weekly rapid response meeting.

Radiologists attended the local NHS hospital trust multidisciplinary meetings for breast cancer clinics.

The consultant radiologist was involved in Radiology Events and Learning Meetings (REALMs) at a local NHS hospital trust where radiological discrepancies were anonymously reviewed. Private patients were not discussed unless their care had been transferred from the NHS.

Patients could see all the health professionals involved in their care at one-stop clinics.

Good

Diagnostic imaging

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

We saw evidence surgeons were sent diagnostic images through an image exchange portal (IEP).

Additionally, computer discs were used to share information with partners and medical legal companies. The discs were sent recorded delivery and the password sent out by e mail.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

We saw evidence in the patient records we checked that patient consent was obtained. This was recorded by the radiologist and signed by the patient. This included consent for imaging interventional procedures and for use of contrast.

We saw evidence of use of a corporate consent form being used in addition to those.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, and Mental Capacity Act 2005.

Is the service caring?

Good

Diagnostic imaging

Good

Our rating of caring stayed the same. Following this inspection, we rated caring as good.

Compassionate care

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

We saw there were multiple thank you cards displayed on notice boards.

The radiation manager had recently received an inspiring people award from Spire.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed this while on inspection.

Patients said staff treated them well and with kindness. Examples of feedback included, Radiographer was very personable and efficient and super-efficient and just went smoothly.

Staff followed policy to keep patient care and treatment confidential.

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

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

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

Understanding and involvement of patients and those close to them

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

During the inspection we spoke to the services lesbian, gay, bisexual, transgender, queer/questioning (one's sexual or gender identity) (LGBQT) lead. They told us of the support and advice they had provided for patients undergoing transition who required surgery.

Good

Diagnostic imaging

Staff made sure patients and those close to them understood their care and treatment. The radiology managers gave us an example of them personally delivering some contrast medium to the home of an elderly patient which had not been available when they were at hospital. They need to take the contrast prior to undergoing a diagnostic procedure.

We saw evidence the service held a regular Patient Experience Group Meeting and prepared a patient forum report where patient feedback about the service was discussed to identify any areas for improvement.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary.

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

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Good

Our rating of Responsive stayed the same. Following this inspection, we rated responsive as good.

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the changing needs of service users.

Referrals for MRI and CT scans were reviewed by radiologists to ensure they fitted the services eligibility criteria.

The radiology manager monitored the diagnostic reports turnaround times. The corporate turnaround time for reports was 2.4 days. The service was meeting its targets.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. The radiology manager looked at historic demand trends and future demand to plan for additional diagnostic appointments slots to reduce patient waiting times if required.

Good

Diagnostic imaging

Managers ensured that patients who did not attend appointments were contacted.

The service had conducted a gap analysis of the issues in relation to imported patient images. Five areas for improvement were incorporated into an action plan.

Meeting people's individual needs

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

We saw evidence of the service supporting patients with diabetes. Patients with this condition were booked in for the first CT or MRI scan at 8am. They were advised to bring their own food but if they forgot there was a hospital kitchen they could use.

Staff discussed with elderly or frail patients in the pre assessments about their suitability of colonography. They provided dietary advice and use of preparation medications.

We saw evidence of a checklist being used. Patients were provided with a preparation leaflet.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Patient information was available in a variety of formats, including large print and audio versions.

The service had information leaflets available in languages spoken by the patients and local community.

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

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

The service was available Monday to Friday and was demand driven in terms of start and finish times. The appointments could start at 7.30am. There were no diagnostic clinics on Saturday or Sunday.

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

Managers worked to keep the number of cancelled appointments to a minimum.

Good

Diagnostic imaging

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

We saw evidence improvements had been made to the corporate referral system which showed patient flow, pause and check processes. This resulted in less cancelled patient appointments.

The service's intranet page provided patients with all the information they needed in relation to the treatments available, booking system and how to get to the hospital.

Learning from complaints and concerns

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

The service had a complaints policy which was in date and version controlled.

At the time of the inspection the service had not received any formal complaints.

The service's complaints policy documented the service would respond to all complaints within 20 working days.

In the hospital overall between 1st January 2023 and 23rd November 2023, 34 formal complaints were received.

31 complaints were responded to within 20 working days. Three complaints were not responded to within 20 working days. However, in all cases complainants received a holding letter every 20 working days which contained an apology, an explanation of the delays and an estimate of when the complaint investigation would be complete. The 3 complaints were responded to in full after 24 days, 28 days and 33 days respectively.

The service identified the highest category of complaint was clinical care followed by communication. Action plans had been developed to improve in these areas.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Although no formal complaints had been received in the diagnostics and imaging department at the time of the inspection, managers told us they would deal directly with patients who raised any concerns about the service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Is the service well-led?

Good

Diagnostic imaging

Good

Our rating of well-led stayed the same. Following this inspection, we rated well-led as good.

Leadership

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

The management of the Diagnostic Imaging department sat in the portfolio of the Director of Clinical Services. The Radiology Manger reported to them.

Staff we spoke with told us leaders were visible and supportive.

The service had a whistle blowing policy which was in date and version controlled. This was a corporate policy.

Staff we spoke with knew how to report matters under the whistle blowing policy.

Any additional Leadership information can be found in the Surgery report.

Vision and Strategy

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

The staff we spoke with were aware of the services vision, mission, and values. These were displayed on the front page of the computer screens when staff logged on along with the purpose of each one.

The hospitals values were, driving clinical excellence, doing the right thing, caring is our passion, keeping it simple, delivering on our promises and succeeding and celebrating together.

The strategy for the diagnostics department had four areas, regulatory compliance, safety culture, quality improvement and patient safety. All 4 areas had an explanation as to how the strategy would be achieved.

Any additional Vision and Strategy information can be found in the Surgery report.

Culture

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

We saw evidence the radiology manager kept the diagnostics team focussed on personalised care which followed the services values.

On the office noticeboard there was information about staff wellbeing and how to obtain help.

Staff we spoke with were aware of the role of the Freedom to Speak up Guardian and how to raise issues with them.

Staff told us they worked in a supportive caring culture.

The service had an equality and inclusion strategy which explained what the service wanted to achieve and how it would be delivered.

There was evidence the service had several staff wellbeing activities which included, a meeting group for staff to attend, colleague health and wellbeing sessions, colleague wellbeing area, mental health first aiders, a colleague wellbeing champion, and a remembrance garden.

The service had a "You said, we did" process for staff feedback. There was evidence feedback had been acted upon.

We saw evidence the service recognised excellence amongst the teams through excellence awards. The award identified the team, what they did and what values were demonstrated.

Any additional Culture information can be found in the Surgery report.

Governance

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

The radiology manager was chair of the Radiation Protection Committee which met annually. The meeting had a set agenda and terms of reference.

The service was managed by a radiology information system (RIS) which was a corporate system obtained from an external provider.

We saw numerous policies were displayed on the office wellbeing board for staff to use.

The services governance framework was set out in a policy which was in date and version controlled.

Complaints were monitored through the weekly rapid response meeting, the monthly clinical audit and effectiveness meeting, the quarterly clinical governance committee, and the quarterly medical advisory committee. Areas of concern were escalated to the relevant Head of Department to manage locally, with progress tracked through the monthly clinical audit and effectiveness meeting and quarterly clinical governance committee.

Any additional Governance information can be found in the Surgery report.

Good

Diagnostic imaging

Management of risk, issues, and performance

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

On the office notice board, the top 3 departmental risks were displayed which were, aged equipment, administration of Buscopan which relieves the pain of stomach cramp but can have some side effects, and power cuts.

The service used an audit management and training system to record audits and any resultant learning or training requirements.

The radiology manager was the service's Radiation Protection Supervisor (RPS) who was responsible for the radiation risk assessments. During inspection these were checked and found to be in date.

The service used an external medical physics expert who acted as departmental Radiation Protection Advisor (RPA).

The contact details for the RPS and RPA were displayed on the office notice board should staff need to contact either of them.

The service had a risk register which included the risk of aged equipment in the x-ray department. We saw evidence the risk was being managed and had control measures rated as excellent in place.

Staff we spoke with were aware of the departmental risks.

We saw evidence the hospital had carried out a strengths, weaknesses, opportunities, and threats (SWOT) exercise and conducted a gap analysis to identify where they needed to improve across all the services provided in the hospital.

Based on the strategic performance in 2023 the key opportunities for 2024 included, focussing on stakeholders and how to continue to get quality feedback and how to learn from it, focus on learning and improvement, gaining the best opportunities for collaborative working, gain further relationships and productivity within the health economy, maintain environmental and sustainability responsibility and initiatives, develop commercial links with new partners and provide bespoke services, grow service provision, build on competencies and training for staff, review talent and map future opportunities for succession planning and growth, embedding of scenarios and safety challenges to regularly test systems and processes to gain assurance the systems work.

The service had a business continuity plan which was in date and version controlled.

Any additional Management of risk, issues, and performance information can be found in the Surgery report.

Information Management

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

All staff send secure e mails via a secure e mail platform and all radiology staff have a secure NHS e mail address.

Good

Diagnostic imaging

We observed staff kept the worklist and referrals from public view by using a computer tilt screen.

Staff we spoke with were aware of the services data protection policy, the Caldicott principles and the confidentiality policy.

The local Caldicott Guardian was available for staff to contact for advice.

The Caldicott Guardian is a senior role in an organisation which processes health and social care personal data. They make sure that the personal information about those who use the organisation's services is used legally, ethically, and appropriately, and that confidentiality is maintained.

Any additional Information Management information can be found in the Surgery report.

Engagement

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

There was a link on the service's internet page which displayed patient feedback information. The service showed it was rated 4.88 out of 5 based on the feedback from 349 patients.

The most recent patient survey results and Friends and Family survey showed that between July and November 2023, 86% of patients had an overall very good experience, 12% had a good experience and 2% had neither a good nor bad experience.

A staff survey had been completed between October and November 2023. 157 or 92% of staff out of 171 who could have taken part had responded. The service used 3 external sources to capture patient feedback which were, Google review which scored 4.3 out of 5, NHS review which scored 5 out of 5 and doctify review which scored 4.88 out of 5.

Any additional Engagement information can be found in the Surgery report.

Learning, continuous improvement and innovation

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

We saw evidence the radiology manager had created a folder for staff which contained embedded X -ray images, what the routine projections were and what the assessment criteria of the images were. The purpose was for staff to be able to obtain consistent high-quality images from the X-rays they were taking by seeing what they should look like.

In August 2023 the service introduced Governance Folders in every department. These folders contained the most up to date governance information and were designed to ensure everyone had access to governance information, including staff who may not access their e-mails frequently. The folders were updated when new information was available. Updates were printed and handed to the head of department during the daily safety huddles. The head of department updated their folder.

Any additional Learning, continuous improvement and innovation information can be found in the Surgery report.

Good

Outpatients

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

Is the service safe?

Good

Our rating of safe stayed the same. Following this inspection, we rated safe as good.

Mandatory training

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

The service had a mandatory training policy which was in date and version controlled.

The corporate target for mandatory training was 95% for all modules. Staff had until the 31 March each year to complete the training modules before the recording system was reset and commenced again in April each year.

Staff received and kept up to date with their mandatory training.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training through had a computer-based system.

We checked the computer based mandatory training records which showed all staff were up to date with their mandatory training.

In addition to maintaining computer-based records, we saw in the 10 staff files that we checked, a record of which mandatory training the member of staff had completed accompanied by the training certificates.

Safeguarding

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

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Although the service had not made any safeguarding referrals staff, we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

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

Although the service did not treat children staff followed safe procedures for children visiting the department.

In addition, we saw evidence staff had completed safeguarding children and young people training.

The service had an adult's safeguarding policy and a children's safeguarding policy. Both were in date, version controlled and followed intercollegiate guidance.

The service had 3 managers trained to safeguarding level 4. The Director of Clinical Services was the safeguarding lead. If they were not at work, one of the other level 4 trained managers would cover and be available to provide advice for staff.

The Director of Clinical Services told us they would quality assure all safeguarding reports submitted by staff.

In the 10 staff files we checked we saw evidence of up-to-date disclosure and barring service checks (DBS).

Cleanliness, infection control and hygiene

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

The service had an infection prevention control policy which was in date and version controlled.

The IPC policy had recently incorporated the National Healthcare Cleanliness Standards. Heads of departments were held responsible for the cleanliness in their department.

The service also had an Infection Prevention and Control Guidance for suspected or confirmed COVID-19 positive patients which was in date and version controlled.

The service had a Surveillance of Healthcare Associated Infections policy which was in date and version controlled. The purpose of the policy was to ensure the hospital met its statutory obligation to report alert organisms and other healthcare associated infections (HCAI) to the regulatory bodies, by providing evidence of regular surveillance.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Public waiting areas were visibly clean and tidy.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Good

Outpatients

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

On inspection staff were observed to be bear below the elbow, used correct handwashing techniques, and used (PPE) where appropriate when in contact with patients.

We saw a hand hygiene audit conducted between 1 Oct 2023 to 30 Nov 2023 showed a 98.7% level of compliance.

Staff cleaned equipment after patient contact.

On inspection staff were observed cleaning equipment then labelling it to show when it was last cleaned.

We saw the Quarterly Hospital Cleanliness Audit of the outpatient's department conducted between 1 and 5 November 2023 showed a 96% level of compliance.

We saw evidence the service held quarterly infection prevention and control committee meetings which were attended by department heads. There was a set agenda covering 15 different areas to report upon.

Environment and equipment

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

Staff conducted daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families. There was a reception desk and a patient waiting area where there was a drinks machine for patients and their families to use.

There were 10 consulting rooms. There were 2 rooms not in use which were checked during inspection and were found to be visibly clean and tidy. They contained suitable equipment for consultants to use when treating patients.

Staff disposed of clinical waste safely.

On inspection we saw resuscitation equipment readily available. Each piece of resuscitation equipment had unbroken seals applied which were dated to show the equipment was clean and ready to use.

There was evidence the resuscitation equipment was checked daily.

The service had enough suitable equipment to help them to safely care for patients.

During inspection we checked 30 consumable items stored in 3 separate locations. All were in date. Each storage area was visibly clean and well ordered. Consumable items were stored in clear labelled plastic trays.

There were also large quantities of PPE available for staff.

Daily stock checks were conducted by nurses who would order items if the stock were low.

All staff we spoke with told us there was never a shortage of equipment.

We saw evidence the service had an asset register which recorded which equipment the service had and when it was required to be serviced.

The service had a contract with an external company for the servicing and repair of equipment. The contract included a service level agreement with an agreed time scale for the company to attend and repair the equipment or replace it.

The service had a fire incident management plan which was in date and version controlled. There was evidence had been tested on 3 October 2023. There were 3 minor matters resulted from the test which culminated in the fire incident management plan bring updated.

We saw fire extinguishers fixed securely on wall mounts, all had labels indicating they had been tested. The fire extinguishers were stored in accordance with the Fire Extinguisher regulations which form part of the Regulatory Reform (Fire Safety) Order 2005 which outlined to prevent fire extinguishers from being moved or damaged, they should be mounted on brackets or in wall cabinets with the carrying handle placed 3-1/2 to 5 feet above the floor.

We saw evidence a disposal of sharps audit for Outpatients had been conducted in the audit period for 1 October 2023 to 31 December 2023 which showed a 98.6% level of compliance.

The service held quarterly medical devices meetings attended by department heads. There was set agenda which covered areas such as, incidents, safety alerts, servicing, and contracts.

Assessing and responding to patient risk

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

We saw evidence in the 10 staff files we checked and from speaking to staff they had received training in how to respond promptly to any sudden deterioration in a patient's health.

The service conducted a daily crash bleep test to simulate a patient requiring urgent medical attention. A test was conducted during inspection and all the required staff responded to the bleep.

All referrals for outpatient appointments were reviewed by the Director of Clinical Services to identify any risks before the patient attend the hospital.

There was evidence in the 10 patient records we checked staff completed risk assessments for each patient on admission or arrival using a recognised tool.

The service used a surgical safety checklist to identify any patient risks. The checklist was kept with the patient medical record.

We saw an audit of the surgical safety checklist outpatients had been conducted between1 October 2023 to 30 November 2023; this showed 100% compliance.

We saw evidence the service has a deteriorating patient's policy which was in date and version controlled.

Staff we spoke with, knew about, and dealt with any specific risk issues.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others.

During inspection, the daily safety meeting was observed. The meeting was attended by heads of each department who discussed ongoing issues and risks in their department including patient or staffing issues.

The discussions included all necessary key information to keep patients safe.

When patients were discharged, they were provided with information as to what to do if they felt unwell. This included who to contact to seek advice from at the hospital.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service employed 6 staff nurses, 2 were full time and the 4 others worked reduced hours.

The service employed 4 health care assistants (HCAs), 2 were full time and 2 worked 25 hours per week.

The service had 2 apprentices on 5-year contracts while doing nursing training. While on work placement they worked as HCA`s.

The service used 3 staff nurses as bank staff, 1 worked 37.5 hours per week, the other 2 worked 6 hours per week.

Data for September 2023 showed registered nursing staff were 1.04 above the establishment and Health Care Assistants were 0.86 below establishment.

A review of staffing showed between August to October 2023 showed 10% of staff used were bank or agency staff.

The outpatient's deputy manager we spoke with told us they could adjust staffing levels according to the clinic demand. This meant on busy days staffing levels were raised using bank staff to support employed staff.

On average there were 2 staff nurses and 1 HCA working on each shift.

The shifts were, 7.30am to 8.30pm, 8am to 1.30pm, 1pm to 4.30pm and 5pm to 8.30pm Monday to Friday.

Nurse staffing was planned 2 weeks in advance. Staff were able to submit 3 preferences for which shift to work per month. To maintain safe staffing only 2 members of nursing staff per week were allowed to be on leave. The service had low vacancy rates, low turnover rates and low sickness rates.

The service provided data which showed over a 12-month period from October 2022 the average clinical staff sickness was 7.3% and non-clinical staff was 8.4% accross all hospital staff. Managers told us this was consistent with levels of sickness from previous years.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

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

Medical staffing

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

All of the consultants were independent practitioners and had personal responsibility for the care they delivered. Whilst they were not Spire employees, they were required to operate according to Spire policies and procedures when practising at Spire hospitals. Many were employed by the NHS and worked across several other independent providers.

There were 82 consultants who worked privately at the hospital providing clinics in the outpatient department from 8.30am until 8.30pm Monday to Friday. The clinics covered 31 different specialities.

The service had enough medical staff to keep patients safe.

Records

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

Patient notes were comprehensive, and all staff could access them easily.

During inspection we reviewed 10 sets of outpatients ` medical records. All were comprehensive and contained all relevant information.

We saw an audit of Physiotherapy Outpatient notes had been conducted covering from 1July 2023 to 30 September 2023 which showed 100% compliance.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely for 3 months at the hospital before being taken away for central storage.

Medicines

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

We found medicines that were for single use only were clearly marked and clinical staff described the process if a further supply was required.

Good

Outpatients

There was a process in place for the pharmacy team to monitor and support with the appropriate prescribing of antimicrobials. The pharmacy was open during the weekday and on Saturdays, however we found the week before the inspection, due to staff shortages the pharmacy was not open during usual hours. Therefore, patients would not have been able to access their prescriptions at the hospital which might have caused a delay to them accessing their medicines.

If the patient urgently needed their medication they would have had to go to an external pharmacy, which might have incurred additional cost to have the prescription dispensed.

The hospital did direct patients to other open pharmacies, or they were advised to return to the service the following day to collect their prescription.

Staff stored medicines safely.

There was a process in place to review the medicines stocked and expiry dates were checked regularly. However, we found not all the prescribing documents were managed safely. There was a risk unauthorised staff and people could access the prescribing documents.

Prescribing documents to be used within the hospital were not stored securely, and the service had not assessed the risk associated with where they were stored, which could have allowed unauthorised access to the prescribing documents.

There was a system to track prescriptions when given to the prescriber, however this was not consistently followed.

There was a record of who was issued the prescriptions, and on some occasions, there was a check that the prescription was issued to the patient prescribed the medicine but not in all cases.

An emergency medicine trolley was available, and a process was in place to complete checks regularly. We checked the trolley; all medicines were within their expiry date. Emergency medicines were also available within treatment rooms when people had certain procedures completed. Clinical staff were aware of the process to follow to report medicines related incidents.

We saw evidence of a service level agreement (SLA) between pharmacy and the outpatient's department.

The aim of this SLA was to define the level of Medicines Management support offered to the outpatient's department by Pharmacy and to define the outpatient's role in medicines management. The SLA aimed to enhance relationships and working practices between the 2 departments.

Incidents

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

Good

Outpatients

The service told us 2 patients had attended outpatients' appointments and patients had attended physiotherapy appointments all complaining of the same issues. The patient care was audited, and it was noted 1 of the issues was that the Venous Thromboembolism (VTE) policy had not been recirculated in outpatients. The policy was recirculated as a result.

The learning was shared in the with outpatient's department that any patient complaining of a potential deep vein thrombosis (DVT) was always reviewed by the Resident Doctor. This practice is now audited.

The service had an incident reporting policy which was in date and version controlled.

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

Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service had not recorded any no never events.

Managers shared learning about never events with their staff and across the service.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with the service's policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

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

We saw evidence of shared learning from an event at another Spire hospital. The information was displayed on notice boards for staff to read.

Staff met to discuss the feedback and look at improvements to patient care. We saw evidence of this during the rapid response meeting and safety huddle which we attended during inspection.

We saw on the Governance Matters circulation covering 30 October to 5 November there was a section on what was learned from incidents. There were 6 learning areas identified which were shared with staff.

The Governance and Quality Risk Manager we spoke with explained they had oversight of all incidents reported in the hospital.

They told us each incident reviewed by them and categorised depending on the level of harm and investigated accordingly.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Good

Outpatients

The service had incident reporting and Duty of Candour policies which were in date and version controlled.

Staff we spoke with understood the principles of duty of candour. Managers we spoke with gave us examples when the principles of duty of candour had been applied.

Is the service effective?

Good

Effective was not rated during the last inspection. Following this inspection, we rated effective as good.

Evidence-based care and treatment

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

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

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice introduced in 2008 following substantial changes and updates in legislation, policy, case law, and professional practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

The Director of Clinical Governance told us the service did ensure it identified and implemented relevant best practice and guidance, such as NICE guidance. The process for this was through the provider's corporate governance department. They provided quarterly bulletins with NICE guidance for all Spire hospitals.

The Director of Clinical Governance reviewed the information and implemented the NICE guidance relevant to the identified department. The implementation was conducted by the department head and signed off by the Director of Clinical Governance when completed.

The Director of Clinical Governance told us this process worked well.

We reviewed the audit information for the Cosmetic Surgery cooling off period. The cool-off period was at least 2 weeks before having surgery. This gives the patient time to ask any further questions, have another consultation if they wished or to change their mind if they chose not to proceed.

This was conducted in the audit period between 1 October 2023 and 31 December 2023 which showed 100% compliance.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered, and recorded pain relief accurately.

Staff told us as part of the patients' consultations post operative pain injections were administered if required.

We saw evidence in the 10 sets of patient notes we reviewed that patients' pain was discussed and recorded.

Patient outcomes

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

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent, and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes.

Managers and staff conducted a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Improvement is checked and monitored.

Competent staff

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

We checked 10 staff files which were held on a computer-based system. All the documentation complied with Regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014 set out in Schedule 3.

We saw evidence the service conducted monthly registration audits to confirm staff registrations and qualifications for various professional bodies were in date.

All of the consultants were independent practitioners and had personal responsibility for the care they deliver. Whilst they were not Spire employees, they were required to operate according to Spire policies and procedures when practising at Spire hospitals. Many Consultants were employed by the NHS and worked across several other independent providers.

Every Consultant was listed on the General Medical Council (GMC) medical register and underwent a thorough vetting process before being granted "practising privileges" to practice at a Spire hospital. They were subject to regular review by their Spire Hospital Director.

Good

Outpatients

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

The service had a driving clinical excellence in practice programme for staff. This was developed in collaboration with a local teaching hospitals NHS Trust and organisations in the Leeds Academic Health Partnership. The completion of this programme was designed to support continuing professional development and the collection of evidence in support of professional revalidation.

Managers gave all new staff a full induction tailored to their role before they started work. We saw evidence of this is in the 10 staff files we reviewed.

We saw evidence of skills and learning passport for new staff. The purpose of the passport was to record and acknowledge learning and development during the 12-week induction. Line managers and colleagues supported staff to work through the passport assisting in gathering all the information, skills and knowledge needed for the role.

Managers supported staff to develop through constructive appraisals of their work. We saw evidence on inspection all staff had recently had a half yearly review which was recorded in their staff files.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. We saw evidence of this through the service's nursing apprenticeship scheme.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

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

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective internal multidisciplinary meetings to discuss patients and improve their care.

Patients could see all the health professionals involved in their care at one-stop clinics.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

Good

Outpatients

The service had information displayed on notice boards around the department for different illnesses or medical conditions accompanied by a quick-response code (QR code). The code when clicked on took the patient to advice as to how best to manage the illness or medical condition.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

We saw evidence in the patient notes we checked of patients being given diet and exercise advice as to how to best recover post operatively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

We saw evidence in the staff files we checked, and the services training records all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers told us at pre-assessment patient meetings the dementia lead for the service would attend if the patient was identified to have cognitive difficulties.

Is the service caring?

Good

Our rating of caring stayed the same. Following this inspection, we rated caring as good.

Compassionate care

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

Good

Outpatients

During the inspection we spoke with seven patients.

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

All 7 patients we spoke with said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

The most recent patient survey results and Friends and Family survey from October 2023 showed that 63% of patients strongly agreed they felt really cared for, 30% agreed they felt really cared for and 7% neither agreed nor disagreed they felt cared for.

The response for November 2023 showed 70% of patients strongly agreed they felt really cared for, 17% agreed they felt really cared for and 9% neither agreed nor disagreed they felt cared for

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

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

Understanding and involvement of patients and those close to them

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

During the inspection we spoke to the services lesbian, gay, bisexual, transgender, queer/questioning one's sexual or gender identity (LGBQT) lead. They told us of the support and advice they had provided for patients undergoing transition and required surgery.

We evidence the service held a regular Patient Experience Group Meeting and produced a patient forum report where patient feedback about the service was discussed to identify any areas for improvement.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary.

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

Good

Outpatients

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Good

Our rating of responsive stayed the same. Following this inspection, we rated responsive as good.

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the changing needs of the local population.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

The service used a choose and book system which general practitioners (GP`s) could access for appointments with outpatient consultants. This system allowed patients to choose which consultant they wished to see depending on the specialism, on which day and at what time.

Managers told us 70% of the appointments were made through this system. The availability of consultants and an efficient appointment booking system meant the service could see up to 200 patients per day.

Staff who managed the appointment system told us they were able to identify gaps and were able to offer patients earlier appointments on occasions.

Appointments were available Monday to Friday between 8.00am and 8.30pm.

Staff told us post operative outpatient appointments were made after the patient was discharged from surgery.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. Managers told us consultants would ring patients who did not attend an appointment and arrange another time and date.

Managers ensured that patients who did not attend appointments were contacted.

Good

Outpatients

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

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

Staff had access to communication aids to help patients become partners in their care and treatment.

There was signage clear enough to be understood by people who are unfamiliar with the environment.

The building was designed so that people with a disability could access and use services on an equal basis to others. There were wide corridors, automatic doors and disabled toilet facilities which facilitate wheelchair access.

Access and flow

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

Managers monitored appointment times and consultant availability to make sure patients could access services when needed and received treatment within agreed timeframes.

Managers worked to keep the number of cancelled appointments to a minimum.

We saw that 5 appointments had been cancelled by the service between 1 August 2023 and 31 October 2023; all had since been rebooked. Any cancelled appointments were recorded on the service's incident reporting system so the cause could be identified, and action taken to prevent a reoccurrence.

When patients had their outpatient appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

There were no access and flow issues as the service controlled the appointments based upon patients and consultant availability.

Learning from complaints and concerns

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

The service had a complaints policy which was in date and version controlled.

Good

Outpatients

The service's complaints policy documented the service would respond to all complaints within 20 working days.

Between 1st January 2023 and 23rd November 2023, 34 formal complaints were received by the hospital.

31 complaints were responded to within 20 working days. Three complaints were not responded to within 20 working days however in all cases complainants received a holding letter every 20 working which contained an apology, an explanation of the delays and an estimate of when the complaint investigation would be complete. These 3 complaints were responded to in full after 24 days, 28 days and 33 days, respectively.

The service identified the highest category of complaint was clinical care followed by communication.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to manage them.

Staff knew how to acknowledge complaints.

Is the service well-led?

Good

Our rating of well-led stayed the same. Following this inspection, we rated well-led as good.

Leadership

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

Staff we spoke with told us leaders were visible and supportive.

The service had a whistle blowing policy which was in date and version controlled. This was a corporate policy.

Staff we spoke with knew how to report matters under the whistle blowing policy.

Any additional Leadership information can be found in the Surgery report.

Vision and Strategy

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

Good

Outpatients

The staff we spoke with were aware of the services vision, mission, and values. These were displayed on the front page of the computer screens when staff logged on along with the purpose of each one.

The hospitals values were, driving clinical excellence, doing the right thing, caring is our passion, keeping it simple, delivering on our promises and succeeding and celebrating together.

Any additional Vision and Strategy information can be found in the Surgery report.

Culture

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

The service has an equality and inclusion strategy which explained what the service wanted to achieve and how it would be delivered.

Staff we spoke with were aware of the role of the Freedom to Speak up Guardian and how to raise issues with them.

Staff told us they worked in a supportive caring culture.

The service has an equality and inclusion strategy which explained what the service wanted to achieve and how it would be delivered.

There was evidence the service had several staff wellbeing activities which included, colleague health and wellbeing sessions, a colleague wellbeing area, mental health first aiders, a colleague wellbeing champion and a remembrance garden.

The service had a “You said, we did” process for staff feedback. There was evidence feedback had been acted upon.

We saw evidence the service recognised excellence amongst the teams through excellence awards. The award identified the team, what they did and what values were demonstrated.

Any additional Culture information can be found in the Surgery report.

Governance

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

Consultants were responsible for clinical decision-making and the quality of the care they delivered, the hospital was responsible for ensuring that there were systems of monitoring and oversight in place, designed to ensure that consultants practised in accordance with hospital policy, and in line with their practising privileges.

Complaints were monitored through the weekly rapid response meeting, the monthly clinical audit and effectiveness meeting, the quarterly clinical governance committee, and the quarterly medical advisory committee.

Areas of concern were escalated to the relevant Head of Department to manage locally, with progress tracked through the monthly clinical audit and effectiveness meeting and quarterly clinical governance committee.

Any additional Governance information can be found in the Surgery report.

Management of risk, issues, and performance

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

All consultants were required to maintain adequate minimum levels of medical malpractice indemnity cover, in keeping with GMC guidance. The provider carried out regular checks to ensure that indemnity certificates were in place.

We saw evidence the hospital had conducted a strengths, weaknesses, opportunities, and threats (SWOT) exercise and conducted a gap analysis to identify where they needed to improve.

Based on the strategic performance in 2023 the key opportunities for 2024 included, focussing on stakeholders and how to continue to get quality feedback and how to learn from it, focus on learning and improvement, gaining the best opportunities for collaborative working, gain further relationships and productivity within the health economy, maintain environmental and sustainability responsibility and initiatives, develop commercial links with new partners and provide bespoke services, grow service provision, build on competencies and training for staff, review talent and map future opportunities for succession planning and growth, embedding of scenarios and safety challenges to regularly test systems and processes to gain assurance the systems work.

The service had a business continuity plan which was in date and version controlled.

Any additional Management of risk, issues, and performance information can be found in the Surgery report.

Information Management

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

All staff sent secure e mails via a secure e mail platform and had a secure NHS e mail address.

Staff we spoke with were aware of the services data protection policy, the Caldicott principles and the confidentiality policy.

The local Caldicott Guardian was available for staff to contact for advice.

The Caldicott Guardian was a senior role in an organisation which processes health and social care personal data. They make sure that the personal information about those who use the organisation's services is used legally, ethically, and appropriately, and that confidentiality is maintained.

Good

Outpatients

Any additional Information Management information can be found in the Surgery report.

Engagement

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

The most recent patient survey results and Friends and Family survey showed that in October 2023, 84% of patients during the initial outpatients' appointment had an overall very good experience and 16% had a good experience.

In November 2023, 79% of patients during the initial outpatients' appointment had an overall very good experience,13% had a good experience and 8% had neither good nor bad experience.

We saw evidence a provisional 2023 staff survey had been completed between October and November 2023. This showed that 157 or 92% of staff out of 171 who could have taken part had responded.

The service used 3 external sources to capture patient feedback which were, Google review which scored 4.3 out of 5, NHS review which scored 5 out of 5 and doctify review which scored 4.88 out of 5.

Any additional Engagement information can be found in the Surgery report.

Learning, continuous improvement and innovation

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

In August 2023, the service introduced Governance Folders in every department. These folders contained the most up to date governance information and were designed to ensure everyone had access to governance information, including staff who may not access their e-mails frequently. The folders were updated when new information was available. Updates were printed and handed to the head of department during the daily safety huddles. The head of department updated their folder.

Any additional Learning, continuous improvement and innovation information can be found in the Surgery report.

Inspected but not rated

Medical care (Including older people's care)

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

Is the service safe?

Inspected but not rated

We did not rate safe. We found:

Mandatory training

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

See surgery report for further information.

Safeguarding

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

See surgery report for further information.

Cleanliness, infection control and hygiene

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

The endoscopy service performed well for cleanliness. We saw evidence that theatre cleans took place immediately after the completion of endoscopies.

See surgery report for further information.

Environment and equipment

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

The design of the environment followed national guidance. The endoscopy area had a dirty utility area for the manual cleaning and disinfection of endoscopes.

Inspected but not rated

Medical care (Including older people's care)

The department had suitable facilities to meet the needs of patients. The theatre in which endoscopy procedures were completed had appropriate ventilation.

Staff had enough suitable equipment to help them to safely care for patients and themselves.

Staff had quick access to the resuscitation trolley which was checked daily and weekly.

The service had safety tested all electrical equipment.

See surgery report for further information.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

A surgical safety checklist was completed with patients undergoing endoscopies. This provided details of safety checks completed at the start of the endoscopy procedure and before any of the team left the endoscopy room.

See surgery report for further information.

Staffing

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

The endoscopy service was on the same roster as the theatre staff, please see the surgery report for further information.

Records

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

Please see the surgery report for further information.

Medicines

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

The service had standard operating procedures for medical gases such as Nitrous Oxide and carbon dioxide used in endoscopy.

Please see the surgery report for further information.

Incidents

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

Inspected but not rated

Medical care (Including older people's care)

Endoscopy reported no clinical incidents in the last 6 months.

Please see the surgery report for further information.

Is the service effective?

Inspected but not rated

We did not rate effective. We found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Please see surgery report for further information.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Please see surgery report for further information.

Pain relief

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

Staff carrying out endoscopy procedures checked levels of pain pre, during and after the treatment. The National Early Warning Score (NEWS) was used to monitor a patient's condition.

Please see surgery report for further information.

Patient outcomes

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

The service inputted to the national Private Healthcare Information Network (PHIN) to improve patient outcomes.

Please see surgery report for further information.

Competent staff

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

Please see surgery report for further information.

Inspected but not rated

Medical care (Including older people's care)

Multidisciplinary working

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

Please see surgery report for further information.

Seven-day services

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

Please see surgery report for further information.

Health promotion

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

Please see surgery report for further information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff obtained consent for the endoscopy procedure at the pre assessment stage, and this was checked on admission as part of the World Healthcare Organisation (WHO) checklist.

Please see surgery report for further information.

Is the service caring?

Inspected but not rated

We did not rate caring. We found:

Compassionate care

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

Please see surgery report for further information.

Emotional support

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

Please see surgery report for further information.

Inspected but not rated

Medical care (Including older people's care)

Understanding and involvement of patients and those close to them

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

Please see surgery report for further information.

Is the service responsive?

Inspected but not rated

We did not rate responsive. We found:

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

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

Please see surgery report for further information.

Meeting people's individual needs

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

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Access and flow

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

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Learning from complaints and concerns

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

Please see surgery report for further information.

Is the service well-led?

Inspected but not rated

We did not rate well-led. We found:

Inspected but not rated

Medical care (Including older people's care)

Leadership

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

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Vision and Strategy

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

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Culture

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

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Management of risk, issues and performance

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

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Inspected but not rated

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Engagement

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