Spire Roding Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 16-17 November 2016. This was an announced visit.

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

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

We rated this hospital as requires improvement overall. Our key findings were as follows:

We rated safe as requires improvement because:

- The surgery service used the WHO Surgical Safety checklist; however despite this, there were a number of serious incidents and a high number of reported incidents in the service.
- Cleanliness within the outpatients and imaging department did not always meet national or local standards.
- We found four private prescriptions in the imaging department which staff were unable to account for. This was investigated by the hospital.

However,

- There were low surgical site infection rates across surgical specialities.
- Staff knew how to report concerns and most staff felt that they received good and timely feedback about reported incidents.
- Staff were able to describe how to follow safeguarding procedures correctly.

We rated effective as good because:

- There were good patient outcomes across surgical specialities. The service performed well in national clinical audits.
- There were short length of stay and low readmission rates.
- Patients had access to effective and timely pain relief.
- Multidisciplinary working (MDT) was encouraged. There was good multidisciplinary team working between doctors, nurses and allied health professionals.
- The surgery service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

However,

- Some consent forms were unsigned so could not clearly show confirmation of consent.

We rated caring as good because:

Summary of findings

- Patients spoke highly of the care they received at the hospital, and felt fully involved in decisions made about their care and treatment. Patients told us staff were friendly, helpful, and professional.
- Care was delivered in line with relevant national guidelines.

We rated responsive as requires improvement because:

- There were concerns about waiting times during clinics and late theatre start times because of consultant delays or consultants not attending.
- Complaints and actions arising from complaints were discussed in governance meetings. Staff also had a good understanding of how they would handle a complaint they received. However, there was no risk assessment or action plans for some of the complaints which is deemed good practise.

However:

- Patients had access to effective and timely pain relief.
- The admission guidance, exclusion criteria, and discharge processes were clear and well documented.
- The service had a dementia strategy in place that adhered to the Royal College of Nursing guidelines.

We rated well led as requires improvement because:

- The hospital's risk management documentation did not provide adequate assurance of actions taken to mitigate or rectify concerns. However, new governance arrangements, such as committees and reporting structures were being embedded into practice.
- There was a vision and strategy in place for the surgery service, but many of the non-management staff we spoke with were not aware of future plans or strategic vision for the service.
- Risk management processes did not provide sufficient assurance that risks and issues were addressed in a timely and appropriate way.
- Some consultant doctors felt there was limited communication and engagement between the hospital leadership and the consultant body.

However,

- The senior management team were visible within the hospital and encouraged an open and transparent culture. Staff told us there was a positive organisational culture and they enjoyed working at the hospital, and felt valued.
- New governance arrangements, such as committees and reporting structures were being embedded into practice.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with [number] requirement notices that affected both surgery and outpatients diagnostics and imaging. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	The arrangements for governance and performance did not operate effectively. We were not assured that the hospital had appropriate systems in place to respond to risks and issues in a timely way. There had been one serious incident and two more post reporting period. There had been ten post-operative infections. All three serious incidents were fully investigated in line with the hospital policy using a root cause analysis method (RCA). However, when viewing a sample of other incidents we were not confident that these were adequately investigated nor that timely action were undertaken to address any identified risks and concerns. Staffing levels and multidisciplinary working were safe and met patients' needs. Surgery services were found to be caring. Patients were treated kindly and with compassion. Patients felt involved in decisions made about their care and treatment. Services were responsive to meet patients' needs. The admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs. There were appropriate systems in place to respond to a deteriorating patient. Medicines were managed safely and record keeping in all surgical areas was completed and audited, with any shortfalls addressed. Patients were well cared for on the ward and in theatres. Pain was well managed and patients' nutrition and hydration needs were met well.
Outpatients and diagnostic imaging	Good 	Staff were aware of their responsibilities for reporting incidents and we saw evidence that learning was shared. All HCA and nursing staff in the outpatients department had received an appraisal known as 'enabling excellence'.

Summary of findings

Patients we spoke with spoke highly of the care they received at the hospital, and felt fully involved in decisions made about their care and treatment.
Patients told us they were able to get an appointment with the hospital quickly and easily.
From July 2015 to June 2016 the outpatients department was regularly meeting its referral to treatment times.
Staff told us that the senior management team were visible within the department, and encouraged an open and transparent culture.
However:
Cleanliness within the outpatients and imaging department did not always meet national or local standards. We saw that clean and dirty equipment was not always segregated.
The hospital had a clear process in place for secure management of private prescriptions which had been in place since 2015. However, during our inspection, we found four private prescriptions in the staff only area of the imaging department which staff were unable to account for. A full investigation was immediately started.
There was a lack of consistency in the way consultants provided copies of clinic notes for independently funded patients.
Managers told us there were concerns about waiting times during clinics due to consultant delays or not attending. Data for waiting times had not been historically collected by the service. However, following our inspection managers informed us that a system had now been put in place for waiting times to be recorded.
Some managers found the risk register challenging to maintain because of its size. Whilst staff were able to articulate actions being taken to mitigate risks on the register, these were not always clearly recorded.

Summary of findings

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Services we looked at

Surgery and Outpatients and diagnostic imaging

Summary of this inspection

Background to Spire Roding Hospital

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

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

Our inspection team

Our inspection team was lead by:

Inspection Manager - Max Geraghty, CQC

The team comprised five CQC inspectors, and specialist advisors with expertise in surgery, outpatients diagnostics and imaging, and governance.

Why we carried out this inspection

This inspection was part of our scheduled comprehensive inspection programme for independent health hospitals.

How we carried out this inspection

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

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive to peoples' needs?**
- **Is it well led?**

Before visiting we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. Patients were invited to contact CQC with their feedback.

We visited the service to undertake an announced inspection on 16 & 17 November 2016.

As part of the inspection process we spoke with members of the senior leadership team and individual staff of all grades. We met with staff working within the surgical and outpatient areas.

We spoke with inpatients, and people attending the outpatient's clinics. We looked at comments made by patients who used the services at Spire Roding Hospital when completing the hospital satisfaction survey and reviewed complaints that had been raised with the service.

We inspected all areas of the service over a two day period, looking at outpatients and surgical care. We spent time observing care on the ward and in the outpatients department. We reviewed policies, procedures, training and monitoring records, as well as patient's records where necessary.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experience of the quality of the care they received at Spire Roding Hospital.

Summary of this inspection

Information about Spire Roding Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited the ward area (comprised of 27 individual rooms), consulting rooms, treatment rooms, the day case unit, the operating theatre suite, endoscopy suite, pharmacy and outpatients area. We spoke with more than 30 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 20 patients and five relatives. We also received 10 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 15 sets of patient records.

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12 months before this inspection. The hospital has been inspected five times, and the most recent inspection took place in January 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 1434 inpatient and 6745 day case episodes of care recorded at the hospital; of these 14% were NHS-funded and 86% other funded.
- 13% of all NHS-funded patients and 23% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 47,817 outpatient total attendances in the reporting period; of these 52% were other funded and 48% were NHS-funded.
- 296 consultant doctors, including surgeons, anaesthetists and radiologists worked at the hospital under practising privileges. Three regular resident medical officers (RMO) worked on a one week on, one week off rota. The hospital employed 37.7 whole time equivalent (WTE) registered nurses, 24.6 WTE care assistants and four receptionist, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- 1 Never event
- 267 clinical incidents: 161 no harm, 63 low harm, 43 moderate harm, 0 severe harm, 0 death
- Zero serious injuries
- Zero incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- 52 complaints

Services accredited by a national body:

- BUPA accreditation: breast and colorectal
- Macmillan Quality Enviromental Mark
- SGS ISO 13485:2003, EN ISO 13485:2012, Directive 93/42/EEC
- London City University accreditation for placements for student nurse training
- BUPA accreditation: multi parametric prostate imaging
- BUPA Accreditation: MRI and CT

Services provided at the hospital under service level agreement:

- Electrocardiogram report
- Blood transfusion serice
- Dexa scanner service
- Dietetic service
- Nuclear medicine
- Occupational therapy service
- Paediatric nurses
- Radiation protection advisor
- Resident medical officers provision.
- Coloplast stoma nurse
- Laser protection advisor
- SATS Ambulance transfer services
- GE Multivendor Contract for Medical Equipment
- Patient Transfer agreement with local trust

Summary of this inspection

- Gas detection Crowcon in MRI
- Daniels Sharp Safe
- Jenpen Ltd Occupational Health Services

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Information about the service

Spire Roding Hospital provided day surgery and inpatient treatment for patients across a range of specialties. Surgical specialities were: orthopaedics, general surgery, breast surgery, ear, nose and throat surgery, gynaecology, urology, cosmetic surgery, ophthalmology, vascular surgery, and gastroenterology. Between July 2015 and June 2016 1,434 overnight patients and 6,745 day case patients were admitted to the hospital. There were 6,573 visits to theatre recorded in that time. Patients attended for planned surgery and only if there were any post-operative complications would patients receive emergency surgery.

Surgery services at Spire Roding comprised of four operating theatres, three with laminar flow (a specialist system of circulated filtered air filtered to reduce the risk of airborne infection) and one without which were used flexibly Monday to Saturday for surgery specialities. Spire Roding had a dedicated endoscopy unit

The hospital had 24 inpatient beds and 16 day case pods. There was a three bed level one extended recovery unit, although this was not in use at the time of our inspection.

We visited theatres, endoscopy, and the recovery (post anaesthetic) area. We spoke with the managers for both theatres and the ward areas. We spoke with 16 staff and eight patients. We observed care being provided and looked at 12 patients' records.

Summary of findings

Although there were arrangements in place for governance and performance we were not assured they were operating effectively. We were not assured that the hospital had appropriate systems in place to respond to risks and issues in a timely way.

There had been one serious incident and two more post reporting period. There had been ten post-operative infections. All three serious incidents were fully investigated in line with the hospital policy using a root cause analysis method (RCA). However when viewing a sample of other incidents we were not confident that these were adequately investigated nor that timely actions were undertaken to address any identified risks and concerns.

There were concerns regarding the late starts of theatre lists due to consultants arriving late in the morning.

Staffing levels and multidisciplinary working were safe and met patients' needs, however on inspection we found seven staff had no background and criminal record checks and 40 staff were awaiting these checks to come back.

There was a vision and strategy in place for the service, but many of the non-management staff we spoke with were not aware of future plans or strategic vision for the service

Surgery services were found to be caring. Patients were treated kindly and with compassion. Patients felt involved in decisions made about their care and treatment.

Requires improvement

Surgery

Services were responsive to meet patients' needs. The admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs.

There were appropriate systems in place to respond to a deteriorating patient. Medicines were managed safely and record keeping in all surgical areas was completed and audited, with any shortfalls addressed.

Patients were well cared for on the ward and in theatres. Patients' pain was well managed and their nutrition and hydration needs were met well.

Are surgery services safe?

Good

We rated Safe as good because:

- Staffing levels in wards and theatres were good with low use of bank and agency staff.
- All of the clinical areas we visited were visibly clean and tidy, and there was good compliance with hygiene processes.
- Learning from incidents was shared effectively in staff memos, discussion at handover and weekly ward and theatre meetings.
- Medications were administered safely and medication records were well maintained and clear.

Incidents

- Between July 2015 and June 2016 the hospital reported one never event, where a patient received an incorrect lens during a surgical procedure. This was identified following completion of the surgery. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- During inspection, staff we spoke with highlighted two more incidents one classed as a never event which had occurred after the reporting period. This included a wrong site surgery and the use of a non sterilised equipment during surgery which had been used on another patient previously. Both investigations were stated to be in progress.
- The hospital had an electronic system for reporting incidents. We looked at a selection of serious incident records prior to the reporting period and found that investigations and root cause analysis had been undertaken. The hospital reported 267 clinical incidents in the reporting period of which 211 incidents had occurred in surgery or inpatients. No clinical incidents were reported as severe or death.

- We saw minutes that showed that reported incidents were reviewed and discussed during clinical governance meetings, heads of departments meetings and Medical Advisory Committee (MAC) meetings depending upon the nature of the incident.
- Learning from incidents was shared effectively. Learning was disseminated in staff memos and nurses told us it was discussed at handover and weekly ward and theatre meetings. The quality and governance manager and head of nursing and clinical services shared findings and learning from serious incidents with managers each week
- Regulation 20: Duty of candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- We found a good level of understanding of duty of candour responsibilities amongst senior staff. More junior staff did not have a good understanding of the term duty of candour, but were able to describe how they would address a concern with a patient should something go wrong, which reflected openness and transparency.
- The hospital's electronic reporting system included prompts to ensure duty of candour obligations were undertaken. The hospital kept appropriate records of incidents that had triggered a duty of candour response and we saw a sample of these.
- There was a quarterly report of the number of deaths during each three month period and the year to date. There had been no deaths in the previous 12 months before our inspection. Staff told us that any deaths would be discussed in the clinical governance and MAC meetings and when appropriate any learning would be shared with other staff.

Clinical Quality Dashboard or equivalent

- The Safety Thermometer is a national tool used by the NHS for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE - blood clots in veins).
- The hospital used a monthly clinical dashboard and a quarterly reported 'scorecard' as management tools to assess its performance against agreed targets. The ward and theatre dashboard included information on spot-checks such as records of early warning scores, patients' observations, completion of risk assessments and compliance with the World Health Organization (WHO) surgical safety checklist.
- Before our inspection the hospital sent us the scorecards for June 2016, which showed the hospital had a 100% VTE screening rate in the reporting period of July 2015 to June 2016 compared against a hospital target of 95% of adult inpatients having their risk of venous thromboembolism assessed. There had been one case of a 'hospital acquired' venous thromboembolism or pulmonary embolism between July 2015 and June 2016. An investigation had been undertaken into the cause of the embolism.

Cleanliness, infection control and hygiene

- The hospital had policies and procedures in place to manage infection control, including infection prevention, decontamination and waste disposal. A policies and procedures file was accessible on the ward and in theatres. Staff we spoke with knew how to access the policies and procedures if needed.
- There was a lead infection prevention and control (IPC) practitioner, who had additional training and responsibilities. For example undertaking investigations and root cause analysis relating to surgical site infections (SSIs) and conducting hand washing audits.
- We saw the service's annual IPC strategy, which was reviewed quarterly and contained action points monitored through a dedicated infection control working group and clinical governance meeting.
- We reviewed records of regular IPC audits that took place to ensure all staffs were compliant with the centre's policies such as hand hygiene and the use of personal protective equipment (PPE). Results of a hand hygiene audit conducted in April 2016 were presented as evidence prior to inspection, the results displayed 100% compliance.
- There was easily accessible hand washing gel facilities located at the entrance to the wards, throughout the wards and theatres.

Requires improvement

Surgery

- Hand washing sinks were available throughout all the areas we inspected . All sinks in patient areas had posters of 'hand washing technique' displayed. We witnessed staff used a good hand washing technique which was compliant with Health Protection Agency (HPA) guidelines.
- During our inspection we observed staff adhere to the 'bare below the elbows' policy, this demonstrated staff understood and complied with infection control guidelines. However, when observing ward rounds we observed two consultants not adhere to bare below the elbows and nursing staff did not challenge this.
- There was easily accessible personal protective clothing such as disposable gloves and plastic gowns and we saw staff using this appropriately when delivering care.
- Equipment was marked with a sticker when it had been cleaned and ready for use, however we found three pieces of equipment had stickers with no date or time cleaned specified so could not be assured of their true cleanliness.
- Decontamination and sterilisation of instruments was managed on site in theatres. This facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics.
- The clinical waste unit was secure and all clinical waste bins we looked at were locked. We checked the sluice on the ward it was tidy and well organised; however, we noted the sluice needed refurbishment as the walls were in need of repair and the floor was heavily stained.
- Cleaning rotas and duties were kept in the ward office. We reviewed cleaning schedules which were all up to date, fully completed and signed including who was responsible for cleaning different areas and equipment (HCAs and housekeepers). All cleaning records were complete for the two months prior to our inspection. Cleaning equipment was colour-coded and used appropriately.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The sharp bins were clearly labelled, within date and tagged to ensure appropriate disposal. None were overfilled. Syringes and other disposable single use medical equipment was discarded appropriately into the sharps bins. Laryngoscope blades were single use and handles had single use sheathes.
- We noticed that sharp safe cannulas (a thin tube inserted into a vein) and sharp safe hypodermic needles (hollow needle) were being used. These devices reduce the risk of a member of staff receiving a sharps injury.
- Clinical and domestic waste bins were available and contained no inappropriate items. A member of staff was able to clearly describe to us the arrangements for the segregation of waste.
- The clinical areas and wards we visited were visibly clean, tidy, well organised and clutter-free. Disposable curtains were used in the recovery area and there was no evidence of dust. Infection prevention and control was generally well managed. All bays, side rooms, toilets and shower facilities in wards were seen to be clean.
- The cleaning of theatres was done daily by theatre staff and in between theatre cases. We observed good wiping down and decontamination between patients in theatres and hand washing by doctors and nurses was witnessed. Domestic staff were in attendance to clean floors and walls at the end of the operating list. However, when we visited theatres we found the floor of the sterilising area to be dirty and the area where medical fittings and screws for surgical implants were kept was unclean. This was highlighted to the theatre manager during inspection and a deep clean of the theatres was carried out.
- Documentation provided by the hospital showed there had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) or Meticillin Sensitive Staphylococcus Aureus (MSSA) from July 2015 to June 2016.On inspection of the pre-assessment area we found MRSA and MSSA screening of orthopaedic and neurology patients were consistently being carried out for all patients as per Department of Health guidance. Documentation provided detailed two incidents of E-Coli during the reporting period, however neither were reportable as these were not E-Coli bacteraemia.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. In the PLACE audit 2016 The Hospital scored 99% for

cleanliness which is better than the national average of 98% but scored 85% for condition appearance and maintenance which was lower than the national average of 93%.

- Three of the four theatres had laminar flow air filtration systems. These were mainly used for orthopaedic procedures and enabled containment and control of airflow, so reducing the risks of cross contamination and infection due to air borne organisms.
- We found inconsistencies in the reporting of post-operative infection rates. The hospital recorded 10 post-operative wound infections per 5,300 patients between July 2015 and June 2016. This is very low compared to other providers with similar activity levels.

Environment and equipment

- All of the clinical areas such as the inpatient ward, extended recovery unit and day case pods and theatres we visited were well organised and quiet. The inpatient ward was well laid out with adequate space to move and no clutter or trip hazards blocking walk ways. Patients on the wards looked comfortable.
- The staff we spoke with confirmed they had access to the equipment they required to meet peoples' care needs. Each theatre had forced air warming blankets and fluid warming systems to keep patients warm during and after surgery.
- Portable appliance testing (PAT) labels were not always attached to electrical items showing it had been inspected within the last year and was safe to use. The hospital director stated that some labels had become dislodged due to cleaning. We saw evidence that PAT testing had been carried out.
- Resuscitation equipment was available in all clinical areas with security tabs present and intact; the trolley was located in a central position, which was easily accessible from different areas of the ward. Resuscitation trolley checklists demonstrated a robust checking process. We saw that checklists were completed daily and in full, audit and policy documents were present, signed and up to date for all trolleys. All necessary trolley equipment was present, within date and in working order.
- Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was checked on a regular basis with appropriate log books. We checked two anaesthetic machines and these had been serviced within the last 12 months. The inspection team identified the log books and examined all were complete with signatures for the days theatres were in use.
- Theatres used a smoke extraction system for all major surgical cases, in accordance with HSE evidence which prevents exposure and harmful effects of diathermy plumes (surgical smoke) to staff. (RR922) (2012) guidelines.
- Health and Safety Control of Substances Hazardous to Health (COSHH) assessments in theatres were up to date and displayed.
- There was a machine for testing blood on the ward and we saw records of daily calibration and monthly maintenance checks.
- We spoke to the maintenance manager who confirmed there was a generator with sufficient fuel to maintain electricity for a significant time should mains power be cut off. Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut.
- Temperature checks of fridges and freezers within kitchens were completed daily by kitchen staff and a log book was kept. Log book records showed temperature recordings were within accepted range.
- Medical gases were securely stored and we saw evidence of quarterly air quality testing in conjunction with up to date training competencies.
- The hospital had an endoscopy specific theatre which operated Monday to Friday 8am – 8.30pm, as well as Saturday 07.30am – 1.30pm. Endoscopy Services were not accredited by the Joint Advisory Group on GI Endoscopy (JAG).Staff told us they were anxious by the thought of JAG accreditation but expected to be compliant in 2017.However, a consultant told us whilst they were keen to have JAG accreditation they feared the investment required to bring the unit up to standard would be too high especially as the unit was not operating to full capacity.
- We noted the endoscopy equipment was aged but the hospital had a rolling replacement programme in place with full replacement of equipment scheduled for 2017. The environment was cluttered and poorly maintained. There was no division between clean and dirty scopes. There was no reverse osmosis water present. We noted one of two washers within the decontamination area was not functional.

- We observed two endoscopy procedures. We found the decontamination area and process was not in line with the June 2014 British Society of Gastroenterology (BSG) guidelines for decontamination of equipment for gastrointestinal (GI) endoscopy. This was a safety risk as there was no assurance of the scopes being decontaminated effectively in line with national guidelines. However, to avoid contamination staff told us scopes were processed one at a time.
- The inspection team viewed the theatre implant registers. We found a loose leaf ring-binder file for orthopaedic implants and although it was well organised, the loose leaf papers presented the risk of accidental loss or removal of a particular record. All other implants except ophthalmic implants were recorded in bound registers. The registers were viewed as being up to date and legible so therefore deemed adequate.

Medicines

- All arrangements for medicines were checked by our specialist pharmacist inspector.
- We found that medicines were managed safely. The hospital had an on-site pharmacy which provided for hospital inpatients and outpatients between 8am and 5pm Monday to Friday and Saturday 9am to 1pm. The pharmacy manager told us about plans to extend the pharmacy in January 2017 by an extra hour of opening every day.
- Pharmacists visited the ward five days a week to check and re-stock the medicine supplies.
- Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times.
- Access to the pharmacy during opening hours was by designated pharmacy staff only. There were specific procedures for other named staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse in charge holding separate keys, so that single access was not possible.
- Medicines CDs and patient's own medication were stored in locked cupboards or trolleys. Keys for the locked storage areas were kept in a safe with an electronic code which was only known by pharmacy staff and senior nurses. The security code was changed every six months.
- Stocks of controlled drugs (CDs) were audited by the pharmacist. Controlled drugs are medicines that need extra checks and special storage arrangements because of their potential for misuse. Stock levels were limited and monitored.
- CDs were checked on at least a daily basis by registered nurses or pharmacists and ODPs. The CD registers and order books were completed in line with local procedures.
- Staff told us near misses were recorded and learnt from, and gave an example of where the wrong dose of a pain killing medicine had been dispensed. An investigation showed that medicines of a different dose were previously located next to each other on the same shelf. As a result of the incident, the items were now stored on different shelves. The learning from these incidents helped to improve medicines' safety and therefore patient safety.
- We saw that allergies were recorded in all patient records and medicines administration records we reviewed, and they were acted upon.
- Where medicines required cool storage, ambient temperature checks of the storage areas including cupboards and refrigerators were carried out and recorded, and were all within the required range. However on inspection we found the temperature of a locked fridge within a treatment room had not been recorded for two days. Staff told us if the reading was out of the required temperature range, a member of staff contacted the pharmacist for advice so that corrective action would be taken where necessary.
- For patients being discharged, medicines to take away (TTA) were delivered to the patient. The TTA stock cupboard was checked weekly by the pharmacy team so that the RMO and senior nurse were able to discharge patients out of hours. Stock was checked and reconciled against a documented list. Should a patient have their own controlled drugs, they were stored in the controlled drug cupboard and returned to the patient on discharge.

- Information from the hospital demonstrated that audits of medicines management took place and any shortfalls were identified and investigated.
- We observed the medication round and saw that medicines were administered safely. Medicines administration records were well maintained and clear about the medicines prescribed and administered. Patient medicine rounds were observed and patients were advised to not take the medicines without the knowledge of the nursing staff to ensure safe practice.
- At the morning briefing of theatre staff it was confirmed that theatre anaesthetic equipment had been checked. The anaesthetic machines were checked daily by an operating department practitioner (ODP) and the bottled oxygen supply was checked daily by the head porter.
- Emergency medicines used for the treatment of anaphylaxis or cardiopulmonary resuscitation were clearly labelled, available for use, and regularly checked by clinical staff in each department. A record of the expiry dates for all the emergency medicines was kept in the pharmacy department and monitored by the pharmacy technician on a weekly basis. All the emergency medicines we looked at were correctly stored and in date, and remained ready for use.

Records

- The hospital used a paper-based records system for recording patients' care pathways. These were documents that covered the patient's journey from admission through surgery to discharge which included a local record of the patient's stay. There were different care pathways available for the different types of surgery undertaken at the hospital; for example cataract, hernia repair and major and intermediate shoulder surgery.
- We looked at nine sets of care records. Care records were stored in unlocked cupboards accessible by staff only in a room behind a reception desk.
- NHS records were available for patients whose treatment was funded or part funded by the NHS.
- We looked at the pre-assessment information and saw that any tests and investigations undertaken were clearly documented and the patients' medical and social history was recorded prior to them being admitted for surgery.
- Risk assessments were available and completed during pre-assessment and then followed up on the ward.
- We saw evidence of completed WHO safety checklists and completed signed consent forms. However, when looking at some patient notes we saw no evidence of mechanical VTE prophylaxis given on prescription charts or patient care pathways when the patient was assessed as at risk of VTE.
- The records gave an accessible record of the patients' journey through the hospital including the procedures undertaken and showed the input of the various specialisms including the anaesthetists and physiotherapists.
- However, when looking at three sets of case notes of discharged patients we saw no evidence of a post operative medical entry in two sets. We had no assurance that these patients had been assessed post operatively so care for these patients could have compromised.

Safeguarding

- The hospital had an identified staff member who was the lead for safeguarding adults and children and the point of access for staff should they have questions about safeguarding issues.
- Three staff members were unable to demonstrate access to the safeguarding policy. However, staff were able to identify the potential signs of abuse and process they would follow to raise a safeguarding referral.
- The hospital reported two safeguarding concerns during the reporting period of July 2015 to June 2016. However, staff we spoke with were unable to give any examples of safeguarding concerns raised.
- There was good completion of mandatory safeguarding training within the surgery service. Safeguarding awareness was included in corporate induction and additional safeguarding training was available for staff depending on their seniority and role.
- Staff we spoke with confirmed they had received safeguarding vulnerable adults training as part of mandatory training but were unaware of what level they had completed.
- Patients we spoke with told us they felt safe in the hospital.
- The hospital had a policy and guidance on female genital mutilation (FGM). All staff were aware of FGM and how to escalate concerns appropriately. Doctors and nurses felt comfortable in managing and escalating concerns in this area.

Requires improvement

Surgery

Mandatory training

- Mandatory training was monitored and all staff expected to attend on an annual basis. Compliance was discussed during appraisal. We reviewed three appraisal reports which included details of completed mandatory training.
- Nurses, health care assistants (HCA) and operating department practitioners (ODPs) told us that mandatory training was booked by ward managers for surgical wards and the theatre manager in theatres.
- Staff told us mandatory training was a mixture of on-line training and face to face training, and that it was always completed in work time. We were shown mandatory training on-line known as E-learning. The system highlighted any breaches. Staff could access their own learning record using this system.
- The hospital mandatory training programme included health and safety, infection control, information security, manual handling, workplace diversity, fire safety, safeguarding, resuscitation, PREVENT and compassion in practice.
- All anaesthetics and recovery staff (registered nurses and operating department practitioners (ODP) completed resuscitation training annually.
- Senior staff told us that the same agency and bank nurses were used where possible. Local induction checklists and staff handbooks were completed with the nurse in charge on their first day of work.

Assessing and responding to patient risk

- Risks to patients were considered by clinicians and patients at their pre-admission assessment and should there be any concerns the surgery would not take place.
- The American Society of Anaesthesiologists (ASA) used a grading system of 1-6 which determines the fitness of patients. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma. Only patients that have been assessed at pre- assessment that are ASA grade one or two have operations undertaken. This was because there were no facilities or staff to support patients who were ASA grade three. The decision was made by the nurse who undertook the pre assessment of the patient if they had any queries regarding patient's suitability it was discussed with an anaesthetist.
- The hospital used the National Early Warning System (NEWS) track and trigger flow chart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse) already undertaken when patients present to, or are being monitored in hospital. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support. We reviewed five completed NEWS charts which were completed correctly and we saw evidence of intervention when indicated. We saw audits of NEWS compliance.
- There was a formal agreement in place for patients to be transferred to the local NHS hospital if they required high dependency or critical care (level two-three).
- There were daily nursing handovers. In addition there was a morning 'huddle'. This was a formal meeting held at the start of each working day where the heads of department came together to discuss potential issues for the day. During our inspection we attended a morning 'huddle'. We observed a brief overview from the night staff and brief discussion of the plans and any potential issues for the day including staffing or changes to the operating lists.
- All patients had their call bell within reach, and patients told us if they pressed it they were responded to almost immediately.
- There were up to date clinical standard operating procedures in the management of emergency situations for example massive blood loss and the management of the deteriorating patient. These ensure a standardised evidence based approach to managing emergency situations; the majority of staff we spoke to confirmed that they had access to these and were aware of the content.
- The resident medical officer (RMO) provided the first response in an emergency situation.

Use of the World Health Organization (WHO) Surgical Safety Checklist

- We visited theatres to observe surgical procedures being conducted. We saw staff applying the specific WHO checklists for different procedures, which ensured the most important safety factors relating to the procedure were highlighted and checked. The WHO checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre.

Requires improvement

Surgery

- We observed multiple examples of the WHO checklist in use. In all cases they followed a standardised, accurate approach were well led and had good staff engagement.
- We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes post-operatively. Staff told us compliance with the checklist was closely monitored and monthly audits took place.
- The July 2016 surgical safety checklist audit demonstrated a compliance of 90% across all five steps. Staff told us if the check list had not been completed correctly it would be discussed with the individual staff member and any themes discussed at staff meetings.
- We attended a pre-operative team brief which was perfunctory but each planned procedure was discussed and notes made. These notes were stored for future reference, should any issues be raised about planning and procedure. This was in line with the 'WHO Guidelines for Safe Surgery' 2009 and Royal College of Surgeons, 'The High Performing Surgical Team-Best Practice for Surgeons' 2014.
- We witnessed anaesthetic practitioners lead the sign-in procedure and complete sign-in of the patient in the presence of the anaesthetist. On transfer of the patient from anaesthetic room to operating theatre, we observed time outs which were led by consultant surgeons once the patient was safely transferred to operating table and secured. The 'time out' is a momentary pause before the procedure begins to confirm essential safety checks are undertaken and this involves the whole team. On transfer of patients into recovery from surgery we witnessed anaesthetists provide full handover to the recovery nurse.

Nursing and support staffing

- The nursing rota was completed daily by the ward manager. The hospital confirmed they had used the Shelford Safe Staffing Tool since January 2015 which is an evidence-based, staffing level tool that enables nurses to assess patient acuity dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity / dependency.
- The number of both trained and untrained staff required was identified. We saw that the required numbers of qualified nurses were available to care for patients. Planned and actual staffing levels were displayed at the time of our inspection at the nurse's station.
- Theatres used the Association of Perioperative Practice (AFPP) staffing guidelines to ensure there were adequate numbers of appropriately trained staff available for each theatre. Staffing guidelines were not displayed but inspection staff saw evidence from staffing rotas and allocations that the guidelines were adhered to.
- The hospital only undertook elective surgery which meant the number of nursing and care staff hours needed on any particular day could be calculated and booked in advance. Employed staff worked their contracted hours flexibly to cover the rota and any gaps were filled by bank or agency nursing staff or by overtime.
- Nurse agency usage within in-patients areas had increased shortly before inspection, staff told us this was due to a lot of permanent staff leaving and that recruitment was on-going. Staff told us that whenever possible they used the same agency nurses to ensure proper orientation and continuity of care.
- We observed a morning nurse handover during our visit. We found that the handover was efficient with all solvent points mentioned in a clear manner. Handover was carried out in patient's rooms with the nurse caring for the patient introducing themselves to the patient.
- During inspection we observed a daily safety brief which was attended by a physiotherapist, pharmacy technician, senior ward nurse, ward manager, RMO and theatre manager. During this brief staffing for the day was confirmed, ALS providers were identified, admissions and cancellations for the day were discussed, equipment checks discussed, NEWS triggers identified, safeguarding cases were discussed, TTOs required confirmed, fasting regimes of patients discussed and specific patient preparation.

Medical staffing

Requires improvement

Surgery

- Surgical treatment at the hospital was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the hospital for many years.
- There were 296 doctors and dentists employed or practicing under rules or privileges.
- The hospital employed three RMOs from an external agency. There was a resident medical officer (RMO) on the hospital site 24 hours a day, seven days a week, who liaised with the consultant and nursing teams. The RMOs worked for seven days and then had seven days off. One RMO worked twice a month at Spire Roding and in between their working week one of the other two RMOs were on site.
- Staff told us that the RMOs were responsive and would come to assess patients when requested. The RMO told us this arrangement was manageable and worked well.
- The Resident Medical Officer (RMO) provided continuous medical cover and conducted regular ward rounds to ensure that all patients were appropriately treated and safe. Any changes in a patient's condition were reported to the consultant and their advice was followed in respect of further treatment.
- Consultants were contacted via their mobile phone or secretary throughout the patient's stay. Consultants provided a contact name and details from their base hospital to cover them during absence and the departments had access to this list. Each cover arrangement was reviewed at the consultants biennial review.
- Anaesthetists were contactable by telephone when not on site and it remained the responsibility of the admitting consultant to make arrangements for appropriate anaesthetic cover when admitting patients. If an anaesthetist was required unexpectedly the anaesthetist involved in the patient's care would be contacted and if unavailable their cover would be contacted. In the event that neither anaesthetist was available the hospital would contact anaesthetists with practicing privileges who are on-call for their local NHS Trust.
- The hospital had a Medical Advisory Committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if they were deemed competent and safe to do so. We were told by the senior management team this was achieved by reviewing the skills and competence of new and substantive consultants and continually monitoring the behaviours and practice of consultants who work at the hospital.

Emergency awareness and training

- The hospital had a service continuity plan that informed staff of the actions they should take in the event of emergencies such as fire or power failure. Senior staff told us that in the event of a power failure any operations in progress would continue with the hospital emergency generator but no other operations would be undertaken until power had been restored. However, nurses were unaware of any major incident plan and where to access emergency information.

Are surgery services effective?

Good

We rated effective as good because:

- There were good patient outcomes across surgical specialities.
- Care was delivered in line with relevant national guidelines.
- The service performed well in national clinical audits.
- There were short length of stay and low readmission rates.
- All of the patients we spoke to said they had effective and timely pain relief.
- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.

However:

- When reviewing patient records, we found some consent forms had no confirmation of consent signed.

Evidence-based care and treatment

- There was a range of clinical pathways and protocols for the management and care of various surgical procedures which had been developed in conjunction

with healthcare professionals from a range of specialties, for example the knee and hip replacement pathway. We reviewed two pathways which were fully completed and easy to understand.

- Care was provided in line with guidance from the National Institute for Health and Care Excellence (NICE). Policies and guidelines were developed based on both NICE and Royal College guidance and were available to all staff. This included the use of national early warning scored system (NEWS) charts to identify and take appropriate action when a patient's condition was deteriorating. (NICE guidance CG50).
- We observed patient care carried out in accordance with national guidelines and best practice recommendations for example early recovery after surgery (ERAS) in knee and hip replacement surgery. The enhanced recovery programme aims to improve patient outcomes and speed a patient's recovery after surgery.
- Mortality and morbidity meetings were held, designed to discuss clinical cases. In addition, feedback from other sites within the company was discussed.
- Within the theatre, we observed that staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection. For example, we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine.
- Senior staff understood specific NICE guidelines that related to operations undertaken and additional NICE guidelines for example in relation to VTE management.
- The endoscopy unit was not accredited through the Joint Advisory Group (JAG) system. The hospital management team told us that that they were collating data to enable them to apply for JAG accreditation. On inspection we found there was no supply of reverse osmosis water which was needed for effective decontamination of scopes. The decontamination area was small and crowded with no clear separation of used and clean scopes.

Pain relief

- All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief.
- We spoke with six patients and four told us nurses responded quickly when extra pain relief was required and the effect was checked by nurses. However two patients told us they felt the nurses asked too much about pain relief and they were unable to sleep for this reason as well as pain relief not always being given on time.
- Patients' pain was assessed as part of the NEWS process and a nationally recognised scoring system was used. We saw each patient's pain management was discussed during nurse handover.
- Patient records showed that pre-operative assessment for all patients included details of post-operative pain relief. This ensured that patients were prepared for their surgery and were aware of the types of pain relief available to them.

Nutrition and hydration

- There was a process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in line with best practice.
- The Malnutrition Universal Screening Tool (MUST) was used to assess patients' risk of being under nourished. The records we reviewed had a nutrition and hydration assessment undertaken.
- Patients with specialist dietary requirements were highlighted at pre-assessment and the catering staff informed.
- Patients we spoke to said they were offered enough to eat and drink and were happy with the variety and standard of food offered.
- All the patients we observed had water jugs on their bedside table so could access drinks.

- The 2016 PLACE audit scored the hospital 92% for food overall which was in line with the England average.

Patient outcomes

- The hospital had good outcomes and processes in relation to hip and knee replacement procedures. Outcomes were measured nationally for example via the National Joint Registry.
- Some national audits were completed to establish outcomes for patients. However insufficient data was available to identify patients' outcomes in all areas.
- Patient Reported Outcome Measures (PROMs) are standardised validated question sets to measure patients' perception of health and functional status and their health-related quality of life. The hospital invited all patients (private and NHS) who had undergone hip or knee replacement surgery to complete a PROMs questionnaire. On inspection we saw the hospital was in the process of introducing on line PROMs data collection for hips, knees, ophthalmology and hernias. Patients were presented with an electronic tablet to complete their PROMs at pre-assessment or on admission.
- Information provided by the hospital showed that there had been nine cases of unplanned returns to theatre between July 2015 and June 2016, which was a similar rate to other independent acute hospitals. In addition there had been 16 unplanned readmissions to the hospital within 28 days of discharge. Reasons for readmission included on-going vomiting and signs of infection.
- Information on comparative outcomes by clinicians for orthopaedic specialities was reviewed on the National Joint Registry (NJR) website (available through the NHS Choices website). We saw named consultants with practising privileges at Spire Roding with indications of their outcomes as being within the expected range.
- The number of referrals and admissions to the hospital were reported on monthly at the clinical governance meeting. The majority of patients received care as a day case. From July 2015 to June 2016 a total of 6,745 patients were treated as day cases and a total of 1,434 patients were treated as inpatients. 52% of these patients were NHS funded.

Competent Staff

- The hospital had in place appropriate job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post.
- Appraisal rates for all theatre staff were at 100% at the time of our inspection. More than 75% of inpatient nurses and other staff working within the hospital had their appraisal completed in the same appraisal year so far.
- Staff told us they received the training necessary for them to do their specific jobs in addition to the mandatory training provided for all staff.
- The head of clinical services told us that nursing staff were required to complete competencies in various aspects of their roles, for example, medicine administration. Staff told us that their competencies were assessed.
- There was a human resource (HR) process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.
- Staff members' registration status was also monitored by a local electronic database and managers. Managers told us it was individuals' responsibility to make sure their registration was up to date as it was a professional requirement.
- The role of the MAC included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken.
- Consultant competencies were assured through annual appraisal, biennial reviews and the General medical council (GMC) revalidation process. All consultants must have an appraisal by an approved appraiser to maintain practising privileges at Spire Roding Hospital. We looked at a selection of consultants' appraisals and saw they included maintaining and developing professional performance, training and development to improve skills and working collaboratively with others to maintain and improve patient care.

Multidisciplinary working

Requires improvement

Surgery

- Care planning took place at pre-assessment with input from the multidisciplinary team, there was involvement from members of the team including doctors, nurses and allied healthcare professionals.
- We observed a good culture in multidisciplinary working and a good team ethos. In particular we witnessed good interaction between patients and physiotherapists who used a variety of equipment and techniques to enable patients to mobilise after surgery. Physiotherapy was available on the ward and following discharge when needed.
- Multidisciplinary teamwork (MDT) was evident throughout the surgical service. This ensured that patients' needs could be met across a range of treatments and therapies. We observed medical staff, nursing staff, therapists and a pharmacist working as a team on the ward. Records of care and outcomes were maintained by the whole multidisciplinary team. Ward rounds took place daily, although this mainly included doctors and nurses. However, we attended a safety brief where a physiotherapist, pharmacy technician, senior ward nurse, ward manager, RMO and theatre manager were present.
- Staff told us that there were MDT arrangements in place with a local trust for patients' cancer care and treatment. However senior management team meetings and MAC meetings identified that availability of MDT information was inconsistent and sufficient information was not always available. We spoke with the MAC chair about the MDT involvement for cancer cases and they acknowledged it was poor and that some cases were not receiving any MDT input. To address this concern the hospital implemented a system of remote MDT access. We were told that all cancer patients within the reporting period were reviewed by this MDT arrangement.
- Discharge letters were sent to patients' GPs with details of procedures completed, follow up arrangements and any medicines prescribed.
- There was a service level agreement in place with a local NHS Trust for transfer arrangements should a patient's condition deteriorate and they require additional care following a surgical procedure.

Seven-day services

- The theatres were available 7.30 am to 8.30 pm Monday to Friday and from 7.30 am to 5.00pm on a Saturday (the hospital operated on most Saturdays during the year and offered a regular six day service).The endoscopy suite operated the same times as theatres Monday to Friday and 7.30am to 1.30pm on Saturday.
- The theatres were also available for any patient needing to return to theatre 24 hours a day, seven days a week when the need arose. There was a staff on call rota which included scrub staff. Staff worked variable hours to accommodate surgeons' requests.
- There was an out-of-hours pharmacy with access available through the nurse in charge of the hospital.
- Physiotherapy services and diagnostic imaging services were provided seven days a week.

Access to information

- Patient records were accessible on the wards and departments. Observation records were kept in each patient's room and were accessible to patients and staff.
- Staff told us they had access to policies and procedures and felt they were kept informed by the management team. Staff told us that they all received a newsletter via email which updated them about events and incidents at the hospital.
- Staff told us they were able to access the internet and intranet for information, we saw an adequate number of computers for staff numbers.
- On discharge further information was provided to patients. Staff said that patients could telephone the ward with any concerns post discharge.
- Discharge summaries were provided to GP's within 48 hours. We observed discharge letters being populated and sent at the time of a patient's discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent. However

some staff were not aware of their responsibilities under the mental capacity act (MCA) 2005 and deprivation of liberty safeguards (DoLS). Staff that were aware were unable to describe the arrangements that were in place should the legislation need to be applied.

- Staff said they had completed training about the Mental Capacity Act 2005. Data provided by the hospital about compliance with training showed a 62% compliance rate for nursing staff and consultants with training about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. This was a notably low compliance as the requirement for the provider was 100%.
- Consent for surgery was only obtained by consultants. Initial discussions regarding consent were commenced by a consultant at the outpatient clinic stage. Once admitted, consent was reaffirmed with the patient by the operating consultant. Consent forms appropriately detailed the risks and benefits to the procedures.
- We looked at the recording of consent for nine patients undergoing surgery at the time of our inspection and found six forms were fully completed, however, two forms had no signatures confirming consent of patients who had been consented and signed prior to the day of surgery.

Are surgery services caring?

Good

We rated caring as good because:

- The feedback from patients we spoke with regarding the care they received was very positive. Patients stated that staff were friendly, helpful, and professional.
- Interactions between staff and patients were friendly and empathetic. Staff gave patients the opportunity to ask questions regarding their care and be involved in decision making regarding treatment.

Compassionate care

- We spoke with 8 patients. All patients spoke in complimentary terms about the staff and stated the care received as being “exemplary”.
- The Friends and Family Test (FFT) was undertaken by the Spire Roding to capture patient feedback. Results showed that between January 2016 and June 2016100% of respondents said they would recommend the hospital. The patient satisfaction survey from January 2016 to June 2016 showed 90% of patients responding 'excellent' overall to the quality of care provided by their Consultant against a target of 89%. However, response rates were below the England average of NHS patients across the same period.
- We viewed interactions between patients and staff, and found staff to be compassionate and attentive. Staff were quick to respond to patients requests and were friendly and supportive to patients and their family members. Staff treated patients with dignity and respect, and were calm and polite on all of the wards we visited.
- We observed all staff knocking on patients’ doors and waiting for a response before entering.
- The 2016 PLACE audit scored the hospital 73% for privacy, dignity and wellbeing, which was lower than the England average of 83%.

Understanding and involvement of patients and those close to them

- Patients told us that they had received sufficient information prior to their planned surgery. Patients were provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. They told us that they had any risks explained to them.
- During inspection a patient told us that a pharmacist had asked about their condition in front of the patient’s mother who was unaware of the patient’s condition. The pharmacist had a duty not to disclose sensitive information such as this.

Emotional support

- Staff explained that visiting hours were flexible and that on occasions relatives may stay overnight.
- Counselling services were available and provided at the hospital where required.

Requires improvement

Surgery

- The hospital offered facilities for religious worship. Staff had a file of relevant contacts and services in a resource folder in the ward area. In addition, if a patient, staff member or visitor required access to a prayer room, a consulting room was made available by staff.

Are surgery services responsive?

Requires improvement

We rated Responsive as requires improvement because:

- There was no risk assessment or action plans for some of the complaints. However, complaints and actions arising from complaints were discussed in governance meetings. Staff also had a good understanding of how they would handle a complaints they received.
- Consultants and staff voiced concerns regarding cancellation of operations on the day of the appointment.
- There were concerns regarding the late starts of theatre lists due to consultants arriving late in the morning.
- Family members of patients were occasionally used to translate, and information literature accessible to patients was seen only in English.

However:

- The admission guidance, exclusion criteria, and discharge processes were clear and well documented.
- All patients we spoke with gave us positive feedback about the service, citing examples such as cleanliness; friendliness of staff, discharge planning and quality of the food.

Service planning and delivery to meet the needs of local people

- The hospital provided services to insured or privately funded and NHS patients, through NHS e-referrals and local NHS Trust contracts.
- The hospital did not provide emergency care and all admissions were planned and arranged in advance of the person's admission.
- As part of the Hospital's refurbishment plan over the 12 month reporting period the hospital opened a new day case unit and refurbished the ward.
- A three bedded extended recovery unit was now available for patients requiring a higher level of observation and care post operatively, this had the capacity to extend to level 2 care if needed prior to patient transfer.

Access and flow

- When patients arrived at the hospital for an operation or procedure they reported to reception and were directed either to the day surgery ward or the inpatient ward.
- The patients were prepared for their operation or procedure in either location and waited to be escorted to theatre for their operation or procedure, after their procedure they were transferred to the recovery room to recover and ensure they were stable and pain free. Then they were collected and taken to either the day surgery unit and discharged home or returned to a room on the ward for overnight stay.
- The theatre manager reviewed the operating lists in advance; this ensured there was adequate time, staff and equipment available.
- Patients told us they were aware of what the approximate time of their operation would be and were kept informed of delays.
- Daily bed occupancy records were completed by surgical managers in advance which identified potential problems, reviewed demand, capacity and workforce. This meant delays any potential problems could be predicted and resolved in advance minimising delays and disruption.
- There were adequate discharge arrangements in place with patients provided with contact details of who should be contacted should any problems occur.
- Patients told us that they were required to confirm that they had somebody at home to support their care before they could be discharged.
- Patients were seen by the resident medical officer and consultant before discharge and all treatment communicated to the patients' GP.
- Many staff we spoke with stated that cancellations of surgery on the day of the appointment had been a problem; however the service was quick to offer an alternative appointment to most of these patients.

Requires improvement

Surgery

- In the 12 month period prior to inspection, 32 surgical procedures were cancelled by the service for a non-clinical reason (for example, equipment failure or patient eating prior to surgery). 29 (91%) of these patients were offered another date for the surgery within 28 days, the remainder chose not to proceed with the procedure.
- Staff and management discussed cancellations for each surgical pathway as part of Quality, Governance and Assurance meetings.
- Some consultants we spoke with voiced frustration and stated that some cancellations were NHS patients who did not attend, thereby impacting theatre efficiency.
- The theatre manager and senior management voiced their concern regarding the late starts of theatre lists due to consultants arriving late in the morning, this resulted in a late finish to the day and sometimes patients were cancelled. This was further corroborated by nursing staff. We were told the considered cause was due to the proximity of the hospital to a major road in London.

Meeting people's individual needs

- The hospital did not have any level two or three critical care beds, however it had a three bedded extended recovery unit which was available for patients requiring a higher level of observation and care post operatively and could be extended to level two care if needed prior to patient transfer.
- To mitigate risk, the hospital only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.
- Staff told us that patients with a learning disability, or with dementia, would be provided with additional care and support to meet their needs. Staff stated that patients with complex needs would be seen at the beginning of the list to minimise the time they had to wait; would be given a link nurse who could offer more individual support, and family members or carers of these patients would have more access to pre-assessment and recovery areas to help reduce any anxiety.
- On inspection we observed a safety brief where a patient with dementia due for admission was discussed.The patient was seen by a dedicated dementia lead during pre-assessment whereby their capacity was assessed.The patient was assigned their own dedicated 'dementia friend'.This was one of the 30 specially dementia trained staff member.
- Staff told us that patients who were living with dementia were allocated staff on a one to one basis. We observed this implementation during safety brief when a patient with dementia was being discussed for admission.
- However, in the patient-led assessments of the care environment (PLACE) audit 2016 the Hospital scored 59% which was significantly lower than the national average of 80% in relation to care for patients living with dementia.
- Staff told us prior planning took place for patient admitted with special needs, pre- assessment staff would notify ward managers of the patient's specific needs so adjustments could be made. We saw in the kitchen notifications had been sent to the chef to advise them of specialist diets of patients; this meant the chef could plan a suitable menu in advance.
- Staff told us that translation services were available in a variety of forms, for example face to face or telephone translation. On inspection we saw the telephone translation service used; however senior nursing staff told us that family members were occasionally used to translate. We found this not good practice as a patient's family member may lack medical understanding, impartiality and may cause impropriety or discomfort with personal issues.
- Patient information leaflets were in English. However, we were told that literature was also available in other languages when required. Specific information leaflets were available which were given to patients at pre-assessment therefore they had time to read the information prior to their operation. This also meant that relatives had the opportunity to read the information and were well informed.
- All food at the hospital was cooked on site; we observed the kitchen area which was clean and well organised. We spoke to the catering staff who took pride in their work and told us they wanted to create healthy tasty food for patients and staff.

Requires improvement

Surgery

- In the PLACE audit 2016 the hospital scored 89% for standard of food which was slightly lower than the national average of 91%.However they scored 92% for standard of ward food which was the same as the national average.
- The patients and staff we spoke to said the food was of good quality with a variety to choose from and catered for individual needs, for example, halal food and vegetarian options.
- All patients we spoke with gave us positive feedback about the service, citing examples such as cleanliness; friendliness of staff, discharge planning and quality of the food.

Learning from complaints and concerns

- The hospital had a complaints policy in place to provide staff guidance in the management of complaints. On review of this policy we identified certain omissions.
- We saw no reference of duty of candour in respect of complaints of moderate or above harm, there was no reference to the training staff receive in complaints handling and management and there was no defined level of competence for the individual responsible for investigating complaints.
- The hospital had received 52 direct complaints between July 2015 and June 2016.
- Senior management told us and we saw that staff followed the hospital complaints process and all complaints received by the hospital had been managed as per the Complaints policy.
- We were told by senior management if a patient was dissatisfied with the result of their complaint they would be provided with contact details of the Independent Sector Complaints Adjudication Service (ISCAS) who acts as the NHS equivalent to the complaints ombudsman. Two out of the 52 complaints were referred to the Ombudsman or ISCAS.
- We saw information in the hospital about how to raise concerns via a form titled “Please talk to us”. This form could be completed either whilst the patient was in the hospital or could be sent in after discharge. Staff were encouraged to respond to complaints or concerns at the time of complaint.
- Hospital managers told us that complaints were acknowledged within two working days and then a response provided within 20 working days. If this timescale was not possible, for example because further information was required, a holding letter was sent to the complainant so that they were aware their complaint had not been forgotten and was still being looked into.
- During Inspection we reviewed five complaints files which were held on the hospital incident reporting system. All the complaints had met the two and 20 working day response timescale, there was evidence of investigation and the response to patients addressed all aspects of the concerns raised.
- We found that risk assessments were not present in two of the five files and action plans were not present in three of the five complaints. In each of these three complaints the actions had been identified within the final response letter which had been sent to the patient.
- Complaints were a standard agenda item on the clinical governance committee meetings and heads of department meetings, we saw the minutes of these meetings to confirm this.
- There were mechanisms in place for shared learning from complaints through the staff meetings, team briefings and safety briefings.

Are surgery services well-led?

Requires improvement

We rated Well-Led as requires improvement because:

- Seven staff had no background and criminal record checks and 40 staff were awaiting these checks to come back.
- There was a vision and strategy in place for the service, but many of the non-management staff we spoke with were not aware of future plans or strategic vision for the service.
- Some consultant doctors felt there was limited communication and engagement between the hospital leadership and the consultant body.
- Risk management processes did not provide sufficient assurance that risks and issues were addressed in a timely and appropriate way.

However:

- Staff we spoke with stated that the senior leadership team were visible around the service.
- There was a positive leadership culture and good morale among staff.

Leadership and culture of the service

- The hospital director led the organisation supported by the acting head of clinical services who was also ward manager. Leadership within surgical services was provided by the theatre manager who managed theatre activity and clinical services managers who managed nursing staff on the ward, and a clinical governance manager who oversaw clinical governance both within surgery and throughout the hospital.
- The ward and theatre staff told us they found the ward and theatre manager approachable. Staff also told us that the both the hospital director and head of clinical services were visible and approachable.
- Staff told us that they were kept up to date either by managers in face to face meetings or by the monthly staff newsletters.
- Many members of staff told us their morale was good. Staff told us that the hospital was a friendly place and they would recommend it as a place to work. We noted that many staff had been employed by the hospital for over ten years.
- Management told us of a staff reward scheme knows as 'Inspiring people awards'. A committee made of various members of staff and supported by the hospital director reviewed nominations to forward for an award using a matrix tool. Staff we spoke with were unable to tell us if anyone had won an award, however posters were displayed of the award winners in the dining room, staff rooms, and on notice boards throughout the hospital.

Vision and strategy for this this core service

- Some staff were aware of the hospital vision to 'make a difference every day' as staff had been given the opportunity to contribute ideas to its development.
- The service had a strategy document in place to plan for future developments. Senior staff we spoke presented a vision of service for the hospital with goals to be the independent provider of choice to NHS commissioners, and to meet professional and regulatory standards for care and achieve the 'Spire balanced Scorecard target scores.'
- Many of the staff we spoke with were not aware of the long term vision for the service and did not feel there was a strategy in place for future development.
- The theatre manager told us their vision was to obtain JAG accreditation for the endoscopy unit. However the manager noted that as it stood the endoscopy unit would not be suitable for accreditation.
- Surgical activity within the hospital had continued to grow and this had included the increase in NHS contracted patient operations.
- As of April 2016, the service was performing to the standards required to meet CQUIN (Commissioning for Quality and Innovation) targets.

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

- The hospital held meetings through which governance issues were addressed. The meetings included the Medical Advisory Committee (MAC) meeting, Heads of Department (HOD) meeting, Senior Management Team (SMT) meetings and the Clinical Governance Committee.
- The role of the MAC included periodically reviewing existing practicing privileges and advising the hospital on their continuation. The MAC chair gave examples where practicing privileges had been suspended or withdrawn as a result of concerns raised.
- The MAC met every three months. The minutes from June 2016 demonstrated that key governance areas were discussed including training, risk assessments, clinical incidents, never events and complaints.
- Senior management confirmed that headline messages were disseminated to consultants via email, for example of a dehydrated patient having a pulmonary embolism post surgery.
- We were told by a senior member of staff that the process of feeding clinical experience and views from the consultant body to clinical governance was weak and stated that consultants would say they were not invited to give feedback. Consultants told us that

inter-clinician dialogue on risk and quality issues was minimal. We felt the MAC did not facilitate good communication channels with clinicians for the interest of quality.

- We spoke with four consultants, one stated that there was no inter-clinician communication and said, " there are 30 odd anaesthetists working here and we are like passing ships at night". Consultants described the hospital's governance as reactive rather than pro-active.
- There was an internal assessment of the hospital's performance against other Spire Hospitals which was discussed during senior management team (SMT) and heads of department (HOD) meetings.
- The hospital risk register recorded 141 identified risks. The management team acknowledged that the hospital risk register was a large document and was challenging to maintain. We were not assured of the arrangements to review the risk register as we saw actions were not always clearly documented and were not completed in a timely manner. For example, where there was retention of a foreign body following surgery the action was closed seven months later and there was no evidence of the action taken to reduce the risk.
- We reviewed the clinical governance committee meeting minutes held in November 2016. The minutes stated there had been two data protection breaches in quarter two of 2016, whereby a patient had been discharged with another patient's colonoscopy image report and another patient had been given a discharge summary from a different patient.
- We reviewed the actions taken in response to these incidents and found insufficient recording of actions taken to mitigate or prevent such incidents from recurring. The risk was rated low risk on the register.
- We spoke with the hospital director regarding these incidents. They identified the Caldicott guardian for the hospital and stated they were new to the role. The director acknowledged that lessons learnt were not clearly detailed or documented in the incident report and risk register. The hospital director acknowledged the lack of assurance and recognised that evidence was not being recorded properly.
- There were a variety of service level agreements in place to support hospital services for example the testing of blood, availability of blood products and the analysis of specimens. We saw evidence of these and staff reported good working relationships.
- We spoke with the hospital director who informed us that seven staff had no background and criminal record checks as of 7 November 2016. 40 staff were awaiting these checks to come back (noted as an 18 week wait at the time of inspection).
- We were informed that these staff members did not have clinical contact whilst awaiting checks and a chaperone system was in place with a documented risk assessment. However, this deemed a practical challenge for 40 staff. Spire policy states that every employee should have a DBS every ten years.

Public and staff engagement

- The governance lead told us the hospital was in the process of looking to write to previous patients in order to form a patient representative forum. We were told the advice from Spire has been to focus on key areas and target key patients to begin with. This was to commence at the start of 2017.
- From July 2015 to June 2016 the hospital received six items of rated feedback on the NHS choices website. Four indicated a rating of 'extremely unlikely to recommend' and two a rating of 'extremely likely to recommend'. Negative comments included lack of action and sensitivity provided by specialists, dissatisfaction with treatment and advice around pain management, and an administrative appointment error. Positive comments included caring and attentive staff and being treated with dignity and respect.

Innovation, improvement and sustainability

- We saw staff wanted to learn, develop and improve their skills; they were given protected time, resources and encouragement to do so.
- Information submitted from the hospital prior to inspection detailed: plans to follow a comprehensive action plan to recover oncology services; launch satellite centres to increase referrals, and develop an engagement strategy with GPs.

Requires improvement

Surgery

- The hospital had a dedicated resuscitation training officer who delivered a programme of local training in resus skills, care of the deteriorating patient and sepsis management.

Good

Outpatients and diagnostic imaging

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

Information about the service

Spire Roding Hospital provides a range of outpatient clinics and diagnostic imaging services for independently funded and NHS patients including children aged between three and 18.

The outpatients department provided clinics for a range of different specialities including dermatology, ear, nose and throat (ENT), general surgery, gynaecology, neurosurgery, ophthalmology, orthopaedic surgery, pain management and urology. The diagnostic and imaging service offered computerised tomography (CT), magnetic resonance imaging (MRI), X-ray, mammography and ultrasound. Physiotherapy was also contained within the outpatients department and offered a variety of treatments including rehabilitation, mobilisation techniques and acupuncture.

The outpatients and imaging service was located on the ground floor offering level access throughout. The outpatients department had its own waiting area, 19 consulting rooms, two treatment rooms, phlebotomy and dressings clinic. Within the imaging department CT/MRI and X-ray had their own individual waiting areas, changing rooms and reception desks.

The outpatients department had 47,871 attendances between July 2015 and June 2016, of these 48% were NHS patients and 52% were independently funded. The department saw a small amount of children equating to 4% of attendances.

During the inspection we visited the outpatients, physiotherapy and imaging departments. We spoke with 12 patients and 33 members of staff including managers, consultants, radiographers, physiotherapists, nursing staff, health care assistants and administrators. We observed the outpatients and imaging department environments, checked equipment and viewed patient information. We reviewed information provided by the hospital before the inspection.

Good

Outpatients and diagnostic imaging

Summary of findings

Staff were aware of their responsibilities for reporting incidents and we saw evidence that learning was shared.

All HCA and nursing staff in the outpatients department had received an appraisal known as 'enabling excellence'.

Patients we spoke with spoke highly of the care they received at the hospital, and felt fully involved in decisions made about their care and treatment.

Patients told us they were able to get an appointment with the hospital quickly and easily.

From July 2015 to June 2016 the outpatients department was regularly meeting its referral to treatment times.

Staff told us that the senior management team were visible within the department, and encouraged an open and transparent culture.

However:

Cleanliness within the outpatients and imaging department did not always meet national or local standards. We saw that clean and dirty equipment was not always segregated.

During our inspection, we found four private prescriptions in the imaging department which staff were unable to account for.

There was a lack of consistency in the way consultants provided copies of clinic notes for independently funded patients.

Managers told us there were concerns about waiting times during clinics due to consultant delays or not attending. Data for waiting times had not been historically collected by the service. However, following our inspection managers informed us that a system had now been put in place for waiting times to be recorded.

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the outpatients and imaging department for safe as requires improvement because:

- Cleanliness within the outpatients and imaging department did not always meet national or local standards.
- We saw that clean and dirty equipment was not always segregated.
- During our inspection, we found four private prescriptions in the imaging department which staff were unable to account for. We saw that staff reported the incident and since the inspection the hospital have told us about actions they have taken to prevent this happening again.
- We found some PGDs were not completed correctly or did not have the required signed declaration by staff.
- Controlled drugs incidents were not always reported as required.
- there was a lack of consistency in the way consultants provided copies of clinic notes for independently funded patients'.
- There were carpets within the outpatients waiting area and consultation rooms. This had been recorded on the outpatient's risk register, and a refurbishment had been planned for the following year.

However, we found that:

- Staff were aware of their responsibilities for reporting incidents.
- Medicines and controlled drugs were stored securely in locked cupboards. Emergency medicines were correctly labelled and readily available for use.
- Staff were able to describe how to follow safeguarding procedures correctly.
- There was a process in place for deteriorating patients within the outpatients department.

Incidents

Good

Outpatients and diagnostic imaging

- There were 51 clinical incidents reported within the outpatients and diagnostic imaging departments from July 2015 to June 2016. This was lower in comparison to similar independent acute hospitals.
- There were 16 non-clinical incidents reported within outpatients and diagnostic imaging between July 2015 and June 2016. This was comparable to similar independent acute hospitals.
- There were no never events reported within the outpatients and diagnostic imaging service from July 2015 to June 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff we spoke with were aware of their responsibility to report incidents. Staff escalated the incident to their manager, or reported it on the hospital electronic recording system.
- Managers told us that when staff reported an incident they would investigate it by speaking to those involved. Managers provided feedback to individual staff members and shared learning from incidents with all staff during monthly departmental meetings and at daily safety briefings.
- We saw an example of a controlled drug (CD) incident that was under investigation at the time of our inspection. Staff had recorded the incident on the electronic reporting system, and reported it to the controlled drugs accountable officer (CDAO) and Spire superintendent pharmacist.
- We saw evidence of learning from incidents. Within the physiotherapy service staff had been given additional training on safe use of the equipment following two incidents involving patient falls.
- Staff discussed medicine incidents and safety matters at the medication management governance committee meeting on a quarterly basis. This was attended by the heads of department and a representative from each core service. The pharmacy staff had also participated. Between 19 April 2016 and 24 August 2016 there were 10 medicines safety incidents reported, one of which occurred in the outpatients department.
- Staff told us near misses were recorded and learnt from, and gave an example of where the wrong dose of a pain killing medicine had been dispensed. An investigation showed that medicines of a different dose had been located next to each other on the same shelf. As a result of the incident, the items were then stored on different shelves.
- We reviewed the Spire Healthcare policy for adverse event and near miss reporting. The policy was up to date and provided comprehensive guidance to staff on adverse event and near miss reporting detailing use of duty of candour, reporting to external agencies, incident grading, investigation and root cause analysis. The policy applied to all Spire Healthcare employees and did not refer to staff working at the hospital who were not employees such as consultants working under the auspices of practising privileges. However, we were informed that the consultant handbook required consultants to report accidents they were involved in or witnessed as soon as practicable.
- Staff within the outpatients and imaging departments had varying knowledge in relation to the duty of candour. The duty of candour regulation requires providers of health services to be open and transparent when things go wrong. This includes some specific requirements, such as providing truthful information and an apology. The hospital management team informed us that no duty of candour incidents had taken place within the outpatients department.
- We reviewed the duty of candour policy, which was up to date. The policy provided staff with a definition of what the duty of candour is and the requirements of the regulation. However, the policy did not refer to how compliance with the duty of candour would be monitored and reviewed and where such incidents should be reported to within the governance structure.
- The imaging department reported two incidents involving ionising radiation between July 2015 and June 2016. We saw the incident log for one of these and saw that actions had been taken and lessons learnt.
- The imaging department manager was aware of their responsibility regarding ionising radiation (medical exposure) regulations IR(ME)R and there were policies and guidelines for the diagnostic imaging department developed in line with IR(ME)R.

Good

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were set out in Spire Healthcare policies and procedures to enable staff to prevent and control hospital-associated infections.
- Clinical staff and clinical support staff we spoke with all understood their responsibilities in minimising the risks of infection, and had completed learning and development as part of their induction and the hospital's mandatory training programme. In 2016 87% staff across the hospital had completed the mandatory training for infection prevention and control.
- From July 2015 to June 2016 there were two reported incidents of E-coli, and no incidents of Meticiliin resistant staphylococcus aureus (MRSA), Meticillin susceptible staphylococcus aureus (MSSA), or Clostridium difficile (C.diff) in the hospital. There were no reports of healthcare associated infections (HCAI) in the outpatients or imaging department.
- Nominated staff took the lead for infection prevention and control (IPC): a consultant microbiologist who was engaged under practising privileges, and the hospital matron who was the named director of infection prevention and control (DIPC). In addition, a lead nurse for infection prevention and control and link staff in each clinical area worked with the leads to ensure that staff were aware of any relevant information and policy development.
- Cleanliness within the outpatients and imaging department did not always meet national or local standards. During our inspection we saw dust and heavy staining on a floor within a store cupboard in the imaging department. Staff were unable to confirm when the room was last cleaned or who was responsible for the cleaning. We brought this to the immediate attention of the imaging manager and saw that staff promptly removed all supplies from the area, the floor was cleaned, and shelving was installed to ensure future supplies were not on the floor to minimise the risk of cross infection.
- Cleaning schedules, checklists and the use of 'I am clean' labels were used in accordance with local or national policy, such as The Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance.
- We reviewed the cleaning schedules for the outpatients department that contained work instructions and allocations. The schedule showed that carpets were deep cleaned every three months, there was a monthly rota for the store room and single items and a weekly cleaning rota for the toys. The rota indicated that the schedule was mainly complied with, although we noted gaps with the store room cleaning.
- The Department of Health code of practice on the prevention and control of infections and related guidance (2015) requires that there is clear segregation of clean and dirty equipment and waste in hospitals. Staff showed us there were separate clean and dirty utility areas in the outpatients department. There was a large dirty utility room located on the main corridor and a smaller dirty utility room adjacent to one of the outpatient treatment rooms. However, in the store cupboard in the imaging department there was no segregation of clean and dirty items. The cupboard is not used for clinical purposes. There were clean dry supplies in a cardboard box stored on the floor. Staff also used the room to get changed (although there are designated changing facilities for staff use), and there was waste dental film and other packaging discarded.
- The dirty utility area in the outpatients department was not clearly labelled which could result in staff or patients entering the room by mistake. We saw a heavily stained and dusty floor and a loose skirting board in this dirty utility area, and that clean and dirty equipment was not always segregated. For example, we found cleaning equipment such as vacuum cleaners and mop buckets stored in the dirty utility room. Staff told us this was not in accordance with hospital policy. We brought this to the immediate attention of the DIPC, outpatients' manager, and infection control nurse who confirmed this was the case and removed the cleaning equipment.
- There was no dirty utility area within the outpatients' physiotherapy area or the imaging department. Staff shared one dirty utility room located in the outpatients department, and had to access this through the main hospital corridor. This meant there was a risk of cross contamination. Management told us that the risk of cross contamination was reduced by controls that had been put in place and risk assessed within the department.
- There were no hands free taps in the dirty utility room which is recommended best practice, and the use of elbow operated taps should be considered within this area.

- Surgical instruments used in minor procedures in the outpatients' treatment room were supplied and decontaminated by the hospital on site central sterile supply department. Staff we spoke with told us they were satisfied with the instrument sterilisation service.
- The link IPC nurse undertook hand hygiene audits within the outpatients department including a hand hygiene questionnaire (self-reporting) on a weekly basis and World Health Organization (WHO) hand hygiene (observed practise) on a quarterly basis. Within the imaging department a link nurse undertook hand hygiene audits where staff were observed undertaking the five points of hand washing practise. We saw the audit completed in February 2016 where staff had 100% compliance.
- IPC Audits in uniform policy (annual), asepsis (annual), standard precautions (annual), sharps (weekly), housekeeping (bi-annual) were undertaken in the outpatients department. Audits showed where there was compliance and areas for improvement. Actions were put in to place where weaknesses were found and discussed at team meetings.
- We saw an audit schedule action log was maintained which recorded any issues raised during audits, what action would be taken and by when. For example, a sharps audit undertaken within the imaging department highlighted that an inappropriate pharmaceutical bin was in use which was overflowing with barium cans. An appropriate bin for disposal of barium was purchased and the action closed.
- There was a prevention and control of infection manual in the imaging department that was due for review in 2018. We saw that policies included management of C. diff, Ebola and MRSA, infection surveillance, and management of waste and sharp objects, all of which were based on national guidance and were in date.
- Results of the infection prevention and control audits were communicated through the hospital's governance processes on a quarterly basis. We were told staff that were non-compliant were provided with individual feedback by the person conducting the audit.
- Hand sanitisers were available for use at entrances to the hospital, wards and clinical areas. However, in the majority of areas there were no instructions or information that would encourage their use, and we did not observe staff asking patients or visitors to use them.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff used this when delivering care. We saw that staff adhered to the 'bare below the elbows' policy in clinical areas.
- Clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high-risk used linen. We saw staff complied with these arrangements.
- We saw sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff dated and signed sharps containers when brought into use.

Environment and equipment

- All areas within the outpatients department appeared uncluttered and well maintained. All patient waiting areas were visibly clean with sufficient seating for patients and their relatives.
- All equipment we saw had been appropriately serviced and maintained.
- There were carpets within the outpatients waiting area and consultation rooms. This had been recorded on the outpatient's risk register, and a refurbishment had been planned for the following year.
- Disposable curtains were used within the consultation rooms that were replaced in line with hospital policy.
- We saw that emergency bells were in place within consultation rooms and staff told us they were tested on a weekly basis.
- Within a treatment room used for hysteroscopy and colposcopy we saw cleaning schedules in place with instructions. We saw a checklist where all actions had been completed.
- We looked at the resuscitation trolley stored in the main outpatients department. Staff checked equipment on a daily basis and we saw that records were kept up to date. The trolley was shared by the outpatients and the physiotherapy departments. When we asked managers if a risk assessment had been undertaken in relation to this, we were told that the number and location of resuscitation trollies was in line with Spire policy and had been deemed appropriate, and therefore a risk assessment was not required.

- The resuscitation trolley within the imaging department held both paediatric and adult equipment. We saw that daily checklists were up to date and that all equipment was sealed and in date.
- There were clear warning signs in areas where ionising radiation and magnetism were used.
- The radiation protection advisor performed risk assessments on radiation equipment within the imaging department. Staff told us the last test was in September 2016 where the equipment was rated as 'fully compliant with no improvements required'.
- The hospital had invested in a new digital mammography system and two new ultrasound machines in 2016 to improve standards of care within the imaging department.

Medicines

- An on-site pharmacy service was provided for hospital inpatients and outpatients between 8am and 5pm Monday to Saturday. The pharmacy manager told us the pharmacy opening hours would be extended from January 2017 by an extra hour of opening every day.
- There was a purpose built pharmacy with secure, controlled access. The pharmacy department was visibly clean, with a designated area for the reception and unpacking of pharmaceutical supplies marked 'goods inwards'.
- Access to the pharmacy during opening hours was by designated pharmacy staff only. There were specific procedures for other named staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse in charge holding separate keys, so that single access was not possible.
- Patients had access to medicines when they needed them. Medicines were supplied to the hospital pharmacy through a centrally managed contract with the Spire procurement department. There was a top-up service in all clinical areas for replenishing medicines stock items and for medicines issued on an individual basis.
- Arrangements were in place for the safe order, storage, and issue of prescription stationery to minimise the potential of prescription theft and consequent fraud. There was a designated controlled access area in the outpatients department allocated to store prescription stationery (private prescriptions used to order medicines for outpatients). We saw records that demonstrated that the outpatients' sister and pharmacy manager checked and documented the receipt of each private prescription. Each individual prescription had an identifier number, which was documented on a central record when issued to the prescribing doctor.
- During our inspection, we found four private prescriptions in the imaging department staff only area that were not stored securely. We brought this to the immediate attention of the imaging department manager, outpatients manager, and pharmacy manager. We saw that staff raised an incident report straight away and that an investigation of the incident commenced. The investigation highlighted that the prescriptions found pre-dated the hospital process which was implemented on 2nd September 2015 which meant that staff were unable to account for why the prescriptions were not kept in the designated secure area. The hospital took additional actions as a result of the investigation. This included all prescription pads within the imaging department being returned to the secure storage area in the outpatient department and an amendment made to clarify the prescription storage process.
- Staff administered medicines only when prescribed by doctors. In the imaging department contrast dyes used to improve the visibility of internal body structures in imaging techniques, saline, antispasmodic and anti-sickness medicines were supplied and administered under patient group directions (PGDs). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines, to a predefined group of patients without them having to see a prescriber.
- Requirements for using PGDs are that they need to be signed by each individual member of the multidisciplinary group: in this case the lead consultant radiologist, lead pharmacist, lead radiographer, the clinical governance lead on behalf of the organisation authorising the PGD (head of clinical services/matron, hospital manager) and the individual health professionals working under the direction.
- We reviewed all eight PGDs in use in the imaging department, and saw evidence that staff had undergone

relevant training and assessment. However, we found two PGDs where the commencement and review dates had not been completed, three where the documentary evidence of the required sign off by relevant staff was incomplete, and seven where the required signed declaration by staff using the PGD was incomplete.

- We asked for evidence that the PGDs were being monitored or audited and were told this had not happened since their introduction in 2015. We looked at the medicines audit plan for 2016 and saw that PGDs were not included in the plan. Managers could not confirm when the PGDs would be audited and were unaware of any plans in this area.
- Medicines were stored in locked cupboards or trolleys. Keys for the locked storage areas were kept in a safe with an electronic code that was only known by pharmacy staff and senior nurses. Staff changed the security code every six months.
- The controlled drug (CD) registers and order books were completed in line with local procedures. We looked at the pharmacy CD register and observed that it was difficult to enter information in the 'amount supplied' and 'balance' columns due to the binding of the book. For example, the CD record for tramadol 50mg capsules was not clear on the amount supplied; we read it as five but staff told us it was 15. We brought this to the attention of the pharmacy manager.
- The hospital director was the accountable officer for controlled drugs. Managers told us that Spire required an audit of the controlled drugs every three months. The hospital audit schedule showed that the controlled drugs audits had been undertaken in March, June and September 2016.
- In October 2016 the Spire Roding Hospital CD audit identified five instances where the second signature for CD administration was not completed. We asked for documentary evidence of the incident reports relating to these omissions. We were told that none of the five incidents had been recorded on the hospital incident reporting system as required by the Spire policy. We were informed that a follow up audit was conducted in November 2016; however there was no evidence of any specific learning shared with staff to ensure there were no further omissions.
- A list of signatories of staff authorised to order and administer controlled drugs was maintained by the pharmacy manager and located in the pharmacy to ensure safe ordering. Staff told us that CD destruction takes place at least quarterly and must be carried out by a witness authorised by the controlled drugs accountable officer (CDAO). The CDAO should be aware of medicines requiring destruction, and we confirmed this to be the case. We saw in the CD cupboard in the pharmacy department that medicines awaiting this destruction were clearly labelled and segregated.
- CDs were stored in lockable wall units and registered nurses or pharmacists checked them on at least a daily basis.
- We saw that the hospital had successfully renewed its home office licence to supply and possess controlled drugs in October 2016.
- All clinical staff we spoke with were consistently positive about the pharmacy information and service provided.
- Managers told us the Spire Healthcare chief pharmacist would occasionally visit the hospital to review the pharmacy arrangements. This last happened in October 2016. An action plan was drawn up as a result of the visit, which was described as' work in progress'. This was not available at the time of our inspection but provided by the hospital afterwards. The plan outlined 34 required actions, a date by which they should be completed and by whom. The hospital indicated that all but two of the actions had been completed. The two remaining actions related to communication of lessons learnt from pharmacy audits and regular auditing of the intervention logs with outcomes being fed back to clinical governance. These were scheduled to be completed in early 2017.
- Emergency medicines used for the treatment of anaphylaxis or cardiopulmonary resuscitation were clearly labelled, available for use, and regularly checked by clinical staff in each department. A record of the expiry dates for all the emergency medicines was kept in the pharmacy department and monitored by the pharmacy technician on an at least weekly basis. All the emergency medicines we looked at were correctly stored and in date, and remained ready for use.
- There was an up to date antibiotic protocol that included first and second choice medicines to use, the dosage, and duration of treatment. The audit report for antimicrobial prescribing October to December 2016

stated that there was a very limited amount of data to be able to report on prescribing trends. The audit was therefore to be repeated in the period January to March 2017.

- We saw that staff recorded allergies in all patient records and medicines administration records we reviewed, and they were acted upon.
- We looked at a random sample of medicines stock in the pharmacy department and treatment areas, and saw that these were in date, correctly stored and had been reconciled correctly.
- Where medicines required cool storage, ambient temperature checks of the storage areas including cupboards and refrigerators were carried out and recorded, and were all within the required range. If the reading was out of the required temperature range, a member of staff contacted the pharmacist for advice so that corrective action would be taken where necessary.
- For patients being discharged, tablets to take away (TTA) were delivered to the patient. The pharmacy team checked TTA stock cupboard weekly so that the RMO and nurse were able to discharge patients out of hours. Stock was checked and reconciled against a documented list.
- Where staff gave patients medicines as TTA, they gave specific advice on how the medicines should be stored and handled.
- Staff received and acted on safety alerts relating to medicinal products and medical devices in a timely manner, and provided us with examples of where this happened.
- Some unlicensed medicines were used at the request of a consultant for a particular condition, for example eye drops, and pain relieving medicines. An 'unlicensed medicine' is the term used to describe medicines that are used outside the terms of their UK licence or which have no licence for use in the UK. Where unlicensed specials were requested, consultants were required to provide evidence and complete a 'New Drug/Product request form' prior to the medicines being supplied. The medicines would not be dispensed without supporting evidence. Staff told us the consultants and pharmacists counselled the patients about unlicensed medicines and we saw that this was recorded.

Records

- The service had a policy for the storage and management of patient medical records which detailed storage and retention, who could access them and what to do with them when the patient was discharged.
- During our inspection we saw that patient records were managed safely and securely.
- The medical records team prepared paper based medical records the day before the patient's appointment, upon receipt of a list of patients from the choose and book team.
- There was a lack of consistency in the way consultants provided copies of clinic notes for independently funded patients. NHS patient records came with a medical history attached. Records for independently funded patients were kept by the consultant. The hospital had asked consultants to provide a copy of their notes and letters taken during clinics, however, these were not always legible.
- The hospital had a system for tracking medical records, however staff told us that this was not always filled in correctly and the system was slow. Managers told us that the tracking of medical records was high on the risk register. A process for file tracking was ratified in October 2016 and was being communicated to staff. The senior management team were due to review the procedure in April 2017.
- If a medical record was not available, for example if a patient had surgery the previous day, then staff created a temporary file. This would later be merged with the permanent record.
- Medical records were kept on the hospital site for four months following patient discharge. After this time they were stored in a central Spire storage facility. If records were subsequently required, they could be accessed with 24 hours' notice, or sooner if urgently required.
- We looked at nine patients' medical records and saw that patient history, consent, allergies, medicines history and pain management pathways were being routinely recorded, signed and dated.

Safeguarding

Good

Outpatients and diagnostic imaging

- The service had safeguarding policies in place to keep both vulnerable children and adults safe from harm and abuse. If staff had safeguarding concerns these were communicated to the relevant staff. Staff we spoke with correctly described the safeguarding procedures they followed, which was by escalating the issue to the outpatients manager or sister. However, staff told us they rarely had to raise any safeguarding concerns within outpatients.
- Where safeguarding concerns were raised a sticker was placed on the relevant patient record to highlight this.
- We saw posters providing information about the hospital's safeguarding lead throughout the outpatients department.
- Data provided by the hospital indicated that 85% staff had completed training in safeguarding children and adults level two. Within the outpatients and imaging department staff who had responsibilities for the care and treatment of children were 100% compliant with completing safeguarding level three and paediatric basic life support training (PBLS).
- We saw systems in place to ensure the right person received the right radiological scan at the right time. We observed staff within the imaging department checking patient name and date of birth and undertaking risk assessments. This confirmed that safe systems were in place to protect patients from unnecessary radiation through referral and clerical errors.

Mandatory training

- Mandatory training was completed via an online learning management system or in face-to-face training sessions. Managers were able to see from the system what training was required by each staff member and when it had been completed. The governance lead personal assistant held a spreadsheet of mandatory training, and a reminder was sent to individual staff to inform them when training needed to be completed.
- Mandatory training modules included fire safety, health and safety, infection prevention and control, safeguarding children and adults, basic life support, moving and handling and equality and diversity. Data supplied by the hospital showed that compliance was at least 85% for all standard modules. Role dependent training modules included controlled drugs, incident reporting and mental capacity act. Data provided showed that compliance for incident reporting stood at 50%.
- Bank and agency staff who worked in the outpatients and imaging departments were required to produce certificates to demonstrate they had completed the mandatory training. Bank staff in physiotherapy had access to the same online mandatory training as permanent staff members.

Assessing and responding to patient risk

- There was a process in place within the outpatients and imaging department for patients who were deteriorating. Staff would contact the resuscitation team that would include the residential medical officer, senior nurse, matron and outpatients manager, who would assess the patient.
- If a patient needed to be transferred to an acute hospital an ambulance would be called. Staff within the imaging department told us how they had followed this process two weeks before our visit. A patient had stopped breathing and staff had called the resuscitation team who had responded promptly. Staff told us the alarm system was tested every week.
- If staff found something requiring urgent action on a scan they would contact the consultant radiologist and highlight it on the patient's file. Reports marked as urgent were prioritised.
- Within the physiotherapy area we observed staff undertaking a detailed patient assessment, obtaining medical history, functional ability and current emotional state. Staff discussed future prognosis with patients, and precise instructions were given for exercises. Staff recorded comprehensive notes during the assessment.
- A radiation protection advisor (RPA) was based at another hospital site, in accordance with best practice. They visited the hospital regularly to undertake physics testing on equipment and attend meetings. Staff told us that the RPA was readily available and they could contact them by email or telephone. In addition, a radiation protection supervisor was appointed as a permanent member of staff within the imaging department and was easily accessible for advice and guidance.

Good

Outpatients and diagnostic imaging

- Within the imaging department we observed the undertaking of the safety checklist with a patient who attended for MRI scan. This included checking the patient's name and date of birth, explaining the procedure, risk assessment (if patient had pacemaker or metal implants, previous surgery to the brain or heart and experience of epilepsy), patient signature for consent, ensuring patient comfort and showing them the emergency call bell system.
- Justification for X-ray, radiation dose and pregnancy status was recorded in the radiology information system.
- All patients for imaging were referred following consultation or treatment. There was a process in place to check for and obtain previously taken images in advance of any further scans or x-rays being performed. The hospital used the PACS RIS system for effective sharing of images between providers.
- Staff told us that use of contrast dyes was recorded on the radiology information system including the type volume and rate.
- Clear warning signs were seen on the door for the radiation area and magnet hazards within the imaging department.

Nursing staffing

- The outpatients department had a dedicated team of registered nurses, healthcare assistants, medical laboratory assistants, pharmacists, physiotherapists, radiologists, receptionists and administration staff.
- Staffing levels were considered and agreed two days prior to clinics by which time managers were aware of clinic type and numbers attending. There was no specific acuity tool used to assess staffing levels. The department used staffing flexibly to address patient's needs.
- At the time of our inspection the outpatients department employed one full time equivalent (FTE) clinical manager, 5.6 (FTE) registered nurses, three FTE health care assistants (HCAs) and four part time HCAs.
- There were no vacancies within the outpatients department at the time of our visit.
- The outpatients department used bank (temporary) staff on a regular basis. Bank staff were expected to demonstrate that they had successfully completed mandatory training and were provided with a hospital induction programme. Agency staff were not used.
- We saw staff rotas for the outpatients department that showed from Monday to Friday during core hours between five and nine nursing staff were usually on duty with between two and five HCAs, depending on the service needs for that day.
- Staff and patients informed us, and we observed, that staffing levels were at an adequate level to be able to meet patient's needs.
- The physiotherapy department had one FTE clinical manager, five FTE physiotherapists, two of whom were juniors, one physiotherapy assistant and three part time staff. A hand physiotherapist was used on a sessional basis. Bank staff were used when there was a service demand. There were two vacant posts within the department for which there was a rolling recruitment programme. Two members of staff were required to be present within the department at any given time.
- The imaging department employed one FTE clinical manager and six radiographers. There was one radiographer vacancy. Staff told us the post had been recruited to and the member of staff was due to start the following week.

Medical staffing

- The hospital had three residential medical officers (RMOs) sourced through an external agency. The RMOs were given an induction by NES Healthcare as well as a hospital induction. They were expected to complete mandatory training provided by the hospital and participate in regular cardiac arrest scenarios.
- There was 24-hour RMO cover at the hospital. Staff told us they could easily contact the RMO for advice or to review a patient and that they would respond promptly.
- There were 14 consultant radiologists within the imaging department. Staff told us they felt there was good communication with the consultants. Staff told us there was sometimes a gap in the provision of consultant radiologists when there was a change in shift, although this did not usually last for long and had never caused a problem.

Good

Outpatients and diagnostic imaging

Emergency awareness and training

- Spire Healthcare had a business continuity plan issued in November 2015 and due for review in 2018. Staff within outpatients told us that they had no training or skills in relation to major incidents. but records show training was provided in fire safety, resuscitation, managing violence and aggression and in caring for a deteriorating patient in an emergency situation.
- Staff in the imaging department told us that there were back-up generators in case of power failure.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the outpatients and imaging department. We found that:

- Care and treatment was evidence based, and policies we reviewed were up to date.
- Staff in the outpatients department had introduced a minor procedures guideline for consultants to follow. This aimed to ensure patient consent was obtained and improve patient safety.
- All HCA and nursing staff in the outpatients department had received an appraisal known as 'enabling excellence'.
- Staff involved with the planning and delivery of care for children received training in Paediatric Basic Life Support (PBLS) and Safeguarding Level 3 for which they were 100% compliant.

However:

- The director of infection prevention and control (DIPC), lead nurse and link staff did not have specific training for their responsibilities. However, they accessed specialist advice from external experts when required.
- Only 66% staff had undertaken training in Mental Capacity Act (MCA).

Evidence-based care and treatment

- Staff told us they worked to local and national Spire Healthcare policies and procedures following best practice such as National Institute for Health and Care Excellence (NICE) guidelines, which were reviewed and updated by the governance team.
- Staff in the outpatients department had introduced a minor procedures guideline for consultants to follow. This guideline aimed to ensure patient consent was obtained and increase patient safety during all minor procedures. The World Health Organization (WHO) safety checklist had been included within the guideline after staff had consulted the National Safety Standards for Invasive Procedures (NATSSIPS) guidelines.
- Physiotherapy staff used the NICE guidance on low back pain and sciatica in over 16s: assessment and management. This enabled staff to consider the most appropriate physical, psychological, pharmacological and surgical treatments to help people manage their low back pain, with the aim of improving patient's quality of life by promoting the most effective forms of care.
- The imaging department had local policies for intravascular contrast dye administration and parametric prostate magnetic resonance imaging (MRI) which were set out in line with the guidelines of the Royal College of Radiology.
- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross referenced to national audit levels and if they were found to be high a report was made to the radiation protection advisor (RPA).
- Clinical guidelines and standard operating procedures were developed locally with the input of the relevant clinician and pharmacy manager. For example, we saw antibiotic guidelines involved the microbiologist and pharmacy manager.
- We saw other examples of national guidance being applied in practice, for example, NICE Guidance (NG5) – Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes (March 2015).

- We reviewed a number of policies and procedures in the department and found that they were up to date and relevant to practice. Policies were available for staff to view on the hospital intranet and in hard copy policy documents available onsite.

Pain relief

- We observed staff discussing pain relief with a patient undergoing physiotherapy. Staff assessed the patient's pain level and gave advice about appropriate medication and methods of pain management.
- Complementary therapies, such as acupuncture, were used in physiotherapy to help with pain management.
- We looked at nine medical records and saw that pain management assessments were routinely completed, signed, dated and acted upon.
- Patient feedback results from January to December 2015 indicated that 99.4% of patients reported that staff did 'a fair amount' or 'a great deal' to control their pain.

Nutrition and hydration

- We reviewed nine patient medical records and saw that patient's nutrition and hydration needs were being assessed and met. Staff consistently completed the Malnutrition Universal Screening Tool (MUST) during assessment.
- For the period February to June 2016 the hospital's PLACE (Patient-led assessments of the care environment) score for food was 89% which was lower than the England average.

Patient outcomes

- Within physiotherapy a patient specific functional scale (PSFS) was used to record treatment outcomes for all patients. The PSFS is a subjective measure of client centred activities related to their musculoskeletal injury. It is used to measure the improvement of activity performance throughout an episode of care. The hospital reported an 89% improvement rate. We observed physiotherapy staff making good use of this measurement tool with a patient post knee surgery.
- A visual analogue scale (VAS) was used to record patient's pain levels within physiotherapy. If staff were concerned about a patient's recorded pain level they would liaise with consultants and use acupuncture to ease the pain where appropriate.

Competent staff

- All staff in the outpatients and imaging departments undertook an appraisal known as 'enabling excellence'. Staff objectives were set at the beginning of the year, reviewed mid-year and completed at year-end. During appraisals individual learning requirements and performance issues would be discussed. All staff we spoke with said they had received their appraisal. Information received from the hospital before our inspection confirmed that all appraisals for nursing staff and HCAs within the outpatients and imaging department were up to date.
- Staff who recently started at the hospital told us they had completed an induction programme which they found informative. HCAs undertook a one day formal induction process and were then supervised by another member of staff for two weeks, ensuring that they were competent with the processes. Within imaging new staff would undergo a hospital wide induction and then a specific induction which would help them become more familiar with the department procedures and use of the imaging equipment. New staff had competencies to complete, and would be paired with a radiographer until these had been signed off by the supervising attendant.
- Nursing staff in the outpatients department told us they were supported to complete their revalidation which was signed off by the outpatients manager.
- Physiotherapists received one to one supervision on a weekly basis. Staff were given protected time each month to complete continuous professional development. This could be by peer review, listening to podcasts or having consultants contribute to their training.
- The hospital told us that all health care professionals in the imaging department were registered with the Health and Care Professional Council.
- Physiotherapists using acupuncture were British Medical Acupuncture Society (BMAS) trained. One physiotherapist had extended scope training and therefore able to provide expert knowledge for complex cases. Staff were given monthly refreshers on using the gym equipment.

Good

Outpatients and diagnostic imaging

- The director of infection prevention and control (DIPC), lead nurse and link staff told us they had not undertaken additional training for their responsibilities. However, they accessed specialist advice from external experts when required and told us they had an interest and experience in the subject matter.
- Within the outpatients and imaging departments there were no paediatric nurses in post. Staff involved with the planning and delivery of care for children received training in Paediatric Basic Life Support (PBLS) and Safeguarding Level 3 for which they were 100% compliant. There was no specific paediatric pathway or local procedures. However, when staff required advice they could contact the children's nurse based at Spire Wellesley Hospital.
- Opportunities for staff development were usually supported by managers. One member of staff within the imaging department told us how they had been able to develop their role by attending management fundamentals training. A member of staff in the outpatients department told us that during their appraisal they had identified that they wanted to develop their knowledge in hysteroscopy. They had been supported by managers to do this and had found this beneficial in developing their skills.

Multidisciplinary working

- Multidisciplinary working was encouraged within the service. Staff told us that there were good working relationships within and across teams. Nursing and HCA staff said they were able to speak openly with consultants. Staff were able to share concerns or best practice at departmental safety huddles.
- Spire Healthcare held a national multidisciplinary team meeting every week purely for breast care. The meeting was managed through an intranet application service where patient's details, radiological and laboratory results were recorded. A meeting would be requested by the oncology lead at Spire Roding Hospital, and the Spire co-ordinator would organise oncology, radiology and surgeon participation. Patient outcomes were recorded and placed on the relevant medical file. The meeting was held remotely via telephone conference and Spire consultants could view images through picture archive communication system mail. The hospital informed us that they had no patients on the Spire multidisciplinary meeting between September and November 2016.
- One consultant told us they attended weekly meetings with the imaging department for group learning. This had helped a good working relationship develop between them, assisting in the sharing of information and clinical knowledge.

Seven-day services

- The outpatients department was open Monday to Friday between 8am and 9pm, and on Saturdays between 8am and 7pm for specific clinics. The physiotherapy department was open Monday to Fridays 7.30am to 9pm, and on Saturdays between 7.30am and 1pm.
- The imaging service was available six days a week with an on call service out of hours. If a radiologist was required out of hours they would be contacted for assistance by the hospital. Consultant radiologists were able to view urgent images remotely, but would attend site to formally report on images.
- A resident medical officer was on site 24 hours a day, seven days a week.

Access to information

- Staff accessed hospital polices on the intranet. The policies we reviewed were up to date.
- Samples of blood and urine samples were taken to the hospital specimen laboratory centre and sent to another Spire hospital in Brentwood for processing. The majority of histology specimens were sent to the same Spire Hospital in Brentwood with a few being tested at another acute NHS hospital. Nurses labelled the specimens and entered them within the pathology register. There were two collection times, once in the morning and once in the afternoon. Results would then be made available to the specimen laboratory centre electronic log. Results for blood counts were available within hours whereas more specialised histology tests could take weeks. Staff told us that the system worked well and that the outpatients manager was readily available for any queries.

Good

Outpatients and diagnostic imaging

- The imaging department used the picture archive communication system (PACS) to store and share images. The radiology information system was used to store patient details, dose information and for reporting.
- The hospital had provided secretarial support in the past 6 months to assist with sending letters to GPs. The letter was typed and sent to the relevant consultant, who would be given 48 hours to sign. If it was not signed within this timeframe the letter would then be sent and signed on behalf of the consultant. Staff told us that letters were typed and sent between seven and ten days of the patient being seen in clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a policy for the Deprivation of Liberty Safeguards (DoLS) issued in April 2016.
- Data provided by the hospital indicated that only 66% required staff had received training in the Mental Capacity Act (MCA). Staff told us that they seldom had to put the training in to practice, but if an issue arose, they would discuss it with the outpatients manager. Consultants we spoke with said that they rarely saw patients who lacked capacity.
- Consent for physiotherapy treatments was documented on the patient's registration form. There was an additional consent form for acupuncture, and verbal consent was taken before each session began.
- We viewed nine patients' medical records and saw that consent was consistently being documented, signed and dated.
- The service was introducing a new form for minor procedures where consultants had to demonstrate that consent had been obtained. We viewed 10 minor procedure plans completed between 4 November and 15 November 2016, for which consent had been gained in all cases. On one record the date was omitted. Verbal consent had been obtained for one colposcopy procedure.

Are outpatients and diagnostic imaging services caring?

Good

We rated the outpatients and imaging department as good for caring because:

- All patients we spoke with spoke highly of the care they received at the hospital.
- Staff were seen to interact with patients and their relatives in a considerate manner and patient privacy and dignity was respected.
- From January to June 2016 the hospital wide Friends and Family survey scored above 97% for the number of patients who would recommend the hospital.
- Patients told us they felt fully involved in decisions around the care and treatment.

Compassionate care

- All patients that we spoke with within the outpatients and imaging departments spoke highly of the care they received from staff at the hospital. No negative comments about the caring and compassionate aspects of the service were given.
- Patients told us: 'the kind of quality you see is incredible', 'there are good opportunities to ask questions', and 'communication ahead of the appointment was excellent'.
- One patient informed us that they had two appointments cancelled, the first of which they had not been told about until they arrived at the hospital. They told us that they still chose the hospital as the nursing staff were good and facilities were excellent.
- Staff were observed interacting with patients and their relatives in a respectful and considerate manner.
- Staff respected patients' privacy and dignity. Individuals were provided care and treatment within individual consultation rooms where doors were closed. We observed staff knocking on doors before entering.
- Seats in the main outpatients waiting area were positioned sufficiently away from the reception area to allow patients to have private conversation with reception staff.

Good

Outpatients and diagnostic imaging

- From January to June 2016 the hospital wide Friends and Family survey scored above 97% for the number of patients who would recommend the hospital. This was similar to the England average score across the same period. Response rates to the survey were on average 18% for the same period, which is below the England national average.

Understanding and involvement of patients and those close to them

- All the patients that we spoke with said that they fully understood why they were attending the hospital. Patients told us they were involved fully in discussions about procedures and treatment options, and were given time to make decisions and ask questions.
- One patient we spoke with said that when they had seen the consultant the procedure was explained fully so they knew what to expect. The patient's partner confirmed they had been involved in the discussions and was happy with the treatment their partner had been given.
- Physiotherapy staff told us they recommended the best treatment option available to the patient, but would listen to the patient and adapt their practice once all options had been discussed as long as no risks were involved.
- Patients told us they had seen letters sent from the hospital to their GP.

Emotional Support

- We observed that staff were happy to answer patients' questions and provided leaflets on several different conditions and treatments.
- We saw staff spend time talking to patients and showing empathy and encouragement to complete aspects of therapy.
- In physiotherapy we observed staff discussing patient's wellbeing with them. Staff were aware of the emotional impact of pain on patient well-being and the patient's quality of life was assessed along with clinical improvement and effectiveness of treatment.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Patients told us they were able to get an appointment with the hospital quickly and easily.
- The service had a dementia strategy in place that adhered to the Royal College of Nursing guidelines.
- Chaperone and interpreting services were available to meet individual patient's needs.
- From July 2015 to June 2016 the outpatients department was regularly meeting its referral to treatment times.
- The hospital had launched a new fast track breast clinic with a full field mammography machine.

However:

- The separate area in outpatients for families with children was not clearly designated.
- Within the outpatients department there was no clearly defined patient pathway for patients with a learning disability.
- Managers told us there were concerns about waiting times during clinics due to consultant delays or not attending. Data for waiting times had not been historically collected by the service.
- Managers were not consistently meeting the 20 day response time for complaints and action plans were not always completed within the complaint files.

Service planning and delivery to meet the needs of local people

- Managers told us there had been an improved relationship with the local clinical commissioning group (CCG) over recent months. Senior managers from the hospital met with the CCG on a quarterly basis to plan for people's care, with more regular contact via telephone and email.

Good

Outpatients and diagnostic imaging

- The patients we spoke with told us they were able to get an appointment with the outpatients department quickly and easily. Some patients booked through the e-referral system that enabled them to book an appointment suitable for their individual needs.
- Evening and weekend appointments were available to patients depending on consultant speciality, providing flexibility to patients working during the week.
- There was adequate seating in the main outpatients waiting area. There was access to hot drinks. Staff told us that if a patient was hungry they were able to get them something to eat from the staff restaurant.
- A separate area in outpatients was designated for families with children, although this was not clearly demarked. On the day of our visit adults without children were waiting in the area. Some children's toys were available and a notice indicated that more children's activities were available at reception. There was no separate children's waiting area within the imaging department.
- Signposting could be seen both at the front of and within the hospital. Not all areas of the outpatients department were easily navigated. For instance, there were two imaging receptions: the main reception for X-ray and ultrasound where patients had to book in and one for MRI and CT scan, but it was not always clear where patients had to go. The reception area for MRI and CT scans was not always manned. Staff said they would always help patients with directions if asked.
- Patients at the hospital told us they had access to free parking and there were usually spaces available.
- Patient leaflets were available in outpatients waiting areas providing information about different procedures and conditions. Limited information was provided in different languages or alternative formats such as 'easy read' or large print.

Meeting individual people's needs

- Within the outpatients department there was no clearly defined patient pathway for patients with a learning disability. Staff said that they often had little notice that a patient with a learning disability would be attending and were unable to give us examples of how they would assist this patient group. An audiologist told us that they were able to seek advice from the British Academy of Audiologists regarding patients with a learning disability.
- The service had a dementia strategy and referred to Royal College Nursing guidelines when caring for people with dementia. Staff within outpatients told us that they rarely cared for patients with dementia, but that where necessary they would seek advice from the patient's consultant so that a decision around care and treatment could be made.
- The hospital had formulated a mental health strategy that was due to be ratified the week after our inspection. The strategy involved referring patients between the ages of 18 to 65 who required mental health services to the acute NHS services. The service was provided 24 hours a day for seven days a week. There was currently a consultant available at the hospital that was able to undertake mental health assessments for independently funded patients, although this was not a formal arrangement.
- Notices were displayed around the hospital offering chaperone services to patients. Staff told us that a nurse or HCA would always act as a chaperone within the gynaecological clinic, for example. Within the imaging department a HCA was always present with the radiologist during ultrasound scans.
- A telephone interpreting service was available for people who required translation. If the need was identified on the referral form then this would be booked in advance, although staff told us that there were rarely difficulties in accessing the service on the day when the patient arrived for clinic.
- The outpatients department was based on the ground floor and there was good level access throughout. Accessible toilet facilities were available close to the main outpatients waiting area. The physiotherapy department had equipment which was adapted for patients using wheelchairs.
- In the imaging department cubicles and lockers were provided for patients to get changed. Within physiotherapy patients had the option to change within the private changing rooms, but this was not enforced if they felt uncomfortable doing so.

- Staff told us that a consulting room could be provided for prayer if a patient requested.

Access and flow

- From July 2015 to June 2016 the hospital met its target of 95% patients starting non-admitted treatment within 18 weeks of referral, with the exception of December 2015 when 94% started treatment within that timeframe. For incomplete pathways of referral to treatment, the hospital consistently met its target of 92% within the same period.
- NHS patients were usually referred by their GP and could book an appointment via the e-referral system. This system enabled patients to view current waiting times for first appointments, and choose a time and date which was convenient for them. From October to December 2016 the average waiting time for outpatient appointments was 38 days. Appointments for the orthopaedic clinic were quicker, an average of 28 days, as more clinics had been made available. Independently funded patients would normally receive an appointment within two working days and an SMS text message would be sent as confirmation.
- Staff told us that appointment slots were not always available on the e-referral system and patients would need to wait for the next available appointment. Where this was the case managers told us they worked with consultants to try and provide extra clinics. For example, the hospital had seen an increase in patients with shoulder conditions and appointment availability was not meeting demand. Two months prior to our visit the hospital had agreed with consultants to introduce two extra clinics each week to deal with these types of injuries resulting in extra appointments being available to patients.
- The standard waiting time for physiotherapy after surgery was two weeks. Staff told us they were able to work flexibly and appointment slots were available for urgent patients.
- When the hospital received a referral the paperwork was passed to the pre-assessment team to ensure all required information was present. Administrative staff would then send the patient an appointment letter. Letters would include a map and a health questionnaire for the patient to complete before attending. If the appointment was for the orthopaedic clinic a form would be sent asking the patient details of any previous MRI/CT scans they may have had so that information relating to these could be requested.
- Patients attending the imaging department would be seen by the consultant initially. The consultant would complete a referral form which the patient would take to the imaging department. The radiographer would check the referral to ensure all details were completed and that the test could go ahead.
- Depending upon availability patients would be seen on the same day, which was often the case for patients requiring CT scans. Patients needing MRI scans would normally be given an appointment to return. From July 2015 to June 2016 the hospital had no patients waiting longer than six weeks from referral for MRI, CT or non-obstetric ultrasound.
- Digital images from CT and MRI scans were available for staff to view on the PACS system. Reporting was undertaken on the radiology information system. Many images were ready to view immediately, with the remaining Images ready within two working days. Staff said they ensured that images were available by the patient's next appointment with the consultant. Use of the viewmotion system meant that consultants could view images if they were at another hospital, within 15 minutes of them being uploaded.
- The hospital had launched a new fast track breast clinic with a full field mammography machine. The breast clinic operated a walk in system, and was open Monday to Friday with late opening on Thursday evenings until 9pm.
- Managers within outpatients told us there were concerns about waiting times during clinics. Staff said that this was normally due to consultants either being delayed for clinic or not attending. Consultants were expected to inform reception staff if they were delayed in theatre, who would in turn keep patients and the outpatients manager informed. Data for waiting times at clinic appointment was not available to us during our inspection, as it had not historically been collected by the outpatients department. However, following our inspection managers informed us that a system had been put in place in December 2016 for waiting times to be recorded.

Good

Outpatients and diagnostic imaging

- Managers told us that when consultants were regularly late this was challenged and raised with the hospital director. We were told about one consultant whose services had been withdrawn from the hospital earlier that year for regular lateness without reason.
- Staff told us that consultants were asked to inform them six weeks in advance if they had to cancel a clinic which they normally would do. The patient would be contacted by telephone and an SMS message sent to alert them. Between October and December 2016 the outpatients department had 13 cancelled clinics. Seven of the clinics were avoidable and affected 32 patients, six of the clinics were unavoidable affecting 23 patients.
- From October to December 2016 12,433 appointments were made within the outpatients department and 403 (3%) patients did not attend their appointment. The data did not include minor procedures or physiotherapy appointments. The department did not have an action plan in place to assess and improve DNA rates.

Learning from complaints and concerns

- Between July 2015 and June 2016 the hospital received 52 complaints, of which two were referred to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).
- We saw 'Please talk to us' leaflets available to patients within the outpatients department which explained how a complaint could be made.
- Within the outpatients department complaints were reported on the hospital electronic system and then investigated. Staff told us an acknowledgement was sent within two days of the complaint and a formal response within 20 days. The head of departments attended a weekly meeting where complaints were discussed and lessons shared.
- Staff told us they tried to deal with complaints and concerns as they arose. Physiotherapy staff referred patients with any complaints or concerns to the manager. For example, recently a patient complained that a staff member had not been focused during their treatment. The manager spoke with the patient regarding the complaint, and gave feedback to the staff member involved, dealing with the complaint to the patient's satisfaction.
- We reviewed five complaints files and found that all five complaints were initially responded to within a timely fashion, had thorough investigations with a response and updates recorded. Three of the complaints had holding letters sent at the time of final response so as to extend the investigation period, two of the complaints did not have risk assessments recorded and three did not have actions plans completed although actions had been identified within the complaint response.
- The service had recently introduced a weekly complaints update meeting attended by the head of clinical services, hospital director, governance and compliance manager. Heads of departments who were investigating an open complaint would attend the meeting to provide an update and complaints were reviewed against the 20 day response timescale.
- Managers recognised that they were not consistently meeting the 20 day response time for complaints, and regularly required an extension. This was a particular problem when the complaint involved a consultant where no information was available from hospital records, and a response from the consultant was required. They indicated that they were hoping to address this through the newly set up weekly complaints review meetings, and working more closely with consultants.
- Learning from complaints was discussed at the monthly incidents, complaints and customer satisfaction committee. Learning was shared with staff in departmental meetings and displayed on notice boards.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Managers showed commitment to improvement and were eager to provide consistency and direction.
- Staff felt that managers were approachable and supportive.
- Staff told us that the senior management were visible within the department and encouraged an open and transparent ethos.

Good

Outpatients and diagnostic imaging

- The hospital had an inspiring people committee which awarded staff deserving recognition, and staff told us they felt valued by senior management.

However:

- Some managers found the risk register challenging to maintain because of its size. Whilst staff were able to articulate actions being taken to mitigate risks on the register, these were not always clearly recorded.
- Actions were not always promptly closed by the clinical governance committee.
- A patient survey specific to the outpatients and imaging department was not yet in use.

Leadership and culture of service

- There were clear lines of accountability and responsibility within the outpatients and imaging department. The senior management team comprised of the hospital director, the head of clinical services, business development manager, theatres manager and finance and operations manager. The outpatients and imaging service were led by the outpatients manager, radiology manager and physiotherapy manager.
- The managers of the outpatients and imaging departments reported to the head of clinical services. At the time of our inspection there was an interim head of clinical services (after the permanent post holder had left in September 2016). During this interim period managers had not received formal one to one supervision meetings as they had done previously. However, they felt able to raise issues with senior managers as and when they arose. The hospital was due to recruit permanently to the head of clinical services post the week following our visit.
- Staff within the imaging department told us they had had four managers within the last seven years.
- The senior management team recognised that there had been a substantial turnover in management staffing in the past 18 months. New managers had been recruited, however, there were still gaps within the management structure and key positions to be filled.
- All staff within the outpatients and imaging departments said that their managers were approachable and supportive. Many staff commented that there had been improvements in leadership within the departments over recent months.
- Staff said they felt encouraged by managers to improve and develop their skills and knowledge. However, some staff told us they had been unable to access leadership training although it had been requested.
- All staff we spoke with in the outpatients and imaging departments said that it was a good supportive environment in which to work. There was collaborative working within the department and staff indicated that they felt able to raise issues with consultants and senior staff members.
- The senior management team encouraged an open and transparent ethos. Staff said that there was a 'no blame' culture. Staff we spoke with said that the hospital senior management team were visible and staff felt at ease raising issues with them.
- From July 2015 to June 2016 sickness rates in nursing staff within the outpatients department were variable, peaking at around 10% in February 2016. Sickness amongst HCAs was lower in comparison to other independent acute hospitals within the same period.
- There was no staff turnover for outpatients nurses from July 2015 to June 2016. The rate of health care assistant turnover was around 12% which was higher in comparison than in other independent acute hospitals.
- The outpatients manager recognised the challenges with staff sickness and staff turnover. She said that bank staff were used to cover shifts regularly.
- Enabling excellence plans were devised to help staff develop their role and identify learning needs through appraisal. Where performance issues were identified a performance improvement plan was put in place with individual objectives to encourage people to progress.

Vision and strategy for this core service

- All staff that we spoke with were aware of the hospital's corporate vision which was 'making a difference

everyday'. They told us they had been involved in choosing the vision and viewed patient care as a priority. Staff were seen demonstrating expected behaviours and values.

- Managers within the outpatients and imaging departments expressed ideas for the development of the departments. They showed commitment to improvement and were eager to provide consistency and direction.
- Staff we spoke with told us about future plans for further refurbishment and improved facilities within the department. Several of these were documented within the hospital's three-year plan.

Governance, risk management and quality measurement

- Governance structures were clear. The hospital had 14 specialised committees which fed in to the clinical governance committee. The clinical governance committee reported to the medical advisory committee.
- The clinical governance committee met on a quarterly basis and was attended by the hospital director and heads of departments. The committee had an oversight of risk and quality issues. Items discussed at the meetings included incidents, complaints, clinical effectiveness, patient safety and experience, risk management, governance and compliance and staff mandatory compliance.
- Actions were not always closed off promptly. We saw draft minutes from the clinical governance meeting in November 2016 which followed a comprehensive agenda. We found that of 12 actions reviewed from the previous meeting minutes, six were ongoing. One of these concerned feedback from a controlled drugs (CD) audit dating back to April 2016 for which no update was available as the pharmacy manager was absent. The committee action log indicated that some actions from the CD audit still remained open. Within the November clinical governance meeting it was noted that three further CD incidents had occurred.
- Departmental meetings took place on a monthly basis where incidents and learning were shared with staff, and staff could report up to the head of departments. Outcomes of these meetings were fed in to the hospital senior management team. Key messages from management meetings were emailed to all staff. Hospital managers told us that communicating with staff could be challenging due to the number of part time staff, and were not confident that all staff were aware of key learning points and incorporating them into their practice.
- The senior management team met monthly to review the hospital wide risk register and track the top level risks. We saw the hospital risk register which categorised risks depending on severity.
- Senior managers acknowledged that the hospital risk register was a large document that was challenging to maintain. Managers told us that the risk register was regularly reviewed and were able to articulate actions being taken to mitigate risks. However the actions were not always clearly recorded on the register. For example, a delay in blood specimen sampling was entered on to the risk register in March 2016. This was reviewed in November 2016 but there was no evidence of actions taken to reduce the risk.
- The outpatients department held its own risk register that was maintained by the outpatients manager. We reviewed the risk register and saw that maintenance and cleaning of the carpets was one of the risks raised. Managers told us that there were plans for refurbishment in 2017. When we asked staff about what they felt could be changed within the hospital responses were based around improved cleanliness and refurbishment. This demonstrated that risks and improvements were shared at all staff levels.

Public and staff engagement

- Staff told us that a patient survey specific to the outpatients and imaging department was not yet in use. The hospital was in the process of launching an outpatients feedback form which would help them identify patient need and areas for service improvement.
- The hospital has a customer satisfaction action plan which was monitored by the customer satisfaction committee. Department managers would provide identified patient feedback to the committee so that appropriate actions could be considered.
- From July 2015 to June 2016 the hospital received six items of rated feedback on the NHS choices website.

Four indicated a rating of 'extremely unlikely to recommend' and two a rating of 'extremely likely to recommend'. Negative comments included lack of action and sensitivity provided by specialists, dissatisfaction with treatment and advice around pain management, and an administrative appointment error. Positive comments included caring and attentive staff and being treated with dignity and respect.

- Managers were in the process of setting up a patient forum having written to patients inviting them to become a member.
- Staff were kept up to date about hospital plans and able to ask questions at hospital briefings and head of department question times. Staff also received a quarterly newsletter.
- Staff within the hospital told us they felt appreciated and valued by senior managers. The hospital had an inspiring people committee which awarded staff deserving recognition after receiving nominations. One staff member we spoke with had been awarded an 'inspiring people award' after being nominated by colleagues for their willingness to help.

Innovation, improvement and sustainability

- The hospital had undertaken a refurbishment of some of the outpatients department, reception area, and orthopaedic centre. All staff we spoke with were happy with the improvements made. Final areas of refurbishment were planned for 2017 to bring the whole hospital up to the same standard.
- The hospital had launched a new fast track breast clinic with a full field mammography machine. The breast clinic operated a walk in system, and was open Monday to Friday with late opening on Thursday evenings until 9pm.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff have appropriate up to date DBS clearance.

Action the provider SHOULD take to improve

- The provider should ensure local processes for cleaning equipment are applied consistently, so staff can readily identify if equipment is ready for use and when it was last cleaned.
- The provider should ensure that only one endoscope is processed in the endoscopy decontamination area at any one time, to reduce the risk of cross-contamination.
- The provider should ensure that all storage facilities are used only for their intended purpose to minimise any compromise to infection, prevention and control standards.
- The hospital should consider removing all carpets within the consultation rooms and waiting areas in line with best practice.
- The provider should consider implementing hands free taps, such as elbow operated taps,in the dirty utility area in line with best practice.
- The provider should ensure all consent forms are completed appropriately and that confirmation of consent is documented and signed prior to the patient's procedure.
- The provider should ensure consultants provide legible copies of patient letters and clinic notes to the hospital in a timely way.
- The provider should continue to collect data and undertake audits in relation to waiting times during outpatient clinics, and take actions to improve waiting times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed At the time of our inspection seven members of staff were working at the hospital without background and criminal record checks. 40 staff members were awaiting criminal records checks to come back (noted as an 18 week wait at the time of inspection). This was a breach of regulation 19(1): Persons employed for the purposes of carrying on a regulated activity must— (a) be of good character, (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and (c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed; and 19(2): Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in— (a) paragraph (1)