Spire Healthcare Limited

Spire Gatwick Park Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

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

We rated this service as good because it was safe, effective, caring, responsive and well-led. In medical care (endoscopy only) service, we did not rate caring as we do not have sufficient evidence to rate. We currently do not rate effective in outpatients and diagnostic imaging services.

However:

- There was limited storage space for equipment in the recovery area of theatres.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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

Diagnostic imaging is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, caring, responsive and well led. We do not rate effective in Diagnostic Imaging as we do not have sufficient evidence to rate it.

Outpatients

Good

We previously inspected outpatients with diagnostic imaging jointly therefore we cannot compare our new ratings directly with previous ratings.
We previously inspected outpatients with diagnostic imaging jointly therefore we cannot compare our new ratings directly with previous ratings.
We rated it as good because:

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

Summary of findings

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

Outpatients is a small proportion of the hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, caring, responsive, and well led. We do not rate effective in the outpatient service as we do not have sufficient evidence to rate it.

Surgery

Good

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them

Summary of findings

on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

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

However:

- The environment risk assessment identified limited storage for equipment in the recovery area of theatres

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

Services for children & young people

Good

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to children and young people, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. The children's lead monitored the effectiveness of the

Summary of findings

service and made sure staff were competent. Staff worked well together for the benefit of children and young people, supported them to make decisions about their care, and had access to good information.

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

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

Medical care (Including older people's care)

Good

We have not previously inspected the medical care (endoscopy only) service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

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- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
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Endoscopy is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the Surgery section.
We rated this service as good because it was safe, effective, responsive and well-led. We did not rate caring as we did not observe any patients receiving endoscopy procedures. Please see the caring section of the surgery report for further details.

Summary of findings

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Summary of this inspection

Background to Spire Gatwick Park Hospital

Spire Gatwick Park Hospital is operated by Spire Healthcare Limited. The hospital opened in 1984 and is a private hospital located in Horley, Surrey. The hospital primarily serves the communities of Surrey, Sussex and South London. It also accepts patient referrals from outside this area.

Spire Gatwick Park Hospital provides surgery, endoscopy, outpatients and diagnostic imaging services to adults and children and young people. Outpatient services for children and young people from birth to 18 years of age include; consultations, plaster cast applications, micro-suction, dressings, suture removal, minor surgery, electrocardiography, physiotherapy and X-rays. The hospital provides day case only services that are interventional for children from three to 18 years of age. Care and treatment are provided to people who are self-funded, through private medical insurance and NHS funded.

The hospital has two wards and one day care unit, with a total of 56 bedrooms. The majority of rooms have ensuite facilities with TV and WIFI. The hospital has three theatres (two with laminar flow) and one endoscopy unit. The outpatient department consists of two areas with consulting rooms, treatment rooms for minor procedures and specialist rooms. Outpatient specialist rooms included one for ophthalmology with specialist equipment for examining eyes and a room for gynaecology with specialist equipment for examinations. The diagnostic imaging service includes computerised tomography (CT), magnetic resonance imaging (MRI), digital mammography, ultrasound and plain film X-ray. There are no emergency facilities at this hospital.

The hospital also offers other services such as physiotherapy, an on-site pharmacy, on-site sterile services and a pathology laboratory accredited by the UK Accreditation Service (UKAS).

There are 192 surgeons, anaesthetists and physicians working at the hospital under practising privileges.

The hospital is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostics and screening procedures.
- Family planning
- Services in slimming clinics
- Management of supply of blood and blood derived products

The hospital has a registered manager who has been in post since December 2019. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

The hospital was previously inspected in 2015 and rated as requires improvement, when we found regulation breaches. We subsequently carried out a focused inspection in 2017 to follow up on compliance actions from those identified regulation breaches, and found they have now been met. We did not re-rate the hospital in 2017 as it was a focused inspection.

Summary of this inspection

We inspected Spire Gatwick Park Hospital using our comprehensive inspection methodology. We carried out a short notice announced inspection on 26 October 2021.

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

How we carried out this inspection

During the inspection visit, the inspection team:

- assessed and visited the surgical and medical care which included the endoscopy unit, wards, reception and outpatient areas, pre-assessment area, day care unit, theatres, sterile services department, diagnostic imaging and children and young people services.
- reviewed the overall governance processes for the hospital and reported this as part of the well-led domain.
- spoke with 53 members of staff including senior leaders, managers, doctors, nurses, allied health professionals and support staff, nine patients and four parents, relatives and carers.
- observed patient care and procedures with their consent, looked at patient waiting areas and clinical environments, and attended staff huddles.
- reviewed 12 patient care and treatment records, five incidents, seven complaints and seven compliments.
- looked at a range of hospital policies, procedures and other documents relating to the running of the services.

After the inspection visit, the inspection team:

- spoke with parents of children and young people and carried out virtual interviews with two senior members of staff.
- reviewed further service information such as performance, training compliance, audits, policies, feedback from patients, staff and the local hospital trust.

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

Outstanding practice

We found the following outstanding practice:

- Outpatient services recognised the limited access and long waits locally and nationally for two areas; they implemented a new ophthalmology laser treatment service to improve patients' sight and a new treatment for osteoarthrosis of the knee joint shown to reduce pain and increase function for patients. Managers therefore planned and set up services to meet the needs of the local population.
- Children and young people service introduced a weekend gastro clinic, to provide a 'one stop service' for all gut related conditions. The aim of this was to improve access where children and young people could seek consultation, allergy tests, X-rays, advice from a psychologist and dietician all in one appointment.

Summary of this inspection

Areas for improvement

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

Action the service SHOULD take to improve:

- The surgery service should consider adding storage for equipment in the recovery area of theatres identified on the environment risk assessment.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Insufficient evidence to rate	Good	Good	Good	Good
Outpatients	Good	Insufficient evidence to rate	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
Medical care (Including older people's care)	Good	Good	Insufficient evidence to rate	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	Insufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

We previously inspected diagnostic imaging jointly with outpatients therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Training was mainly completed on line and included anti-bribery, compassion in practice, competition law, data protection, equality & diversity, fire safety, health & safety, infection prevention control (IPC), information governance, managing violence & aggression, and manual handling.

Managers monitored mandatory training and alerted staff when they needed to update their training.

At the time of our inspection compliance in the imaging department was very high with five of the above achieving 100% compliance; four of the above achieving 97.1% compliance and for the other two IPC was 94.3% and compassion in practice was 91.4%. The hospital standard is 95% to be achieved by 31 March 2022.

The head of imaging received monthly reports on the status of the staff compliance with the mandatory training standard, and the staff received notification if their training needed updating.

Clinical staff completed resuscitation training at appropriate levels and were 100% compliant with hospital expectation. Staff told us about a new resuscitation training process where a machine which gave instant feedback, and linked directly to the training system, was being introduced. Staff were being invited to do this updated training at the time of the inspection; the intention was that this training would be quarterly rather than annually.

Good

Diagnostic imaging

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. They explained that they saw patients with dementia and learning disabilities from local care homes on a fairly regular basis and had received training in how to work with these groups. They explained how they would risk assess the patients' needs and ensure enough time was available to encourage patients to cooperate with their imaging procedure.

Safeguarding

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding escalation flow charts, with contact details, were available and displayed for staff reference. Staff also knew the name of the hospital safeguarding lead and how to contact her; they told us they had received safeguarding team talks from her.

The clinical staff in the imaging team were trained to level 3 in safeguarding adults and children. All other members of the team received training in safeguarding adults and children appropriate to their role.

Please see the surgery report for further details of hospital policy.

Cleanliness, infection control and hygiene

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

All areas in the imaging department were clean and had suitable furnishings which were clean and well-maintained. We saw from the noticeboards in the department that the risks relating to COVID-19 had been well managed and staff continued to follow hospital policies relating to minimising all infection risks. At the time of the inspection all staff wore face masks and there were masks available for patients and visitors. Hand sanitisers were available in all areas and we saw staff and visitors to the department using them. Staff were bare below the elbows in all clinical areas.

We saw the most recent infection prevention and control audit results carried out at the department. These showed that the imaging department achieved 100% compliance for environment, hand hygiene and use of personal protective equipment.

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

Staff cleaned equipment after each patient contact, and labelled equipment to show when it was last cleaned.

Please see the surgery report for further details of hospital policies relating to COVID-19, general infection control for management of MRSA, MSSA, and clostridium difficile and decontamination processes.

Environment and equipment

Good

Diagnostic imaging

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

The design of the environment followed national guidance, and the waiting area met the current guidelines for social distancing measures. The setting enabled staff to observe and monitor patients waiting. Corridors and rooms were spacious, allowing staff to carry out scans and imaging tasks efficiently.

Rooms where ionizing radiation exposures occurred were clearly signposted with warning lights. Entry to the MRI scanning room was well-controlled. Some of the equipment in the department that must be kept out of this room, such as portable heaters, were labelled as such. All staff knew what could or could not be taken into the scan room. However, not all equipment was labelled effectively to ensure items were not taken into the room accidentally.

At the time of the inspection there had been an air conditioning failure in the MRI scanning room. This meant the scanner was out of use for a few days; initially, a mobile scanning unit had been sourced to ensure patient appointments could be maintained. New protocols and risk assessments were written along with training guides for staff who did not have previous experience working in a mobile unit, and the risk assessment carried out for moving patients between the department and the mobile unit.

The engineering team were still on site daily and a temporary work around with a mobile air conditioning unit stationed outside with vents into the building had been set up until a critical replacement part was available. This enabled the radiography staff to run the scanner for part of each day following rigorous checks. The incident was well documented with a post project debrief and timeline of what had happened and learning from the air-conditioning failure.

There was a new fluoroscopy unit which had a couch that could accommodate bariatric patients.

We reviewed equipment servicing records which demonstrated that Spire Healthcare used a centralised system for reporting equipment faults and staff told us that response from an appropriate engineer was prompt. Equipment collection and delivery notes and handover forms were kept in a folder, and signed by relevant staff.

Staff completed health and safety checks in the clinical areas, such as daily temperature, humidity, O2 levels and helium levels. Checks also included a weekly legionella check, along with specific technical checks on all equipment in operation.

We reviewed the resuscitation trolley in the department; this was clearly checked daily for content and expiry dates. The department also had access to a defibrillator which staff checked on a daily basis.

Staff wore radiation exposure monitoring devices which were evaluated by a specialist external organisation, and any exposure relayed to the department.

There were two radiation protection supervisors (RPSs) available for the department; their names and contact numbers were displayed and staff we spoke with knew who these people were and how to contact them.

Staff disposed of clinical waste in line with hospital policy, and sharps in line with national guidance. We saw sharps bins were dated and partially closed to prevent spillage.

Assessing and responding to patient risk

Good

Diagnostic imaging

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

The service complied with local rules, ionising radiation regulations 2017 (IRR17), and employers' procedures, ionising radiation (medical exposure) regulations [IR(ME)R. These regulations deal with the safe and effective use of ionising radiation; they were up to date, signed and displayed.

The 'Pause and Check' poster produced by the Society and College of Radiographers was prominently displayed, reminding staff of their responsibilities to identify the patient and the anatomy under investigation and record the exposure accurately and fully.

Staff responded promptly to any sudden deterioration in a patient's health. There was mandatory training in basic life support and more than half of the team had additional training in immediate life support skills. Staff visually monitored patients while imaging was being undertaken, so they could respond rapidly to any patient distress or deterioration. Staff were able to call the registered medical officer (RMO) for support 24 hours a day seven days a week.

Staff completed risk assessments for each patient on arrival, and reviewed this regularly, including after any incident. Referrals for imaging provided some details of patient risks, and staff spoke with patients before undertaking any radiation exposure to ensure exposure was justified.

MRI scanners use strong magnets to produce images, these can affect any metal implants or fragments in the body. Metal objects may also interfere with the magnetic field and can cause a safety hazard. Radiographers in the MRI area ensured all visitors and patients undertook a metal screening assessment before entering the scanning room. This involved completing a detailed questionnaire containing questions relating to previous operations such as hip replacement or cardiac monitoring where metal may remain in the body.

After inpatients were scanned, staff provided details of procedures and any contrast medicines when handing their care to others or back to the ward staff.

We observed staff carrying out imaging procedures; we saw that identity checks, and imaging history were confirmed in detail. This included confirmation of pregnancy status when appropriate. Identification checks were always followed by an explanation of risks from exposure to radiation.

Posters were displayed in waiting areas asking patients to inform the radiographers if they thought they may be pregnant. This was written in a variety of languages.

Staffing

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

The imaging department had 31 staff, this included a manager and deputy along with lead radiographers for x-ray imaging, CT scanning and MRI scanning. At the time of our inspection there was a vacancy for the MRI lead post which was filled by a radiographer in an acting position.

Good

Diagnostic imaging

The team included a mixture of radiographers, specialist sonographers and department assistants supported by an administration and reception team.

In the year to 30 September 2021 two staff had left the service, one of whom had retired and joined the bank staff. There were seven bank staff in total who were regularly employed in the department, familiar with the department practices, and fully up to date with all required training.

There was one vacancy, but the service had successfully recruited a radiographer from overseas to join them in the near future.

The service was able to provide details of sickness rates in the year to 30 September 2021; this reflected absence due to COVID-19 and non COVID-19. Hours lost excluding COVID-19 were 2686.5 (8.1%) and hours lost including COVID-19 were 3518.3 (10.6%).

The manager could adjust staffing levels daily according to the needs of patients. Some staff were able to work across all modalities while others were more specialist. Staffing was included on the risk register due to skill mix; if the correct staff were absent appointments would be re-arranged to maintain safety.

At the time of the inspection the staffing tool used in the hospital was being adapted for use in the imaging department.

Records

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up-to-date, stored securely and easily available to all staff providing care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures. All staff had access to an electronic records system that they could all update.

We observed staff and patient interactions and the imaging procedures undertaken. Identification details were recorded and checked in the electronic clinical radiology information system (RIS).

Patient imaging records were comprehensive, and all staff could access any historical images easily in the picture archive and communication system (PACS) prior to undertaking the requested procedure. PACS is a nationally recognised system used to report and store patient images.

Staff completed a magnetic resonance imaging (MRI) safety questionnaire with patients, and we saw these were completed in full.

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

Radiographers completed post processing following procedures, this included recording the name of the operators who undertook the procedure, confirmation of the imaging performed, and associated radiation dose. Radiologists were able to access images once post processing had been completed to assess clinical findings and produce a report.

The computer systems and record programmes could only be accessed by authorised staff using a password.

Medicines

Good

Diagnostic imaging

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. When contrast media was administered this was done under a Patient Group Directive (PGD). PGDs are written instructions to supply or administer medicines to patients, usually in planned circumstances. We reviewed PGDs used in the department, and all were signed by the appropriate staff. For example, specific named contrast media used during some CT scans which was issued in 2020, and a named contrast agent indicated for intravenous use with magnetic resonance imaging, issued in June 2021, were signed by radiographer, radiologist and pharmacist.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Contrast medicines were stored in in a temperature-controlled cupboard which restricted access to them by unauthorised people. Minimum and maximum temperatures were recorded and staff knew what to do if the temperature went out of range.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the Spire Healthcare incident reporting policy. The hospital used an electronic reporting system and staff at all levels could access the system.

Staff reported serious incidents clearly and in line with hospital policy. Incidents potentially reportable under IR(ME)R were reported appropriately and investigations carried out by staff trained to do so. We saw a record of those reported to the radiation protection advisor (RPA) for the service in 2021 which were not deemed externally reportable under IR(ME)R. This included for example, incidents in the mammography department and in the fluoroscopy room.

Incidents were a regular item on the team meeting agenda and we saw evidence of discussion and learning. All minutes from meetings were emailed out for those who could not attend, this ensured learning was shared with the whole team.

Staff we spoke with were able to discuss a recent incident in the CT scanning room and how they worked through the event, learned from it and made changes to their procedure.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. We saw from some route cause investigations undertaken at the hospital that there was a section on the form to record the duty of candour process.

Are Diagnostic imaging effective?

Insufficient evidence to rate

We currently do not rate effective for endoscopy service, but we noted the following;

Good

Diagnostic imaging

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had policies available electronically to support good practice in all the imaging modalities provided.

We saw examples of some of the operating procedures used in the imaging department; these referenced national guidance such as the RCR (Royal College of Radiologists) and the NPSA (National Patient Safety Agency).

Changes in national guidance were communicated to service leaders from Spire Healthcare and these were implemented locally as appropriate. New policies and relevant NICE guidance was a standing agenda item on all team meetings.

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice. Staff could access up to date policies and refer to them when needed. Staff understood how the Mental Health Act applied to their own role. And awareness of the requirements of the act was included in mandatory training.

Patients attending, who may be subject to the Mental Health Act were highlighted to staff in advance of attendance.

The service took part in a range of hospital and service audits throughout the year to ensure healthcare was being provided in line with their policies, national guidance and standards.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Staff took into account patients individual needs where food or drink were necessary for the procedure.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. Patients were provided with information before fasting scans that detailed how long patients should do this for. Radiographers checked this guidance had been followed when speaking with patients. Fresh drinking water was available in all waiting areas.

Pain relief

Staff assessed and monitored patients to see if they were in pain.

Staff assessed patients' pain. All patients attended as an outpatient or from a ward. Staff assessed patients' pain both before and during imaging procedures. Patients attending from home were advised to bring any medication with them they might require during their attendance. Staff returned inpatients to wards as a priority, for pain relief to be administered if their pain was not controlled. Staff routinely used foam pads to make patients comfortable and kept procedures as short as possible if patients were in any discomfort.

Patient outcomes

Good

Diagnostic imaging

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

The imaging service undertook internal audits that were monitored at provider level but did not participate in any national clinical audits. Managers and staff carried out a programme of repeated local audits to check improvement over time. These audits ensured standards of radiation safety were met consistently, and bookings were made without delay.

We saw examples of audits specific to the imaging service which included for example, the quality of referral forms and the quality of post examination documentation. Clinical audit included cannulation self-audit; a sample of 30 cannulation procedures carried out by each relevant member of staff. These included monitoring the number of attempts, extravasations or any issues.

Staff explained how the World Health Organisation (WHO) surgical safety checklist was implemented in the imaging department during interventional radiology procedures. The five steps were audited according to guidance; we saw that the September 2021 audit was 100% compliant with the standard.

Lead aprons were tested annually, we saw that aprons found to be faulty were 'retired' and replaced.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Radiographers, mammographers and sonographers had undertaken higher educational training to undertake their role. These staff were registered with the Health and Care Professions council (HCPC) and this registration required them to agree to a code of professional conduct to maintain registration.

Registered professionals kept personal competency folders; those we saw were comprehensive. Examples of competencies achieved were; cannulation, venous blood sampling, care of a peripheral venous device.

Clinical staff received regular updates, for example the cardiac team had recently provided an ECG (electrocardiogram) training refresher session.

All staff working in the department were provided with a competency-based induction relevant to their role, and new staff were also allocated a mentor for support. Administrative and radiography staff new to their roles described their induction as useful, allowing them to understand the different areas of the service and meet key people in the hospital.

Staff we spoke with said they had received an appraisal during the year, though they said these had been delayed due to the COVID-19 pandemic. They generally found them useful and integral to supporting their development and aspirations.

The imaging manager kept a log of all staff competencies and specialist skills including radiologists who worked at the hospital. This enabled them to have oversight of any gaps in service provision.

Good

Diagnostic imaging

There were a number of radiographers who undertook cannulation and there was a small specialist group who undertook image reporting.

Staff described the small group scenario training which was sometimes included in staff meetings. The non-registered staff and administration team found these particularly useful to understand the impact of some procedures or actions.

The manager described an incident which had resulted from a staff member not following policy. The outcome was discussed in depth and the staff member was provided with a personal improvement plan and a mentor. The individual found the process supportive and improvement was evident.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. The imaging department worked closely with different medical teams in the hospital such as the cardiac and gynaecology teams. Medical physics and engineering teams were close collaborators in procuring and maintaining equipment and ensuring radiation safety.

There was a daily '10@10' meeting where the hospital director and senior management team or their representatives came together with the department leads for 10 minutes to discuss the day ahead, and any issues from the previous day. This ensured any hospital wide concerns were understood and teams were aware of the impact on the service provision and care to the patients. The '10@10' minutes were displayed in the imaging department for all staff to see; they were well laid out and easy to read with key messages.

Staff told us that they felt that relationships between the visiting radiologists was good; healthcare assistants felt consultants were friendly and approachable. Radiographers told us they had good working relationships with visiting radiologists and could contact them at any time.

Seven-day services

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

Imaging services for outpatients and day cases were available between 8am and 8pm with a radiographer on-call service outside of those hours. Availability of appointments varied depending on which type of image was required. Not all imaging modalities were available at weekends but the staff were flexible in their approach and offered appointments to patients as soon as possible and at a time to suit the patients' requirements.

Health promotion

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

Staff and patients could access relevant information promoting healthy lifestyles and support. There was information available about the variety of imaging modalities and what would happen during scans; what preparation was required prior to a scan; and self-care advice following a scan. We saw numerous examples, such as 'Getting your X-ray or scan results' and 'MRI contrast information'.

Good

Diagnostic imaging

These information leaflets provided a contact number and e mail address for the imaging department, should patients require further information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

There was a Spire Healthcare consent to investigation or treatment policy. This included, the training required to take consent, whose responsibility it was to obtain consent, and when to use implied, verbal and written consent.

Staff in the imaging department used a two-stage consent process with cooling off times for patients undergoing invasive procedures. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff received training in the Mental Capacity Act (2005). In conversation staff demonstrated a good understanding about their responsibilities towards patients under the act, which included a how and when to assess mental capacity of a patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Due to the nature of imaging procedures, consent was documented and gained at each attendance in line with radiation exposure legislation. If patients could not give consent, staff knew that decisions could be made in the best interest of the patient; taking into account patients' wishes, culture and traditions.

Staff we spoke with understood the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time.

Consent training was part of the mandatory training programme and mental capacity was included as part of the mandatory safeguarding training. Staff told us if they had any concerns they would contact the safeguarding lead.

Are Diagnostic imaging caring?

Good

We previously inspected diagnostic imaging jointly with outpatients therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Compassionate care

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures. All staff had access to an electronic records system that they could all update.

Good

Diagnostic imaging

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. Staff explained procedures clearly and with compassion, this meant patients were fully prepared for their procedures. If a patient needed additional support or attended with a carer, efforts were made to involve them in these conversations.

One patient told us 'the explanation of the scan, and the process had been good, that the appointment had been well communicated with her and they knew how to get the results. The wait was minimal and overall the service had been good.'

We observed interactions between staff and patients throughout the department; patients were treated with kindness at all times. Another patient told us that the staff had made them feel relaxed and comfortable, the radiographer had explained the scan well and they were confident the staff were following rules minimising risks relating to COVID-19 and other potential infections.

Recent feedback showed 96% of patients were happy with the care they received and felt it was of good quality.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they could access translation services if required and it was usually known in advance if patients spoke a dialect that was not widely known.

Staff used patient assistance stickers; a sticker, applied to referral forms, which was a discrete label with symbols indicating any special needs such as; hard of hearing, dementia, claustrophobic, needle phobic.

Emotional support

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were discrete areas available where staff could speak with patients if they felt distressed.

Staff recognised and understood the emotional impact undergoing diagnostic procedures might have on patients and provided relevant support. Staff also understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were given clear details of when results would be known and who to contact, to help minimise levels of anxiety while waiting for results.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment, and talked to patients, families and carers in a way they could understand.

Staff were aware of reasonable adjustments that could be made to ensure patients understood the information they were given. This included providing interpreters to support medical discussions within families.

Good

Diagnostic imaging

Staff told us they sometimes saw patients with complex needs such as a learning disability and dementia.

Individual risk assessments were carried out and appointments could be extended to allow for time to reassure patients and ensure they understood procedures.

Are Diagnostic imaging responsive?

Good

We previously inspected diagnostic imaging jointly with outpatients therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the community served. The service provided diagnostic imaging to private patients undergoing elective care. In addition to this during the COVID-19 pandemic the service had supported the local NHS trust by providing services which included diagnostic imaging procedures. This enabled the trust to continue to deliver vital services to patients whose care may otherwise have been delayed. The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Results were not always available during the single visit, however they were available before the next appointment. Diagnostic test results were available to support timely multidisciplinary team decisions on cancer care, treatment plans, and achieve cancer waiting time standards.

Average report turnaround times at the time of our inspection were one day for ultrasound scans and two days for CT and MRI scans, and two days for plain film x-ray imaging. The service's agreed performance standard was to provide all written image reports within five days; staff were achieving 96% compliance with this standard.

If patients did not attend for their appointment staff would contact them by phone to check on their welfare and make a new appointment. Staff informed the referring consultant if patients made the decision not to attend for their investigation at the hospital.

Meeting people's individual needs

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

Good

Diagnostic imaging

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Referral forms provided staff with the relevant information to communicate and care for patients with any specific needs.

Staff received training in equality and diversity and had a good understanding of cultural, social and religious needs of patients and demonstrated these values in their work. Patients with reduced mobility could easily access the imaging department which was on the ground floor and corridors were wide enough to accommodate wheelchairs.

Interpretation services were available for patients whose first language was not English. Staff recognised this was particularly important when considering informed consent for the scan or procedure. A poster displayed the different languages available; this included nine languages other than English.

Throughout the department we saw posters containing information in several languages and information was also available in braille.

The new fluoroscopy unit could accommodate bariatric patients up to 30 stone in weight.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and receive diagnostic imaging within agreed timeframes and national targets. When waiting times for appointments increased beyond those normally experienced this was escalated to senior managers at head of department meetings. Managers and senior leaders looked to extend working hours to meet demand. This was evident during the closure of the MRI scanner due to the air conditioning problems.

Managers worked to keep the number of cancelled appointments to a minimum. Patients were asked about their preferred times to attend, this ensured they would be able to attend. When patients had their appointments cancelled at the last minute due to equipment failure, managers made sure they were rearranged as soon as possible and booked within national targets and guidance.

Routine servicing of equipment was always planned in advance to avoid disruption. The service was also able to direct patients to an alternative provider location if there was significant disruption to the service.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns; information was available in waiting areas telling people how to do this.

Good

Diagnostic imaging

Staff understood the policy on complaints and knew how to handle them; the hospital policy for handing complaints was available on the intranet. Complaint management was undertaken by senior leaders of the service who spoke with patients where possible, so their input was included in all investigations.

Complaints were discussed at the hospital senior management team meetings, the clinical governance meetings and the medical advisory committee meetings. Issues arising from complaints about the imaging service were shared with the team at staff meetings and we saw minutes of team meetings which confirmed this.

Are Diagnostic imaging well-led?

Good

We previously inspected diagnostic imaging jointly with outpatients therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Leadership

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

The Imaging team was led by registered radiographers which included a manager and deputy with specialist leads for MRI, CT, and general x-ray imaging.

Managers were able to detail responsive changes that had been made in the department due to the COVID-19 pandemic, and the plans initiated to improve the service as patient appointments were returning to normal levels.

Staff told us they felt able to approach management and discuss any concerns with them; they felt leaders engaged with and listened to them. The department leadership team had been in post for just under three years and staff had become accustomed to, and respected their management style.

Leaders supported staff in their development and encouraged them to own their achievements. They had an open-door policy and supported staff to raise concerns and seek out support.

Leaders were knowledgeable in the area they worked in and used their experience to inform decisions. There were regular staff meetings and minutes of these showed discussions of service improvement and shared learning discussion.

Vision and strategy

Good

Diagnostic imaging

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

Leaders demonstrated a vision for their service and were motivated to continuously improve. They felt that Spire Healthcare as an organisation recognised the need for investment in imaging equipment and had undertaken a national audit to understand the priorities. Imaging managers were working on their local priorities and at the time of our inspection Spire Gatwick Park, had begun the tendering process for new equipment. The imaging manager said they were taking their time to ensure they made the correct decisions; considering the best equipment, most appropriate room modifications, and considering minimising musculoskeletal injuries to staff.

The strategy for the imaging service was clearly displayed in the department and contained for example, work to improve appointment schedules, and improved turnaround times for urgent scans.

Culture

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

Staff spoke positively and were proud of their workplace, and said team leaders were approachable and fair. Interactions between the manager, the deputy and staff were warm and courteous. Staff told us that they felt heard, and that the manager respected and valued them. The manager considered the wellbeing of staff and made sure they were supported. For example, weekend working was a regular activity at the time of the inspection, but staff undertook this on a volunteer basis and no-one felt obliged or forced to do this.

The imaging lead had undertaken a mental health first aid course and spent some time completing walkabouts to engage with staff and allow them to offload concerns. They told us that this was beneficial to those who needed to offload and to them as the listener. This worked well with the role of the freedom to speak up guardian.

Staff meetings were informative and staff felt comfortable to speak up and contribute. We saw minutes of meetings were available to all staff and covered important issues affecting the department, the hospital and the wider organisation.

The hospital had conducted a staff engagement survey in March 2021 which showed that 90% of staff in Gatwick Park Hospital were proud to work there which was an improvement of 24% from the previous year; 77% of staff had responded to the survey.

Governance

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

Good

Diagnostic imaging

The hospital governance structure at the time of our inspection was well established. A range of meetings supported an effective spread of clinical and non-clinical forums for raising issues, providing solutions, and ensuring actions were agreed to address concerns.

Senior managers had a daily catch up call known as 10@10 to discuss issues and concerns, and actions to address them. This video call was attended by all the hospital heads of department, and at the time of our inspection the imaging manager was able to update senior management and colleagues on the ongoing operational problems with the MRI equipment.

The head of the imaging department or their deputy also attended regular meetings such as, hospital leadership team, safeguarding committee, and infection prevention and control committee.

The quarterly clinical governance meeting included all aspects of the quality of service provision, clinical risks, incidents and alerts, learning from complaints and service improvements. The imaging manager followed up these meetings with monthly team meetings for her team following a similar agenda with specific issues for the imaging team to address and acknowledge. For example, new and updated NICE guidance relating to the service, staffing and equipment. Plaudits received from service users as well as learning from complaints were aired and meetings minutes were shared with all staff in the service.

The hospital held annual radiation protection meetings which included radiologist and radiographer representation as well as the radiation protection advisor (RPA) for the hospital and operating theatre representation. We saw minutes of the meeting for 2021 which included a standard agenda covering all aspects of the imaging service, such as equipment procurement, staff training, radiation incidents and the annual radiation protection audit.

This year's radiation protection audit due to be undertaken in March, had not taken place and a date for the next audit had not been agreed with the service. However, a series of equipment performance assessments had been completed in December 2020 and January 2021 by an independent senior physicist, and authorised by a principal physicist from the nearby NHS trust radiation protection service. Each assessment report included points of non-compliance and recommendations; we saw plans which demonstrated that necessary actions to address issues raised by the radiation protection physicists were dealt with as recommended.

The quarterly hospital health and safety meetings also included radiation protection issues on the agenda.

Managing risks, issues and performance

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

Leaders used information from a variety of sources to ensure they were delivering a quality service. This included patient satisfaction surveys, incident reports, complaints/compliments, training records, audit results, and continuing professional development files. We saw these were discussed in the minutes of the radiology department team meetings.

Good

Diagnostic imaging

The hospital used risk registers to monitor risks throughout service provision as part of the governance structure. The senior managers worked well together to identify risks and make improvements. Senior staff had a good understanding of the issues within their areas. The risk register was updated regularly, with risks added to the register relating to patient care, safety performance and current issues.

Risks that needed addressing at a higher level were escalated to the corporate risk register. At the time of our visit there were two main issues relating to the imaging service; staffing skill mix and the acute operating problem in the MRI room. We learned from staff that hospital managers were supportive and keen to address issues at the earliest opportunity.

The department had several radiation protection supervisors (RPS) who met regularly. Controlled radiation area signs were evident and staff we spoke with knew who RPSs were.

Managing information

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

The service ensured data or notifications were sent to external bodies when needed. The service leads knew when to submit incident notifications to regulators in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Clinical information was held securely in standard imaging electronic systems which all authorised staff could access.

Policies and procedures relating to data management were available to staff electronically, staff completed training in data protection and those we spoke with understood the importance of confidentiality of information.

Engagement

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

The service engaged with patients, seeking feedback to improve the quality of the services provided. Patient feedback was shared with the team and was used to improve the service. Staff knew how to support patients to give feedback and raise concerns.

Feedback from service users was gathered in a variety of ways, for example through surveys, website forums and direct feedback. In the imaging department we saw much positive feedback which managers displayed and shared with staff.

We saw the most recent action plan relating to the survey, there were no concerns relating specifically to the imaging service.

Good

Diagnostic imaging

The hospital had initiated a patient satisfaction quality improvement project in 2021 to develop actions to improve the discharge process.

Staff received a monthly newsletter which kept them informed of issues relating to for example, pay reviews, health and well-being matters, vacancies and new starters and local events.

There was also an annual staff survey which staff we spoke to in the imaging department spoke well of, as they were confident the leadership would address any concerns raised where possible.

There were members of the imaging staff in a local basketball team which the hospital supported by sponsoring the kit.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

There was a point of care pregnancy testing machine available in the department for patients to be tested prior to scanning to ensure it was safe for them to have a CT scan.

In November 2018 the department installed an in vitro whole-blood analyser for critical care tests at the point of care, such as blood gases, electrolytes, metabolites and coagulation. This equipment provides critical results in a few minutes which are important for cardiac and neurologic problems.

Discrete stickers were attached to vulnerable patients' records which indicated the patient's vulnerability with a symbol.

Good

Outpatients

Safe	Good
Effective	Insufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

We previously inspected outpatients with diagnostic imaging jointly therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Staff received 15 mandatory training modules with 11 modules above 90% compliance. The lowest compliance rates were safeguarding vulnerable adults at 82% and health and safety with 86.4% compliance. Managers told us although staff may not have completed their training yet this year they had until 31 March 2022 until they would be overdue. Staff told us they had time to complete mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us their training prepared them for their roles. Staff completed mandatory training on subjects to support them in their roles including; manual handling, data protection and life support.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training system alerted staff when their training was due. Managers reminded staff when they needed to complete their training individually and provided group reminders at team meetings.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. We looked at records showing compliance with safeguarding vulnerable adults training was 82% and safeguarding children had a 95% compliance

rate. These records showed for safeguarding vulnerable adults there was 12 staff with level two, six with level three and four staff that had not completed their training this year. For safeguarding children there were six staff with level two, 15 staff with level three and one member of staff that had not completed their training this year. Managers told us staff had until the end of March 2022 until they would be overdue for these training modules.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had a clear understanding of how to identify and report abuse. The service had a safeguarding lead to provide advice to staff if they were unsure about any aspect of the safeguarding process. Staff said they were able to approach them for support any time they needed.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Managers held a safeguarding committee meeting every three months which included; discussion on safeguarding concerns raised since the last meeting, training compliance, and involvement with other agencies. We saw in minutes from these meetings evidence of engagement between the hospital and local authority safeguarding boards as well as pursuing more engagement with other agencies.

Cleanliness, infection control and hygiene

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

Staff received training in infection prevention and control. Compliance with this training was 95.5% for staff in the outpatient's department.

Clinical areas were clean and had suitable furnishings which were clean and well maintained. We saw all areas in the outpatient department were visibly clean. The waiting room and clinic areas had chairs made with a wipeable material to promote effective cleaning. We looked at furnishing throughout the outpatient's department which was all well maintained. Well maintained furnishings make cleaning more effective as dents and rips in furnishings can prevent thorough cleaning.

The service generally performed well for cleanliness. Cleanliness was audited by the nurse in charge of the department each day. These audits were displayed at the entrance to the department, so patients were able to see the compliance for the current week's cleanliness. We saw records showing the department's cleanliness was 100% for the past month.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We looked at the past four weeks of cleaning records and these were completed everyday apart from Sundays as the department was not open on this day. Staff completed cleaning records for each room with clear areas of responsibility for cleaning staff and clinic staff.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff we saw during the inspection were 'bare below the elbows' and dressed in line with the service's policy. Staff had access to PPE including; aprons, masks and gloves in a variety of sizes. We saw staff used PPE in line with the service's policy. The services policy was in line with national guidance at the time of the inspection.

All staff cleaned their hands before, during and after patient care in line with the World Health Organisation guidance on the “five moments for hand hygiene”. We saw posters reminding staff of these five moments. Reception staff reminded staff and visitors to use hand sanitiser gel on entering the hospital.

The hospital had taken additional precautions to protect patients and staff from COVID-19. At the entrance to the hospital they had signs to instruct patients, visitors and staff to use the hand sanitiser gel and put on a clean mask. We saw many signs reminding people to clean their hands, keep a safe social distance and of the symptoms of COVID-19. The service had social distancing floor signs to help people keep a safe distance from others while waiting to speak to reception staff. The waiting area had clear markings on seats to indicate where it was safe to sit without encroaching on the safe distance between other patients waiting. Each room within the outpatient’s department had been risk assessed to consider the maximum safe occupancy while maintaining social distancing and this information was displayed on a sign next to the doors.

Staff managed sharp clinical waste in a way that reduced the risk of spreading infections. Sharps bins were assembled correctly, and these were not overfilled. Staff used temporary closure lids to reduce the risk of accidental sharps injuries.

The service monitored their effectiveness at controlling the risk of transmission of infections. Staff held an infection prevention and control meeting once every three months which included discussion on audit results, infection control incident trends and changes to policies and procedures. We looked at the minutes of three of these meetings and saw in-depth discussion on issues identified with learning and actions identified to reduce the risks to patients, staff and visitors. Actions included increased cleaning for frequently touched points such as door handles which we saw staff completing.

Staff completed hand hygiene audits to monitor compliance with the service policy. We saw records showing outpatient’s staff had achieved 100% compliance over the past month.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment after patient use and used green labels which showed when items had been last cleaned.

Environment and equipment

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

We saw all areas of the outpatient department were well maintained. The design of the environment followed national guidance. The department had seamless floors with a smooth, slip-resistant and easily cleaned finish. This was in line with the Health Building Note (HBN) 00-08 for flooring. The service limited its use of carpet with this only used in one consulting room which was used for paediatrics to make this room more welcoming to children. This room had clear separation in the room between clinical and consulting areas. Clinical examination areas and the hand washing area had the same fluid resistant and slip-resistant surface as the other clinical areas. This was in line with the HBN 00-09 for carpets.

Staff carried out daily safety checks of specialist equipment. The emergency resuscitation trolley to be used in the event of a cardiac arrest in the outpatient’s department was stored on the ward within the hospital. This was close to the

outpatient's department and was brought to the clinic when needed by the hospital porters. Staff told us when they had needed this in the past the trolley was with them very quickly. The outpatient's department had an emergency paediatric grab bag and an anaphylaxis kit. Staff carried out daily and weekly checks on these. This bag and kit were both sealed with security tags to ensure people could not tamper with the products within them without staff knowing.

The service had suitable facilities to meet the needs of patients' families. The department had two outpatient department areas with clinic rooms, treatment rooms for minor procedures, and specialist rooms. These specialist rooms included one for ophthalmology with specialist equipment for examining eyes and a room for gynaecology with specialist equipment for examinations. Each clinic room had chairs for the patient and a relative to make them both feel welcome to attend.

The outpatient department provided laser treatments and had a procedure to keep people safe while the laser was in use. This included locking the treatment room door, protective equipment for the people in the room and a large laser warning notice attached to the door when the laser was in use.

The service had enough suitable equipment to help them to safely care for patients. Staff told us they always had the equipment they needed including acquiring new equipment for the department. Most large pieces of equipment were loaned under service level agreements which included servicing of these items. The department had an equipment register for their 134 pieces of medical equipment. This tracked when each item was last serviced, when it was next due a service, electrical testing, item name, serial number and hospital identification number. During the inspection all equipment looked at in the outpatient department was in a good state of repair, stored in an organised way, was clean, dust-free and had the required up-to-date checks.

Consumables were stored neatly in trolleys in the consulting and treatment rooms. We looked at 20 items all of which were within date, dust free and sealed.

Patients attending the outpatient's department were booked in at the reception desk which had clear plastic screens to separate patients and staff to reduce the risk of COVID-19 transmission.

The waiting area for outpatient was spacious and light. Chairs and sofas were available to meet patient's needs. Due to COVID-19 precautions, the drinks machines were not operational, but reception staff had bottled water they gave to patients.

Staff disposed of clinical waste safely. Staff correctly segregated waste into clinical and non-clinical waste. The service had clinical waste bins with clear indication about what should be disposed of in them. They also had domestic waste bins for non-clinical waste which had signs on to remind people what could and could not be put into these bins.

The service had and maintained fire safety equipment to reduce the risk to patients from fire. The service had carried out yearly checks on fire extinguishers and these were secured to the wall where staff could access them quickly. All fire doors were in good condition and doors with "Fire door keep locked" signs were locked. This reduced the risk of fire spreading in the event of a fire.

Assessing and responding to patient risk

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

Good

Outpatients

The service assessed and responded to patient risks. Leaders from each department in the hospital held a meeting each day at 10am which discussed the pressures, risks and staffing across the hospital. We saw this included consideration of outpatient activity including any additional risks within outpatients.

Staff knew about patients with a medical history which represented an increased risk. Staff knew in advance when patients with additional needs were attending and planned to meet these needs and reduce risks posed to them. This included patients with reduced mobility that may need more assistance.

Staff responded promptly to any sudden deterioration in a patient's health. Generally, acutely unwell patients would not attend the outpatient's department. However, patients could still become acutely unwell while in the department and staff had training to care for these patients. There were emergency bleep and call systems should staff require the resuscitation team. Staff told us they could also alert the porters via a radio at the nurse station to bring the resuscitation trolley. Staff said when they had needed this it was in the department very quickly. Staff told us about a patient becoming unwell in the department that they assessed, monitored and received support from the registered medical officer. The patient was admitted from the outpatient department to the hospital ward for additional monitoring.

Staff completed risk assessments for each patient during clinic appointments when needed. We saw patients being assessed for risks of general anaesthesia, venous thromboembolism and allergic reactions to medicines. We looked at patient records which when needed had risk assessments completed. Not all outpatient appointments would require the completion of risk assessments.

Staff ensured they considered the risks for each minor procedure. Staff completed a safety checklist before the start of minor procedures in line with the World Health Organisation's surgical safety checklist. This included; confirming the patient's identity, known allergies, and introductions of all staff present to the patient. The minor procedure rooms were ventilated in line with national guidance. Having a well-ventilated room for procedures reduces the risk of infections.

Tissue samples taken in the department were clearly labelled, recorded and checked with a colleague. This ensured patient's samples were tested correctly and prevented delays in results to inform the patient's ongoing treatment plan.

Staffing

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

There are no agreed national guidelines as to what constitutes 'safe' nurse staffing levels in outpatient departments.

Staffing levels and skill mix for each day were planned by the head of outpatients based on the type and number of clinics running and the number of patients attending.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Clinical services in outpatients were supported by registered nurses and healthcare assistants.

The manager could adjust staffing levels daily according to the needs of patients. Staff told us they worked flexibly to meet the needs of their patients. The manager would phone staff to adjust their start and finish times for the following day to ensure they always had enough staff throughout the day. Staff told us this worked well, and they always had enough staff in outpatients to safely meet their patients' needs.

The manager attended a hospital wide call at 10am to discuss staffing pressures in other departments. They then offered or requested staff to work together across departments to ensure all areas had safe staffing levels.

There were enough staff numbers in the physiotherapy department to cover the outpatient physiotherapy services.

The service had enough reception staff to book in patients for outpatients. We saw there was not a long wait to speak with them even at busy periods.

The outpatient department had access to a range of medical consultants, who were granted practising privileges to provide an outpatient service at the hospital. Practising privileges is a system of checks and agreements whereby doctors can practice in independent hospitals without being directly employed by them.

There was a resident medical officer (RMO) on-site 24 hours a day seven days a week. When needed they provided support to outpatients with medical care. This included reviewing patients that deteriorated during their outpatient appointment.

The service had a high vacancy rate of 17.6% however this only represented three posts vacant. Managers knew about this and had recorded this on their risk register. They had taken actions to reduce the risk to patients including reviewing staffing levels every day, using bank staff to cover when needed, and starting the recruitment process to fill these posts.

The service had low turnover rates. The service had a turnover rate of 5.3% for the last 12 months.

The service had low sickness rates. The outpatient's department had an 8.7% absence rate over the past 12 months which included some absences caused by the pandemic.

The service had low rates of bank nurses. The service had used 4.6% bank staff over the past 12 months.

Managers limited their use of bank and only requested staff familiar with the service. The service did not use agency staff. Managers made sure all bank had a full induction and understood the service. Bank staff received the same induction and mandatory training as substantive staff.

Records

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

Patient records were comprehensive and all staff could access them easily. Staff told us records were always easily assessible from their onsite medical records department. Staff told us for new patients they created a new folder and then this was sent to medical records after their first appointment. We looked at five patient records which all had the relevant information within them including; medical history, risk assessments, observations, treatment plans, and tests carried out. All entries in the records we looked at were legible, dated and signed.

When patients transferred to a new team, there were no delays in staff accessing their records. The hospital had a record for each patient that was shared between the different departments in the hospital. Medical staff told us this allowed them to easily see the history of each patient.

Records were stored securely. We saw staff in the outpatient department transported patient records in locked trolleys. Staff stored records in the locked trolleys within the clinic rooms and in locked draws in treatment rooms. Patient records were paper and were stored in the medical records department on site. We saw patient records were returned to this department at the end of clinics.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had an up-to-date medicines management policy with a review date for January 2023. We saw medicines in the department were stored securely. Medical staff prescribed medicines for patients on private prescriptions. Patients could either have these filled by the onsite pharmacy or take them to any external pharmacy. We saw these prescriptions included the patients name, address, and their known allergies. The prescription pads were stored securely. We looked at a record that logged against each script serial number the patient's name and which consultant had issued it. This prevented unauthorised use of these prescriptions.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw staff in outpatient clinics explained options of medicines including the risks and side effects to patients and their relatives. Staff reviewed patient's medicines at follow up appointments.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The department stored medicines in two rooms which were both temperature controlled. We saw records showing staff had monitored the temperature in these rooms and in the two medicine fridges. Storing medicines at the correct temperature ensures medicines have a consistent effectiveness.

Staff followed current national practice to check patients had the correct medicines. We saw staff checking patients' name, date of birth, and address before administering medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw records showing medicine safety alerts were shared with the outpatient department manager at the hospital wide meeting held daily at 10am. The outpatient's department manager then shared these with their staff at their lunch time huddle.

Incidents

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

Good

Outpatients

Staff knew what incidents to report and how to report them. Staff knew how to access the service's incident reporting tool on their intranet. Staff told us they would ask their manager for support if they were unsure how to complete any parts of the form.

Staff had reported incidents in the outpatient department. The service graded incidents depending on if they were considered a serious incident and then on the level of harm. Serious incidents had additional oversight from the managers at corporate group level.

The service had zero never events in the past 12 months.

The service had zero serious incidents in the past 12 months.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff were clear they needed to report all incidents including those that had not resulted in harm to patients. The service had an incident reporting policy which was up to date with a planned review date for June 2024. Their policy encouraged staff to report all types of incidents including near misses and those resulting in no harm to patients.

Staff in the outpatient department had reported 151 incidents in the past 12 months. These were categorised into two moderate harm, 58 low harm, 75 no harm and 16 near misses.

Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation if things went wrong. Staff told us they knew their responsibility to be open and honest with patients and relatives when things went wrong. They told us talking openly with patients when things had gone wrong helped them understand and allowed them to ask questions.

Staff received feedback from investigation of incidents, both internal and external to the service. Incident learning was shared at the hospital wide call at 10am with the leaders for each department. The outpatients service then shared this learning at their lunchtime huddle. We saw this included learning from other departments with consideration of how this was relevant to the outpatient's department.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We looked at five incidents which had been investigated and included contact with patients and staff where needed. Although none of these incidents required a formal duty of candour response the service had offered an explanation to patients with an apology. One incident we looked at related to a positive result from a COVID-19 test, staff had carried out the correct procedures to reduce risk to patients and staff. We saw staff were still following precautions to limit the transmission of COVID-19, including checking all inspection staff had completed a lateral flow test with a negative result before attending the hospital.

Learning was discussed at meetings to share learning from incidents. We saw minutes showing hospital leaders discussed incidents at a meeting held every three months. Staff in outpatients discussed learning from incidents at their team meetings held every three months. We saw this included learning around writing clearly on blood sample vials. This was a rejected blood vial by the hospital's laboratory as the date of birth was not correct. Staff we spoke to knew about this incident and showed us the new blood bottle label printer. The use of patient labels ensured all the information was clearly legible without transcription errors.

Are Outpatients effective?

Good

Outpatients

Insufficient evidence to rate

We currently do not rate effective in outpatients service, but we noted the following;

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We looked at policies related to outpatient care including; duty of candour, safeguarding adults at risk and management of medicines. These were up to date with consideration of national guidance from the Nursing and Midwifery Council, the Home Office and the National Institute for Clinical Excellence.

Leaders monitored national guidance and best practice changes which were reviewed in the clinical governance meeting held every three months. We saw minutes of meetings showing guidance was reviewed for relevance to hospital services and updates made to policies where needed. Staff then were prompted to read updates to policies in their team meetings. This was a standing agenda item for team meetings in the outpatients department.

Staff had easy access to policies to support them in caring for patients. Staff showed us how they accessed policies on the service's intranet.

The outpatient's department participated in the hospitals audit programme including monitoring their medicines storage and security, compliance with the cosmetic surgery cooling off period and use of the surgical safety checklist.

Nutrition and hydration

Patients had access to food and drink to meet their nutrition and hydration needs.

Staff made sure patients had enough to eat and drink. We saw staff gave bottles of water to patients when requested and they offered these to patients they felt needed them. Staff also provided hot drinks and food from the hospital restaurant for patients on request. We saw patient feedback which included thanking staff for providing them with water and hot drinks when they had needed them.

The waiting area had self-service hot drinks machines and water dispensers however these were not in use due to infection prevention and control measures related to the pandemic.

Pain relief

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

Good

Outpatients

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. However, patients were not routinely assessed for pain levels in outpatients as this was not generally the reason for patients visiting.

Staff prescribed, administered and recorded pain relief accurately. We looked at private prescriptions given to patients by the department which included all the required information including; the patients details, known allergies, the medicines name, dose, frequency and route. We saw staff administered local anaesthetic safely.

Patients received pain relief soon after requesting it. Local anaesthetic was stored in the department however no other pain relief medicines were kept in the department. Medical staff when needed wrote a prescription for pain relief medicine which nursing staff took to the onsite pharmacy to be dispensed which they then administered to the patient. If patients were in large amounts of pain in the outpatient department, then they would be admitted to the ward or referred to the local NHS trust for pain management and investigation into the cause.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. We saw where necessary actions were identified and performance over time was monitored. These audits included infection prevention and control, waiting times, patient satisfaction, record keeping and medicines management.

Outcomes for patients were positive, consistent and met expectations. Patient feedback for the hospital showed 93% of patients' expectations were met or exceeded in July, August and September 2021.

The service identified areas for improvement, planned actions and checked these were done. The service had identified 81% of people said there was enough parking at the hospital. Leaders felt this could be improved so created an action plan which included actions related to the outpatient's department; one of which was to increase the opening hours of the department to reduce peaks in patients attending the hospital.

Managers shared and made sure staff understood information from the audits. We saw records showing audit results and learning points were shared with staff at their team meetings.

For our detailed findings on patient outcomes, please see under this sub-heading in the surgery report.

Competent staff

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

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

Good

Outpatients

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke to told us they had completed an induction when starting which fully prepared them for their role. Staff also had a period of shadowing before working independently in the department.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw records showing all staff had completed an appraisal in the last 12 months.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their appraisals were used to talk about how they wanted to develop their skills. The department manager was committed to developing the skills of their staff to continually improve the service offered to patients.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff also attended a brief daily meeting to update everyone. Staff recorded what was discussed at these meetings and stored these records along with team meeting minutes and other updates in folders kept at the nurse's station.

Managers made sure staff received any specialist training for their role. Managers kept records of competencies and supported staff to complete training and competency assessments to broaden their skill set.

Managers identified poor staff performance promptly and supported staff to improve. The department manager told us they monitored staff performance while working alongside them. They had worked with staff that were not performing to the standards required. This resulted in an improved performance and an improved patient experience.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a daily meeting which was attended by a representative from all hospital departments. This meeting was held at 10am every morning with discussion on; safety, risks, learning from incidents, pressures on departments, and support available. We observed this meeting on inspection and saw the meeting was carried out efficiently with a supportive culture.

Patients could access multiple health professionals involved in their care during one visit to the hospital. Staff told us they would arrange patient's diagnostic tests or physiotherapy sessions to coincide with their next outpatient appointment to limit the number times patients needed to visit the hospital.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw nursing and medical staff worked closely together including taking on some roles traditionally completed by medical staff. This was made possible with the support and education from medical staff.

Seven-day services

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

Good

Outpatients

The outpatient department did not provide an urgent or emergency service so was not open seven days a week. The outpatients department was open from 8am until 9pm Monday to Friday and 8am until 2pm on Saturdays. The physiotherapy department was open 8am until 7:30pm Monday to Thursday, 8am until 6pm on Fridays, and 8am until 4pm on Saturdays.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw information posters and laminated cards that had replaced leaflets in stands within the waiting area. These included information on; women's health, services provided by the hospital and keeping active to keep healthy. There were signs, posters and floor stickers reminding patients and staff about COVID-19 precautions and how to help everyone stay healthy.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Patients were offered advice or signposted to the relevant services to meet these needs.

The hospitals website had information about health topics. These included sharing patient stories including one promoting the importance of providing the Human Papilloma Virus (HPV) vaccine to men as well as women.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff could describe and knew how to access policy on Mental Capacity Act. The service had an up-to-date policy for safeguarding adults at risk which included consideration of the Mental Capacity Act. Staff told us they accessed their policies on the hospital intranet.

Most staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance with this training was 83% for outpatients' staff which was below the service's target of 95%. However, this only represented two members of staff and managers told us they had until the end of March 2022 before they would be out of date.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, and the Mental Capacity Act and they knew who to contact for advice. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us they did not often have to carry out a formal capacity assessment as they assumed patients had capacity unless there was a reason to question this. This was in line with the first principle of the Mental Capacity Act which is to presume capacity. Staff were able to describe how to assess a patient's capacity and knew they could ask for support from their manager if they were unsure.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. We saw staff in clinics discussed treatment options in detail to ensure patients were making an informed decision and providing valid consent.

Good

Outpatients

Staff clearly recorded consent in the patients' records. We saw consent was recorded clearly in outpatient records for minor procedures carried out in outpatients and for elective surgery carried out in the hospital on a day in the future as an inpatient.

Are Outpatients caring?

Good

We previously inspected outpatients with diagnostic imaging jointly therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff followed policy to keep patient care and treatment confidential. Clinic and treatment rooms had signs on the doors to indicate if the room was vacant or occupied. We saw staff using these signs when taking patients into rooms. Staff knocked and waited before entering closed doors. Reception staff were discreet when talking with patients to prevent their conversations being overheard by other patients.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff took time to explain treatment options and answer patients' questions. All staff we saw interacted in a respectful way with patients and relatives.

Patients said staff treated them well and with kindness. Patients told us staff were kind to them.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff we asked about providing care for patients with mental health needs talked about the way they provided personalised care for their needs without any judgemental attitude towards these patients.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff providing emotional support to their patients. Staff were passionate about providing a patient centred approach to care and being there to support patients.

Good

Outpatients

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff told us they took patients into a private room, sat with them to listen, provide emotional support and provided them with a quiet space if they preferred. We saw in a recent compliment the patient described how staff had been very supportive when they became distressed in the waiting room after their appointment.

Staff understood how to break bad news and demonstrated empathy when having difficult conversations. Medical staff showed empathy with their patients when breaking bad news to them. The service had specialist nursing staff to support patients receiving treatment for cancer which had additional specialist training in communicating with patients including sharing bad news.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us they understood that patients may expect to receive or receive bad news in their clinic appointments so providing emotional support to their patients was always important.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw staff ensuring patients' relatives were involved in clinic appointment when patients wanted this. We saw a patient attended a clinic appointment; they had thought they were required to attend alone due to COVID-19 restrictions. Staff swiftly and compassionately explained they were welcome to bring a relative to their appointment. Staff then went to find their relative from the car park. We saw staff communicated in a clear, kind and compassionate way with patients and those close to them.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients told us consultants took time to explain everything clearly in a way they could understand. Staff told us how they used interpreters to aid their communication with patients when their first language was not English.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service displayed information on how to raise a complaint in six languages. Staff told us they supported patients to speak out about any concerns they have about their care. The staff collected patient feedback which included overall satisfaction with the hospital's service. Patient feedback was collected each month and for the past 12 months, 91% to 100% of the hospital's patients had reported their experience was either good or very good. This was higher than the average patient experience reported across the Spire Healthcare group.

Staff supported patients to make informed decisions about their care. Staff in clinic appointments carefully explained treatment options to their patients and helped them to come to an informed decision about their care.

Patients gave positive feedback about the service. We spoke to six patients that all provided positive feedback about the staff and the service. We looked at seven compliments from patients that described how caring the staff had been to them.

Are Outpatients responsive?

Good

Outpatients

Good

We previously inspected outpatients with diagnostic imaging jointly therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. Staff assessed the local need for services which had led to the service setting up a platelet-rich plasma treatment as there were long delays for this service in other local providers. Platelet-rich plasma treatment is a new treatment for osteoarthrosis of the knee joint which was shown to reduce pain and increase function for patients. Osteoarthrosis is a disease which involves the reduction of cartilage in the joints causing pain and reduction in mobility.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. The hospital services were structured to allow joint working which allowed patients to have appointments for different services to be booked together. Staff worked together to reduce the number of visits patients needed to make to the hospital while receiving all the services they needed.

Most patients that used the services were funded by health insurance or were personally funded by the patients. The service also worked with local NHS service to treat NHS patients when the local NHS trusts were unable to keep up with needs of the local population. Managers told us they had increased their work for NHS trusts during the pandemic as pressures had been higher on NHS trusts.

Staff made patients aware of costs related to treatments and care. Staff in clinic appointments explained treatment options to patients including details on cost related with different treatment options. Staff told patients about additional costs related to their treatment including those for tests, hospital care, and medical care.

Facilities and premises were appropriate for the services being delivered. The department had two outpatient department areas with clinic rooms, treatment rooms for minor procedures, and specialist rooms. These specialist rooms included one for ophthalmology with specialist equipment for examining eyes and a room for gynaecology with specialist equipment for examinations. The two outpatients' areas had one shared waiting room with reception staff to greet patients as they arrived. The hospital had ample free car parking spaces and a bus stop to link with local public transport services.

The hospital's website listed the treatments and services available to patients and had details on how to contact the hospital to discuss services offered. Patients could book their initial appointment by calling the hospitals booking team that worked Monday to Friday from 8am to 6pm. Patients were able to choose between face to face or video call appointments.

Good

Outpatients

The hospital's website had details of virtual open days where patients could dial into virtual sessions by consultants that explain conditions and treatment options available from the hospital.

Managers ensured that patients who did not attend appointments were contacted. Staff told us they would make arrangement for them to have an alternative appointment.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us how they provided support to patients living with a mental health condition. They told us how they worked with the patient, their family and carers to make plans that meet the patients' needs and keep them safe during their visit. Staff told us additional needs including patients needing an interpreter was identified during the booking process. This information was recorded and shared with outpatient's staff before patients visited the department.

The department was designed to meet the needs of patients living with dementia. The department had clear signs with bold easy to read print and a smooth single colour flooring. Flooring with multiple colours can appear to patients living with dementia as holes in the floor.

The service had facilities to meet the needs of patients with reduced mobility and patients using a wheelchair. The hospital had dedicated spaces for patients with a disability and step free access to the hospital. In the hospital there were level floors with no steps between the entrance and the clinic rooms. The waiting areas had toilets which were accessible for wheelchair users including alarm cords that reached to the floor which was in line with national guidance.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they were informed if patients attending clinic needed an interpreter and that the service had two services to provide telephone interpreters to insure, they had access to an interpreter for all patients. Staff told us they would not use patients' relatives or friends as interpreters. This was in line with best practice as interpretation undertaken by people involved with the patient may be distorted. This distortion can be caused by over protectiveness, bias, conflicting interests or lack of understanding of clinical terminology and is not an appropriate way of communicating confidential information. The service had staff with experience in sign languages that they used for patients needing this.

Access and flow

People could access the service when they needed it and received the right care promptly.

Patients were referred to the outpatient's department from the patients' GPs, by the NHS and by self-referral. Managers understood factors that influenced their referral patterns. Patients could book appointments by phone or messaging via the hospital's website. Patients were offered the most convenient appointment with their preferred consultant.

Good

Outpatients

The outpatient department was open Monday to Saturday. Consultants had regular slots when they held their clinics. However, if patients needed to attend on a different day the department arranged for them to see another consultant within the same speciality. The service did not provide an emergency service although same day and next day appointments were arranged for patients when needed.

Reception staff greeted patients as they arrived in the hospital, checked them in on the hospital computer system and gave them directions to where to wait for their appointment. We saw patients were seen quickly after arriving in the hospital. On the day of our inspection the outpatient department was calm and well organised even at times of peak activity.

When patients required a follow-up appointment or to be booked in for tests, this was completed by staff before they left the hospital. Staff arranged for outpatient appointments and diagnostic tests to be completed on the same day to reduce the number of times patients needed to travel to the hospital.

Patient feedback on access to the service was positive. Patients we spoke with and feedback we read was positive about the waiting times and flexibility in receiving an appointment.

Managers monitored waiting times and made sure patients could access services when needed. The service completed monthly waiting time audits for the outpatient department. Managers told us they used this to identify if there were any areas for improvement. Managers said in the past they had identified consultants who consistently arrived 15 minutes late for their clinics. Managers discussed this with these consultants and arranged to book their first patient 15 minutes later to ensure the clinic started on time.

Staff monitored waiting times for patients in the outpatient's department and were improving. In April to June 2021, 85% of patients were seen within 15 minutes of their appointment time. This had improved to 96% of patients in July to September 2021.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. Managers told us they would ensure patients had another appointment arranged immediately and booked for as soon as possible.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they knew how to raise a complaint.

The service clearly displayed information about how to raise a concern in patient areas. We saw information on how to raise a concern or complaint displayed in six languages.

Staff understood the policy on complaints and knew how to handle them. Staff in the outpatient department told us they always tried to address complaints or concerns immediately to see if they could be solved straight away. Staff told us if the problem could not be resolved patients were given details on how to make a complaint.

Good

Outpatients

Managers investigated complaints and identified themes. We looked at four complaints related to outpatients' services all of which had a completed investigation. Managers told us the most common theme in complaints was payments issues and the most common concern raised was around waiting times.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We looked at four complaints and all had received an acknowledgement on the day they were received. All these complaints received an outcome after an investigation had been completed.

Managers shared feedback from complaints with staff and learning was used to improve the service. The hospital shared learning across different departments at their daily site meeting at 10am. We saw learning from complaints was shared with staff at their daily huddle.

Staff could give examples of how they used patient feedback to improve daily practice. Staff reported the main learning point from complaints was to ensure patients receive a full explanation of treatment options including the associated costs. Staff told us keeping patients updated on any delays was vital as patients were much happier to wait if they were kept informed. Patients we spoke to were happy with the waiting times. Managers and staff were working on ways to improve reductions in waiting times including looking at trends in clinics that often ran late.

Are Outpatients well-led?

Good

We previously inspected outpatients with diagnostic imaging jointly therefore we cannot compare our new ratings directly with previous ratings.

We rated it as good.

Leadership

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

The service had a clear leadership structure for the outpatient department. This was led by the head of outpatients that had worked for the hospital for many years and had a large amount of experience in outpatient nursing. They reported to the director of clinical services and were supported by other senior managers.

Leaders understood the challenges the department faced and led improvements. Staff spoke highly of their leadership at all levels and described them as visible, approachable and knowledgeable.

Leaders supported staff to develop their skills and take on more senior roles. Staff told us how they had been supported to develop their skills. A nurse had been supported to develop their skills in ophthalmology and led to them taking on a more senior role leading a new specialist service for the outpatient's department.

Vision and Strategy

Good

Outpatients

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

The service had a vision for what they wanted to achieve. The hospital had a statement of their purpose 'Making a positive difference to our patients' lives through outstanding personalised care' which all staff knew and understood.

The service had a set of values to help them achieve their purpose statement. These values were:

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

We saw staff providing care in line with these values.

The service had a clinical strategy to turn their vision into action. The service had a provider-wide strategy and a hospital specific strategy. We saw many aspects that applied to the outpatient's department including ensuring their equipment replacement programme worked effectively and ensuring an effective rolling programme of refurbishment across the hospital was carried out to help them meet patients' needs.

The service had included patient groups and staff in the development of their values and statement of purpose. Staff told us about this being discussed at team meetings to gain their views.

Leaders monitored their progress against their strategy. Managers monitored each aspect of their strategy in committee meetings and hospital leadership meetings. This included monitoring patient satisfaction scores at their patient experience committee.

Culture

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

Staff felt respected, supported and valued. All staff we spoke with told us they felt leaders and other staff respected them. They told us they felt valued by staff in their department and by staff from across the whole hospital.

Staff were focused on the needs of patients receiving care. We saw staff worked together as one team to meet the needs of their patients. Staff were welcoming and professional in communication with their patients and each other.

The service promoted equality and diversity in daily work and provided opportunities for career development.

Good

Outpatients

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff told us they raised concerns, and these were viewed as opportunities to improve the service. We saw managers had responded positively to complaints raised by patients with a focus on learning how to improve their service.

For our detailed findings on culture, please see the well led section in the surgery report.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders held clinical governance committee meetings every three months to discuss clinical effectiveness including monitoring their performance against targets. Although these metrics did not focus on outpatient's care as there were ones that looked at the whole patient journey or the hospital overall which included the care provided in outpatients. The hospital held a medical advisory committee meeting every three months which included support from the wider Spire Healthcare group.

The service held meetings to discuss and learn from the performance of the service. The hospital had a wide range of committee meetings held every three months that fed into their clinical governance committee which included; the infection prevention and control committee, the safeguarding committee and the patient experience committee.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The outpatient's department held staff meetings every three months and daily huddles. These allowed staff to discuss changes in detail every three months and any immediate changes to practice daily. Staff we spoke to were clear on their role and what they were responsible for and who they reported to when things were beyond their level of accountability.

Management of risk, issues and performance

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

Leaders and teams used systems to manage performance effectively. They shared performance information with staff via notice boards at the nurse station and via team meetings. The number of patients to be seen in the department was discussed with staff daily at their huddles and staff were able to ask and offer support to each other.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. We saw records showing risks were discussed and the service monitored the number of risks overdue for review at their clinical governance committee held every three months. The service held a health and safety and a risk management meeting every three months when all actions and mitigations were reviewed for current risks. Staff we spoke to knew about the

top risks in the outpatient's department. The department had a poster which displayed thloceir top three risks that were; staffing levels and skill mix, capacity and space to meet the needs of patients while maintaining COVID-19 precautions, and equipment failures. These included their risk rating which was calculated based on the likelihood and consequence of each risk.

The service had plans to cope with unexpected events. Staff told us these plans included an adverse weather plan resulting in staff being unable to attend the hospital. Staff were clear on their responsibilities during these events. Leaders told us they had practiced these plans to see how quickly they were able to arrange additional staff to maintain safe staffing numbers.

Staff were not constrained by financial pressures from delivering safe care and quality improvements. Staff told us they were not dissuaded from pursuing improvement to safety or quality by financial pressures. Staff gave examples of when needing new or improved equipment this had always been greeted with support from their leaders.

Information Management

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

The service collected reliable data and analysed it. Staff and leaders collected and analysed data on staffing, quality and safety. This included monitoring of compliance with; hand hygiene, cleanliness, use and availability of personal protective equipment.

The information systems were integrated and secure. Most records were paper which were kept in locked trolleys. Electronic records and digital information were kept on computers that were secured with usernames and passwords for each member of staff preventing unauthorised access. Staff logged out of computers when not in use.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff told us information was displayed clearly and was easily accessible including information on paper records. Staff had identified additional monitoring that could be used to improve patient care and told us they had been supported to carry out this monitoring. One of these projects was to monitor the cancellations of appointments with the reasons for these to identify trends and themes. Leaders planned to use this information to reduce the number of patients having cancelled appointments.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups and the public to plan and manage services.

Leaders and staff actively and openly engaged with patients. Staff collected feedback from patients and leaders analysed this for trends which was then shared with staff. Leaders compared this hospital's results with the wider Spire Healthcare group which showed the patients were more likely to recommend this hospital to friends and families than the average for all the other Spire hospitals.

Good

Outpatients

The service engaged with the public. The hospital had a website where the public could see information about the hospital including services offered in the outpatient's department. Their website contained hospital news, patient stories and information on how to contact the hospital. The service produced a newsletter for the public which included information on; their new rapid access heel pain clinic, their investment in new ophthalmology equipment and their safety precautions for COVID-19.

Leaders engaged with staff and carried out a yearly staff survey to understand the feelings of their staff. Leaders had produced an action plan to improve their performance of the workforce race equality standards in 2021. We looked at this action plan which included a focus on reducing inequality in their recruitment process.

For our detailed findings on engagement, please see the well led section in the surgery report.

Learning, continuous improvement and innovation

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

Staff and leaders were committed to continually learning and improving services. The service used information to improve care. Staff we spoke to in the outpatient's department were passionate and committed to continuous improvement. Staff told us they saw any concerns, complaints or incidents as an opportunity to make their service better.

The service recognised and rewarded staff for innovations and quality improvements. Staff nominated each other for a shout out scheme that posted supportive comments into a monthly logbook. Leaders nominate their staff for an award after having completed exceptional work or improvement projects. The most recent award for the outpatient's department had been for all staff after having completed their support for NHS cancer services during the surge of COVID-19. Staff received a letter and a monetary reward issued by the hospital director to show their appreciation.

The service encouraged participation in research. Staff in the outpatient's department participated in research into the benefits of carrying out a minor procedure to treat carpel tunnel syndrome in comparison to the traditional day surgery treatment. This showed an increase in effectiveness of the treatment and lower risks for patients including patients not needing to undergo a general anaesthetic.

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

The hospital had a Spire Healthcare training policy which explained the mandatory training responsibilities of staff. Mandatory training was split into departments and job roles. Staff working in the surgery service would have a personalised list of mandatory training for them to complete.

We assessed the mandatory training requirements and it was comprehensive and met the needs of patients and staff. Staff completed training through face to face and e-learning modules. Staff we spoke with told us there were no barriers to accessing mandatory training.

Spire Healthcare set a target of 95% for completion of mandatory training. As of September 2021, compliance with mandatory training for staff working in pre-assessments was 95%, theatres 95% and the ward 87%. Staff that had not completed their training had until 31 March 2022 until it became overdue.

Senior staff through conversation with the inspection team, could demonstrate that they reviewed and had oversight of the hospital's mandatory training completion rates both hospital-wide and in the surgery service.

Safeguarding

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

Good

Surgery

The hospital followed the Spire Healthcare policies for safeguarding adults at risk and procedure for safeguarding the care of children and young people. These policies provided staff with guidance on how to identify abuse and follow the processes if they need to raise a safeguarding concern. These policies covered other elements of safeguarding such as radicalisation and female genital mutilation.

Safeguarding was part of the staffs' induction and mandatory training. Staff had the appropriate level of safeguarding training for their role and could recognise the signs of abuse. Consultants submitted evidence that they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.

The director of clinical services (DCS) was the lead for safeguarding at the hospital, had trained to safeguarding level 4 and had oversight of any referrals made in order to support staff and patients. The interim ward manager was also trained to safeguarding level 4.

We saw safeguarding adults and children and young people flowcharts displayed on notice boards in the surgery service. These gave staff a clear and concise visual reminder about the process they should follow if they have a safeguarding concern.

Most staff had not raised a safeguarding concern whilst working at the hospital but knew who the hospital safeguarding lead was, could demonstrate what constituted as abuse, and explain the safeguarding processes they would follow if they had concerns about a patient. Staff who had raised a safeguarding concern gave us details and explained the actions they had taken.

Safety was promoted in recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the hospital. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

The hospital had a safeguarding committee which met quarterly. We reviewed meeting minutes which showed there was a set agenda and included discussing safeguarding incidents, training and any updates to policy and procedures.

Cleanliness, infection control and hygiene

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

Spire Gatwick Park had infection control policies and procedures to help control infection risk. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection in the hospital and the surgery service. In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. This included a new procedure for when staff, patients and visitors arrived at the hospital, and for patients who needed to home isolate and have a negative COVID-19 test prior to their elective surgery.

COVID-19 was still a risk when the inspection took place and therefore COVID-19 measures were in place at the hospital. During our inspection we saw the following COVID-19 measures carried out to protect patients, visitors and staff:

- Face masks available at the entrance to the hospital.
- Rapid lateral flow tests available to test day patients and visitors for COVID-19 at the entrance.
- Hand sanitiser available at the entrance and throughout the hospital.

- Signs to remind patients, visitors and staff of the need for social distancing to reduce the spread of the virus.
- Posters highlighting the importance of good hand hygiene.

Staff could explain the procedures they would follow if they had concerns about a patient or visitor's infection status.

All staff completed twice weekly lateral flow testing and records of these were maintained. The vaccination status of all staff was recorded in their personnel records. Records showed a high uptake of vaccination amongst the clinical and non-clinical staff working in the surgery service.

All areas of the surgery service we inspected, including the theatres and wards, were visibly clean and tidy. The hospital, since the last inspection in 2017 had continued with its programme of replacing carpet and fabric furnishings, which posed an infection control risk as not wipe clean. On this inspection we saw suitable flooring and furnishings throughout the hospital and the surgery service.

The hospital had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. Cleaning records were up-to-date and demonstrated areas were cleaned regularly and deep cleaned when needed. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. Due to the COVID-19 pandemic PLACE assessments had been cancelled for 2020. The hospital had completed the 2021 audit in October and were waiting the results. The hospital's PLACE audit results for 2019 showed a score of 100% for cleanliness.

Staff used *I am clean* stickers on equipment in the clinical areas to identify that items had been cleaned and were ready for use.

Staff were required to complete infection, prevention and control (IPC) training during their induction and then annually at the level appropriate to their role as part of their mandatory training. We observed staff following good general infection control practices to minimise the spread of any infection; they wore face masks, were bare below the elbow and cleaned their hands before and after contact with every patient. Staff had access to hand washing facilities and personal protective equipment, such as gloves and aprons in a variety of sizes. Clinical handwashing sinks were installed in clinical areas in the theatre suite and on ward corridors and in patients' bedrooms. This meant staff had the facilities needed to effectively wash their hands to help prevent avoidable health acquired infections.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve IPC practices if needed. The hospital had a designated lead for IPC who was available to provide support, advice, training and updates for staff. They also monitored compliance with IPC policies via the audit programme. We reviewed IPC audit data which showed between 97.4% and 100% compliance for the surgery service. The IPC lead told us they were supported by IPC link nurses in the clinical areas. Their role was to increase awareness of infection control issues in their own area and to motivate staff to improve practice.

The audit programme was used to increase and maintain standards and help prevent the spread of infection. We saw evidence IPC and audits were discussed during ward and theatre meetings and issues were raised and an action plan put in place.

Good

Surgery

The hospital had quarterly IPC meetings. We reviewed minutes from these meetings and could see it was an effective way to monitor, promote and maintain IPC standards at the hospital. Actions from meetings were given an owner and progress was reviewed at the next meeting.

The hospital completed water flushing round the hospital and there was a quarterly water management committee meeting. We reviewed documentation that showed that regular water testing was being carried out.

The hospital had a microbiologist on call to give advice and who attended the IPC committee meetings. Minutes we reviewed demonstrated the microbiologist attended these meetings.

Nursing staff carried out infection control risk assessments on all patients as part of their pre-admission assessment process. This included details about any recent illnesses; MRSA status and possible exposure to MRSA or infectious diseases in the month prior to pre-admission screening. This facilitated the identification of infection risks at the earliest possible time in the patient's care pathway to ensure correct infection prevention and control practices were instigated.

The service provided patients with verbal and written information, in their pre-admission information pack and on discharge from the hospital, on how good IPC measures prevented and controlled infection. It included information about hand washing and caring for surgical wounds. This also included information for the patient on how to spot the signs and symptoms of a wound infection and what action needed to be taken if a patient had concerns.

The hospital had two laminar flow operating theatres, a system of circulating filtered air to reduce the risk of airborne contamination. This worked to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments.

Staff followed good practice guidance and maintained clean and dirty flow within the operating theatres. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum.

The hospital had a sterile services quality and management systems manual. There were onsite facilities for the decontamination and sterilisation of surgical instruments. Equipment was tested, maintained and validated to national standards and the service had the required accreditation. The hospital used a track and trace system to trace all reusable accessories to ensure appropriate maintenance, correct decontamination and traceability to associated patients.

The hospital had recorded 15 surgical site infections (SSI) in the reporting period October 2020 to September 2021 which was a rate of 0.2% of the total number of procedures performed at the hospital. Of the 15 SSIs, 87% were superficial which meant the infection occurred just in the area of the skin where the surgical incision was made. The IPC lead told us and we saw evidence in the IPC meeting minutes, that surgical site infections were reviewed to see if trends could be identified and areas of infection control improved on. Of the 15 SSIs reported no common themes or trends were identified. The hospital reported no incidences of c.difficile, methicillin sensitive staphylococcus aureus (MSSA) and methicillin resistant staphylococcus aureus (MRSA) between October 2020 to September 2021.

Environment and equipment

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

Good

Surgery

Since our last inspections in 2015 and 2017, investment in the infrastructure of the hospital had continued. This included the remaining carpets being removed and replaced with appropriate flooring throughout the hospital and upgrades to ward bedrooms and clinical areas. Further refurbishment was planned for the hospital including the theatre area and the daycase ward.

The surgery service had suitable facilities to meet the needs of patients for the type of care delivered. There were three theatres with supporting rooms, two with laminar flow systems which were used mainly for implant surgeries, and one without which was used for general surgery. The recovery area had space for six trolleys for patients recovering from surgery. However, two of the bays were used for equipment storage. Each of the four bays had the required equipment as recommended by the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

The service had two surgical wards with 29 ensuite bedrooms and a 20 bedded daycase ward with a further five single rooms. The rooms were comfortably furnished which patients said met their needs. The service also had a two bedded enhanced recovery unit (ERU) for level 1 enhanced care. Each patient room and bathroom had emergency call bells, which were used to alert staff when urgent assistance was required.

The theatre suite had storage areas for consumables and equipment. However, some larger pieces of equipment were kept in the recovery area behind curtains. The theatre manager told us this was not an ideal way to store equipment but the department was lacking storage space. Although not ideal we found the equipment was clean, neatly stored and could be assessed with ease and meant equipment was not kept along the corridor. However, we did not see this recorded on the environment risk assessment for the theatre area. The ward areas had adequate storage for the department's needs.

The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. Due to the COVID-19 pandemic PLACE assessments had been cancelled for 2020. The hospital's PLACE audit results for 2019 showed a score of 98% for the condition, appearance, and maintenance. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.

Senior staff working in the surgery service carried out environmental risk assessments. We reviewed these assessments and found them to be thorough and in date. Hazards were identified, such as certain equipment and chemicals used in the areas, who was at risk and the controls to mitigate the risks.

During our inspection, we observed staff kept meeting rooms, cleaning and storage cupboards, and utility rooms locked and secured at all times. This meant access to areas unsuitable for patients was controlled.

Both wards and the theatre suite had resuscitation trolleys which were secured with anti-tamper tags making it clear if someone had accessed the equipment. Staff, as per hospital policy, performed daily checks on the resuscitation equipment stored on top of the resuscitation trolleys and monthly checks on the contents. The theatre suite had a difficult airways trolley which was checked weekly. Records we reviewed during our inspection showed all equipment checks were carried out. This showed there was a consistent and regular approach to safety checks.

Good

Surgery

In theatres, staff carried out daily checks of anaesthetic equipment prior to the start of the surgery list in line with the Association of Anaesthetists of Great Britain and Ireland guidelines. They followed the anaesthetic equipment checklist and recorded this once completed. This provided assurance that equipment was ready for use and fully compliant.

The service kept records of equipment across their department, this included service history and electrical testing. We carried out a random check of equipment in the theatre suite and on the wards. All items we checked had a label indicating it had been checked for electrical safety and had been serviced. This provided the assurance equipment was safe to be used.

Staff told us they had enough equipment to provide safe and effective care and treatment to patients. We checked a sample of consumable items for expiration dates and all were in-date. Storerooms were tidy, well organised and items stored correctly according to policies and procedures. This meant staff could easily locate consumable items.

The hospital had bariatric equipment including beds, trolleys, armchairs, commodes and hoists. Senior staff in the service told us they had no issues obtaining this equipment where required.

Pressure relieving pads and equipment were used in theatres to protect patients from pressure injuries. Body warming equipment was also used to maintain patient's body temperature during lengthy procedures.

The hospital had a tracking system for details of specific implants and equipment to be recorded and reported to the national joint registry. We saw that all equipment, implants and prosthesis were tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.

Staff understood their responsibility to ensure they segregated and disposed of clinical waste according to the hospital's waste management policy. During our inspection we saw the correct management of containers for sharps and the use of coloured bags to correctly segregate hazardous and non-hazardous waste. Staff removed clinical waste from the clinical areas at regular intervals to reduce infection control risks. It was stored securely until collected by an external supplier the hospital contracted to dispose of clinical waste.

Assessing and responding to patient risk

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

All surgical patients followed the elective pathway and admissions were booked in advance.

The hospital had an admission criteria which meant the hospital only admitted patients the hospital had facilities to care for. There was no critical care unit at the hospital, although the hospital did have an enhanced recovery unit (ERU) which offered level 1 enhanced care for patients. Level 1 enhanced care meant patients' who needed a greater degree of observation and monitoring which could not be safety provided in the individual bedrooms. The hospital had a standard operational policy for the ERU, which included a definition of the service delivered at the hospital and the admission and discharge criteria for patients to be cared for in the unit.

The hospital admitted patients with co-morbidities such as bariatric patients and patients living with dementia. However, patients with complex co-morbidity would not routinely be admitted for treatment. Admission exceptions were only considered on the presentation of all relevant clinical evidence, a risk assessment and the mitigation of risk and with the agreement from all parties involved in the care of the patient.

Good

Surgery

The service had developed pre and post surgery principles and procedure management during COVID-19. There were clear elective surgery pathways which had been instigated during the pandemic and were followed.

Patients undergoing elective surgery had a pre-assessment to ensure they met the inclusion criteria for surgery and key risks identified that may lead to patient complications during the anaesthetic, surgery, or post-operative period. This assessment was carried out by a registered nurse. It also provided an opportunity to ensure that patients were fully informed about the surgical procedure and the post-operative recovery period.

The service was completing pre-assessments over the telephone rather than face to face since the COVID-19 pandemic. This included patients undergoing a local anaesthetic and patients having a general anaesthetic for total knee and hip replacements. The service was using an electronic pre-operative assessment with patients filling out an online questionnaire before the pre-assessment appointment. This meant clinical staff could review patient data before the appointment, to ensure that any concerns were identified and follow up with questions pre-prepared. Staff told us this system was new and was still being embedded into the service. During our inspection we observed a pre-assessment telephone screening and found it to be thorough, with potential risks identified, additional questions asked recorded and passed to the relevant teams.

If patients needed clinical assessments before their operation, for example, ECGs, blood samples or MSRA screening, this would be completed in an outpatient clinic. Patients were swabbed to assess for any colonisation of MRSA as per hospital policy. If results were found to be positive the patient was provided with a treatment protocol to use at home, according to the hospital's MRSA policy. If necessary, surgery would be deferred until the patient had a negative swab result.

Staff completed risks assessments for patients on admission to the hospital using national recognised tools. These assessments included risks of malnutrition, falls, venous thromboembolism (VTE) and known allergies. Care plans were developed using this information to provide care and treatment and minimise risks as identified. Patients with known allergies were seen to wear a red wristband. This alerted staff to the patient's allergic status and helped mitigate the risk of allergic reactions.

During our inspection we observed the theatre team used the five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks consisted of team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (at the end of the procedure) and debrief. We observed all five steps of the WHO checklist and saw staff fully completed and engaged in all the required checks. We noted the WHO checks was embedded in practice and within the theatre culture.

The hospital audited the WHO checklists. From August 2020 to September 2021 audits showed compliance was 99.8%. Regular feedback was given to the surgical team to make sure the checklist was used correctly and fully. Patient records we reviewed showed staff had complied with the checklist.

Staff had immediate access to blood products, to stabilise patients with life threatening haemorrhage. The blood fridge temperature and stock were checked and recorded daily.

We observed patients being transferred from theatre to the recovery area, and saw the anaesthetist, surgeon and scrub nurse verbally handed over the care and treatment carried out in theatre and discussed medication which had been prescribed for both recovery and the ward.

Good

Surgery

Whilst in the recovery unit patients' health and wellbeing was monitored using the nationally recognised national early warning scores developed by the Royal College of Physicians (NEWS2) for the detection and response to clinical deterioration in adult patients. This is a key element of patient safety and improving patient outcome. Records showed staff used NEWS2 tool to identify deteriorating patients in the recovery areas and on the wards and any changes were escalated appropriately.

If a patient deteriorated, the resident medical officer (RMO) would review and liaise with the consultants for advice about managing increased risks or to consider transfer to an acute hospital if needed. The hospital did not have a service level agreement with the local NHS trust for transferring patients for medical reasons. Staff followed the hospital's protocol and patients would be taken by ambulance to the local NHS trust's accident and emergency department. Staff told us there had been no delays transferring a patient when required.

From October 2020 to September 2021 there had been 13 unplanned transfers, which was 0.17% of all daycase and inpatient admissions. The hospital reviewed transfers to look for themes and trends and to see if lessons could be learnt and changes in practice needed.

The service had an on-call theatre team in case a patient had to return to theatre. From October 2020 to September 2021 there had been 10 re-admissions to the hospital post-surgery with three needing a return to theatre. This was 0.13% and 0.04% of all day and inpatient admissions respectively. The hospital reviewed re-admissions to look for themes, trends and to see if lessons could be learnt and changes in practice needed. We reviewed information and could see re-admissions were investigated thoroughly, no trends and themes had been identified and where lessons had been learnt these had been implemented. For example, catheterisation training.

The hospital had a sepsis screening tool and sepsis care pathway for staff to use if they suspected a patient had sepsis. The tool was aligned with current best practice. Staff we spoke with were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the RMO. Sepsis training was part of the competency training for clinical staff.

Consultants were required by the practising privileges agreement they worked under, to be contactable at all times when they had inpatients in the hospital. Furthermore, they needed to be available to attend the hospital within an agreed timeframe to respond to any urgent concerns. The RMO and nurses told us that consultants were easily contactable out of hours, such as at night or over a weekend should staff be concerned with a patient's condition. Individual consultants remained responsible for the overall care of their admitted patients.

Theatre staff attended a safety huddle each morning, where the operating list was discussed. Any potential patient risks or issues were highlighted and planned for.

Nursing staff on the wards undertook handover between each shift which included an update on all inpatients and highlighted any specific concerns such as infection risks or safeguarding concerns. During our inspection we saw effective communication of key information to keep patients safe between staff of all grades and roles.

The hospital had a daily communication meeting held at 10am, Monday to Friday. Representatives from each department attended these meetings. The meeting covered a range of subjects and included current patient risk in the hospital. This enabled staff to gain a wider view of risk throughout the hospital. There was no communication meeting at the weekend but a senior manager was on call if support was needed by the teams and departmental huddles still took place.

In addition, the hospital resuscitation team met daily, seven days per week, in response to a call bell test where responsibilities were reviewed. Each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and runner. This was in line with best practice guidance issued by the Resus Council (UK). Any ongoing concern would be escalated to the 10am meeting for support.

Staff working in the surgery service told us the hospital carried out emergency scenarios such as fire, major haemorrhage and cardiac arrest to simulate what they would do in an emergency. Staff were provided with feedback and any lessons learnt were shared with the department. The hospital had developed cards for each team member if a major incident should occur. Each card had the role's responsibility, the actions they needed to take and other relevant information. This was an effective way to make sure the team was organised and worked effectively in an emergency.

Staff at the hospital completed adult basic life support, immediate or advanced life support training depending on their role. Data provided by the hospital post inspection showed life support training compliance was 89% for pre-assessment staff, 91% for theatre staff and 89% for ward staff. At the time of our inspection, the hospital was introducing a resuscitation quality improvement programme (RQI). This used a mobile skills station where staff could practice their cardio-respiratory (CPR) skills. A real-time verbal and visual feedback was given when performing compressions and ventilations to know if they had been effective. The system measured the quality of CPR delivered and designated a score. RQI had been designed to train staff in effective CPR skills and to help them retain these skills. We observed staff being shown the skill station, practicing their CPR and being given feedback on their performance.

Patients at discharge were given aftercare booklets which included what to do if patients had concerns or certain symptoms. It included information on reducing the risk of deep vein thrombosis, falls prevention and caring for wounds, the signs and symptoms of an infection and who to call if there was a problem. Ward staff would routinely call patients 48 hours after discharge to check how the patient was recovering and this was recorded in the patient's records.

Nurse staffing

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

Managers ensured the ward and theatres had enough skilled staff to provide appropriate care and treatment on site. The service knew patient admissions in advance and manages calculated staffing levels to ensure safe staffing levels were planned according to the number of patients using Spire Healthcare staffing guidance and best practice.

In the operating theatre, there was adequately skilled staff to manage the elective surgery list. The theatre manager followed the Association for Perioperative Practice (AFPP) guidelines. The AFPP recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. We observed and records showed theatre staffing met these recommendations. Senior theatre staff told us they reviewed their staffing daily to ensure the theatre list could go ahead. On the day of our inspection a theatre list had to be cancelled due to staff sickness on the day and cover could not be found to make the service safe at such short notice.

Staffing levels on the ward were calculated using an evidence based electronic patient acuity and dependency monitoring tool. The tool could be manually adjusted to take account of individual patient needs. On the day of our inspection the ward was staffed with the planned number of staff to ensure safe staffing.

Good

Surgery

Any staff shortages in the surgery service and across the hospital were discussed at the daily communication meeting, which was attended by a representative from all hospital departments. Plans would be put in place to ensure services were staffed safely, for example approving the need for additional staff or cancelling a surgical list if needed.

Senior staff in the service told us there were ongoing difficulties with recruitment and this was recorded on their risk register. At the time of our inspection there were nine vacancies across the surgery service which was a vacancy rate of 11.5%. This meant the service was reliant on bank and agency staffing for safe staffing levels. However, where vacancies occurred, the service did their best to fill the role with regularly used bank or agency staff. This meant they were fully embedded and accustomed to the working practices of the hospital and the teams they worked in.

Medical staffing

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

Each patient was admitted to the hospital under the care of a named consultant with the relevant experience in that area of medicine. Consultants led and delivered the surgical service at the hospital under practising privileges. A practising privilege is, "Permission to act as a medical practitioner in that hospital" (Health and Social Care Act, 2008). The hospital had granted 192 consultants/health professionals practising privileges, including but not limited to; specialist surgeons such as orthopaedic, ear nose and throat and urology, and anaesthetists.

There was a Spire Healthcare practising privileges and appraisal policy. The policy set out the requirements for each consultant concerning their indemnity, appraisal, General Medical Council registration, Disclosure and a Barring Service (DBS) check. DBS assists employers to make safer recruitment decisions and prevents unsuitable or unqualified people from working with vulnerable groups, and yearly mandatory and appraisal proof of compliance.

All consultant surgeons, paediatricians and anaesthetists had to complete an application for admitting rights. This information was used by the hospital management team to determine whether the person had the required skills and experience to carry out treatments at the hospital. Consultants had to demonstrate they were competent to perform the procedures included as part of their practising privileges and they were working within their normal scope of practice. Medical staff who could not demonstrate they had the relevant skills were not granted practising privileges.

There were robust processes in place for reviewing practising privileges at the hospital. The director of clinical services and the hospital director reviewed these every two years, and certain information such as mandatory training and appraisal information were reviewed yearly.

The hospital had a medical advisory committee (MAC) to ensure doctors working in the service continued to meet the required standards to practice at the hospital. The MAC made sure any new consultant was only granted practising privileges if deemed competent and safe to practice.

Clinical staff in the surgery service told us they had a good working relationship with their consultants, they were comfortable contacting them when the need arose and found them to be helpful. During our inspection we saw interactions between the nursing teams and the consultants and found them to be mostly friendly, professional and with mutual respect.

Nursing and theatre staff told us they could contact any consultant, out of hours or when not onsite, if they needed advice about the best care and treatment for a patient and they would attend the service if required. The consultants undertook a daily review of the patients under their care and plan of care was developed and communicated to the clinical staff and recorded in the patients' notes.

The resident medical officer (RMO) provided daily medical cover 24 hours a day, seven days a week, on a rotational basis. RMOs were employed through a formal contract with an agency. They worked a one week on one week off rota. This ensured that their duty weeks were balanced with consolidated periods of rest.

The RMO was the doctor responsible for the care of the patients in the absence of the consultant. They provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of a cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required.

Records

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

Records were predominantly on paper. Staff used specific care pathway paperwork for each patient which ensured they kept the relevant records for that procedure. Records contained information from when a patient had been booked for a procedure until follow up care after discharge had finished. Records were multidisciplinary, meaning each clinical team wrote in the same set of records, including the surgical team.

We reviewed four sets of patient records and found these to include the relevant assessments of care needs, risk assessments and were patient centred and personalised. Each record contained a sepsis pathway, ready for use if required. Records seen were accurate, comprehensive and provided a clear picture of the care and treatment each patient received from their initial contact through to discharge.

We saw evidence in the patient records of ward to theatre handover and theatre checklists completed. This ensured continuation of patient care between the teams.

Where appropriate patient care records contained stickers identifying equipment and implants used during surgery. This meant they could clearly be tracked and traced.

Records were easily available to staff providing care, stored securely and locked away when not in use. This meant there was restricted access to prevent unauthorised access to confidential patient care records.

The hospital audited 30 sets of notes each quarter to monitor compliance. From July 2021 to September 2021 record keeping compliance was 100%. This demonstrated staff were completing records in full to provide a comprehensive record of patient's care and treatment.

Theatre staff maintained a log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

Discharge letters were sent electronically to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided. This ensured continuation of patient care.

Once patients were discharged and no further follow up care was required, records would be retained and stored securely within the medical records department. This department had responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured medical records were readily accessible for each episode of patient care and tracked throughout the hospital.

Medicines

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

Staff followed the hospital's policies and procedures when prescribing, administering, recording and storing medicines. The hospital had its own pharmacy with their staff being responsible for the supply and top-up of medicines used in the theatre area and inpatient wards and take-home medicines for patients. Nursing staff told us pharmacy staff provided a good service and were available and accessible when needed.

A pharmacist was on site between 9am and 5pm Monday to Friday and between 9.30am and midday on Saturday. A pharmacist was on call 24 hours a day, seven days a week to provide an out of hours service when require to support staff. The on-call pharmacist was contacted for any controlled drugs (CD) if this was required out of hours.

During our inspection we found medicines were stored appropriately in locked cupboards on the wards and in the theatre area. We checked a selection of medicines in the surgery service and found all were in date and kept in line with manufacturers advice. Stock matched the records. Fridge temperatures were recorded daily, and staff sought advice from the pharmacy team when the temperatures were found to be outside recommended ranges.

The service was registered with the Home Office and held a controlled drug (CD) licence as required and in line with the Misuse of Drug Act 1971. The service had a CD accountable officer. We reviewed the CD register and a sample of CDs which showed all CDs were stored securely and any CD administered had two signatures recorded as required. Stock matched the register. Staff carried out daily checks of their CD stock and records were clearly maintained. Staff were clear and knowledgeable about the managements of CDs. We observed staff dispensing and administering a CD for one patient. They ensured the CD register was signed only after this had been administered which was in line with best practice.

The hospital did not use patient group directions (PGD). A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor.

Medicines prescribed on the medicine chart were dated and signed by the prescriber. Prescriptions detailed the dose and the time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the patient.

Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines. The resident medical officer (RMO) sought advice from the consultant surgeon or anaesthetist prior to changing any patient's medicine as the consultant had overall responsibility for the patients' care.

The pharmacy team completed medicine audits, for example prescribing appropriate medicines, and turnaround time of drugs required at discharge. The team shared audit results with the departments to decide on setting up action plans if needed. Medication incidents were reviewed, investigated and learning from these were shared with staff. There had been 22 medication incidents including six near misses. The highest factor in medication incidents was prescribing error with six incidents. Patient adverse reaction to medication was the second highest incident rate with four. The hospital held

quarterly medicine management meetings to monitor the safe and effective use of medication systems and processes used at the hospital and put in action plans if needed. Post inspection we reviewed minutes from these meetings and could see there was a set agenda which included, medicine incidents, audit results, drug safety alerts and issues to be escalated to the clinical governance meeting.

Incidents

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

All incidents were reported in line with the Spire Healthcare incident reporting policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

The hospital used an electronic system for reporting incidents. All staff could access the incident reporting system. Staff said they knew what constituted as an incident and were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. There was a no-blame culture and staff said they felt confident in reporting incidents.

The incident review working group discussed and investigated incidents if needed. Findings from this group were discussed at the quarterly clinical governance meetings. We reviewed three sets of minutes and saw evidence incidents, adverse events and near misses were discussed, investigations into incidents reviewed, actions taken to reduce risk and reduce the likelihood of reoccurrence put in place and to see if there were any trends emerging. For example, the hospital was investigating unplanned admission following day case to overnight stay conversion to see if any trends or themes could be identified. The hospital saw incident reporting as a tool to drive improvement. Incident information from the clinical governance meeting was fed back by the heads of department to their teams. This happened in a number of ways, via team meetings, emails and during handovers.

Staff we spoke with said they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.Staff gave us examples of when change was needed as a result of an incident. For example, extra training in bladder scanning after a scan was attempted over a surgical dressing. Staff confirmed managers supported them when they were involved in incidents. Staff were encouraged to reflect on incidents they had been involved in.

Minutes from the medical advisory committee (MAC) meetings showed incidents were discussed at these meetings. This showed that consultants had awareness of incidents being reported at the hospital.

From October 2020 to September 2021 there had been 692 clinical and non-clinical incidents reported relating to the surgery service; 210 from the theatre area and 482 from the ward area. This was 73% of all incidents reported in the hospital. Of these, 38% of incidents were rated as no harm, 26% rated at low harm (minimal harm – patient required extra observation or minor treatment) and 4% rated as moderate harm (moderate harm: short term harm - patient required further treatment, or procedure) and there was no incidents of severe harm (permanent or long-term harm), 17% of incidents were classed as a near miss.

Good

Surgery

Two incidents during this period had been recorded as Serious Incidents Requiring Investigation (SIRI). The hospital had completed investigations into these incidents and provided evidence of the learning from the investigations that had resulted in changes of practice.

There had been zero never events in the same reporting period. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

There was an effective process for investigating any incident that may cause harm to patients. A senior manager undertook a root cause analysis (RCA) following any incident and developed an action plan to minimise the risk of reoccurrence. Managers shared investigation outcomes with staff as part of lessons learnt. We reviewed the last three incidents requiring an investigation and saw evidence this occurred.

Staff we spoke with in the surgical service could explain duty of candour and understood their responsibility to be open and honest with patients and their relatives when something had gone wrong. During our inspection a surgical list needed to be cancelled due to staff sickness. Senior surgery staff immediately explained to patients the reason for their cancelled surgery. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a Spire Healthcare duty of candour policy. It was the responsibility of the senior management team to ensure the principles of the duty of candour had been completed.

Patient safety alerts were a set agenda item at the quarterly clinical governance meeting. Heads of departments ensured actions from patient safety alerts were acted upon where needed and information shared with staff.

Safety thermometer

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

The hospital used the safety thermometer to monitor patient safety. The safety thermometer is a measurement tool for improvement in health care, which focuses on the most common harms to patients; pressure ulcers, catheter or urinary tract infections, venous thromboembolism episodes and patient falls.

The hospital collected this data from patients and used it to monitor performance and put in measures to improve patient care. In the reporting period October 2020 to September 2021, the service had reported one hospital acquired infection, one hospital acquired pressure ulcer and one hospital acquired urine tract infection. In the same timeframe there had been 11 falls.

We saw evidence of how the service used this data to improve patient safety. For example, the ward had invested in motion sensors to help in the prevention of patients falling.

Are Surgery effective?

Good

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

Good

Surgery

Evidence-based care and treatment

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

The service had up-to-date policies and procedures to ensure care and treatment was delivered in line with national guidance and best practice. Policies we reviewed referenced national guidance including the National Institute for Health and Care Excellence (NICE), The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

Patients were assessed using the American Society of Anaesthesiologist (ASA) grading system for pre-operative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled the staff and anaesthetists to plan specific post-operative care for patients as required.

Staff followed guidance for surgical site infection prevention and treatment in line with NICE guideline (NG125) which included antiseptic skin preparations and antibiotics before skin closures.

In the operating theatres, staff monitored patients' temperatures in line with NICE Clinical Guideline CG65- Hypothermia: prevention and management in adults having surgery.

Updates to policies, due to change in guidance and tracking of policy review dates, were carried out at a corporate level and cascaded to the hospital for implementation. Changes to policies was a standing agenda item at the hospital's quarterly clinical governance meeting. Changes in working practice was the responsibility of the head of department to execute and staff were required to sign to say they had read the update to the policy. Changes to policies and procedures was also a standing agenda on the medical advisory committee (MAC) meeting. Staff could access policy documents on the hospital's database. These measures ensured staff working in the service were following up-to-date practices and providing safe care to patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory training.

The hospital completed a range of audits throughout the year to ensure healthcare was provided in line with their policies, national guidance and standards. This included the Spire Healthcare audit programme, a rolling programme of set audits and hospital specific audits. Audit results were collated and used to benchmark against the other hospitals of a similar size within the Spire Healthcare Group.

Nutrition and hydration

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

Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Patients were advised about pre-surgery fasting times (omitting food and fluids except water before operation) during the pre-assessment process. The service followed the Royal College of Anaesthetists guidance about pre-operative fasting to ensure patients fasted for the safest minimal time possible. Written information about pre-surgery fasting times was also sent to the patient. The service offered patients staggered admissions to ensure they did not fast for longer periods than necessary.

The hospital monitored patient fasting times as patients fasting for longer times than required could affect their wellbeing and the outcome of their surgery. At the last inspection in 2015, 50% of patients met with best practice guidelines around fasting times. The service had worked hard to improve fluid fasting times for patients. A working party had been set up, which included representatives from the teams involved in patient fasting and an anaesthetist, to see where problems arose in the patient pathway that lead to patients' fluid fasting longer than needed. The hospital realised a team approach was needed to solve the problem and to have procedures that worked for all teams. Changes in working practice had been implemented and the service introduced a 'think drink' campaign. This approach saw compliance improved consistently at 95% of patients meeting best practice guidelines around fluid fasting times each month.

Staff used the Malnutrition Universal Screening Tool (MUST) to assess, monitor and record patients' nutrition and hydration needs throughout their hospital journey. Fluid balance charts were used to monitor patients' fluid intake. We reviewed patient records and saw that these were consistently completed. Nausea and vomiting was formally assessed and patients were prescribed anti-emetic medicines (medicines to prevent / relieve sickness) if required.

We observed patients had access to hot and cold drinks and meals were presented well. Staff told us they offered support to patients with food and fluids, although most patients did not require assistance.

Feedback from patients relating to meals was positive. The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2019 showed a score of 97% for the ward food score. Due to the COVID-19 pandemic PLACE assessments had been cancelled for 2020.

Pain relief

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

Patients had access to a variety of pain relief as appropriate for their surgery. Staff completed regular assessments to ensure that patients' pain was controlled and administered pain control as prescribed. Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

We reviewed patient care records and observed the ward round and saw pain was assessed, documented and managed throughout the patients' care. Staff took appropriate actions when patients' pain was not well controlled. For example, changing a patient's pain prescription. Patients were also prescribed anti sickness medicines to manage the side effects of some pain-relieving medicines if required.

Nursing staff discussed post-operative pain relief with patients as part of their pre-assessment and gave them written information as well to support these discussions. Pain management was part of the patient discharge process. Pharmacy and nursing staff would speak with patients about their pain medicines and gave clear instructions on its use at home. Patients also had written information on how to manage their pain or discomfort in the aftercare booklet that was given to patients on discharge.

Patients we spoke with said their pain was managed well and pain relief was available to them when they needed it.

The pain group was part of the medicine management committee which met quarterly. The minutes of these meetings showed that pain management was included in the agenda. Post inspection we reviewed pain trigger audit results. These audits measured how soon analgesia was given to patients after staff had been alerted for the need of pain relief, and other related measures such as was patient's pain level reassessed after an analgesia was given. Audits results showed from October 2020 to September 2021 there was a 90.5% compliance. We saw in minutes from the medicine management committee meetings these audit results were discussed, investigated and actions being put in place to increase compliance. This showed the hospital was committed to improving the care and treatment they gave to their patients.

Patient outcomes

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

The hospital had systems and processes in place to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment. Managers and staff used results to identify areas for improvement.

The hospital participated in national audit programmes such as the National Joint Registry (NRJ), Patient Reported Outcome Measures (PROMs) and the Patient Led Assessment of the Care Environment (PLACE). Data from these audits provided an indication of the outcome or quality of care delivered to patients by the service.

National Joint Registry (NJR) recorded outcomes at this hospital for patients that underwent primary and revision joint replacement procedures. Hospitals were required to submit 100% of their eligible information to the National Joint Registry. In the reporting period 2019/2020, the service had achieved 97.3% for their NJR submission. The hospital's performance was within range or better than expected for all the key indicators of data quality.

The hospital collected Patient Reported Outcome Measures (PROMS) data for hips and knee outcomes and this was reported on a national data programme. PROMs data assessed the quality of care delivered to patients from the patient perspective. PROMs calculated the health gains after surgical treatment using pre- and post-operative surveys. We reviewed data submitted to PROMs which showed, 98% of patients reported a positive improvement after their hip surgery and 94% of patients reported a positive improvement after their knee surgery. However, the response reporting rate for patients was last than half those having procedures. The hospital had identified this and were putting in plans to increase the return rate.

The staff also carried out regular audit of the National Safety Standards for Invasive Procedures (NatSSIPs). This is a national safety standard aiming to reduce the number of safety incidents for invasive procedures in which surgical Never Events could occur. The latest audit for October 2020 to September 2021 showed the service had achieved 99.8% compliance in their audit.

We reviewed data submitted to the above audit programmes and saw outcomes for patients was overall positive, consistent and met national standards of expectations.

The hospital submitted data to the Private Healthcare Information Network (PHIN). PHIN is an independent, not-for-profit organisation. It publishes key performance measures on their website to help patients make informed decisions where to have their care and treatment, by providing patients with straightforward and easy-to-understand information about the quality and safety of care in the private healthcare sector.

Good

Surgery

The service participated in the hospital's audit programme which demonstrated compliance and identified areas for improvements to improve patient care, treatment and outcomes. Results from audits were monitored and discussed at the hospital's clinical governance and medical advisory committees on a quarterly basis as well as at a corporate level. If actions were required, this would be fed back to the departments.

Competent staff

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

All staff with a professional qualification were subject to pre-employment checks to ensure their professional qualification was active and with no restrictions in place.

All staff working at the hospital had an induction programme relevant to their role and the department they worked in. Induction included a Spire Hospital new starter employee guide and a local orientation. New staff to the ward were encouraged to spend time in the other hospital departments, including pharmacy, to understand how each department worked, how the hospital worked as a whole in the patient journey and to get to know other staff in other teams.

New staff were required to complete e-learning and face-to-face training. Clinical staff working in the surgery service worked in a supernumerary capacity alongside an experienced staff member until they were competent to work alone.

Staff completed competency training depending on their role and the area they worked in. This ensured staff had the appropriate skills and knowledge to manage patients safely and effectively. Each member of staff, including bank staff, had their own training folder where evidence of training taken and completed competency training was kept.

The service supported staff to undertake training in order to maintain their professional registration and revalidation. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers.

The hospital employed a clinical educator to support the learning and development needs of staff.

The service was currently training their clinical staff to work in the enhanced recovery unit (ERU) by completing the national competency framework for registered practitioners, level 1 patients and enhanced care areas. At the time of the inspection, 12 of the 16 contracted nurses had completed the programme. This meant the facility could be better utilised in the future as demand for higher acuity patients increased.

Managers supported staff to progress through regular development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported by their managers to improve their practice where indicated. Data provided post inspection showed all staff working in the surgery service had completed an appraisal in the last 12 months.

Multidisciplinary working

Good

Surgery

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

The hospital had a daily communications meeting, which took place every morning and was attended by the senior management team and a representative from each department in the hospital. All staff contributed to provide an overview of the hospital's activity. Any relevant information was taken back to each department and cascaded to the team. Management and staff described the meeting as an opportunity for different teams to come together and to discuss the hospital as a whole. We observed this meeting on inspection and saw the meeting was carried out efficiently with a supportive culture.

During our inspection we observed effective multidisciplinary working between different teams involved in patient care and treatment in the surgery service. There was clear communication between staff and we observed safe and effective handovers of care, between the ward, theatre and recovery staff. We observed physiotherapists and the pharmacy team gave support to patients and clinical staff pre and post operatively.

Seven-day services

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

The hospital did not provide emergency care. All surgical patients followed the elective pathway and admissions were booked in advance

The operating theatres operated six days a week. Theatre staff were on-call should there be any unplanned returns to theatre. For this, they provided an emergency service 24 hours a day and seven days a week and had an established on-call rota. Nursing cover was available on the wards when the hospital was open both during the day and overnight for patients who required an overnight stay.

Consultants undertook a daily review of their patients and either visited or telephoned the service for an update at weekends. Consultants were available out of hours, during weekends and on call 24 hours a day for patients in their care. The resident medical officer (RMO) was based on-site at the hospital and provided a 24 hour a day, seven days a week service. The RMO provided clinical support to consultants, staff and patients.

Allied health professionals including physiotherapy and radiology staff provided care and support out-of-hours. The pharmacy service was available during the day six days a week. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed.

Health promotion

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

Patients attended pre-operative assessment appointments where their suitability for surgery was checked. This included the completion of a health questionnaire, and an opportunity for the nurse to provide advice or refer patients on to other appropriate services if they required these services.

Patients having joint surgery, such as for hip or knee replacement, would see a physiotherapist on a one to one basis with tailored information specific for the patient. Patients were given pre-operative and post-operative exercises and assessed for need of occupational therapy or support from social services.

Good

Surgery

COVID-19 was still a risk when our inspection took place and therefore COVID-19 measures were in place at the hospital. This included, as a preventative measure, limiting the number of objects in communal areas, such as patient information leaflets. However, leaflets were available via the clinical staff, consultants and allied health professionals.

The hospital used laminated health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of social distancing and washing hands to reduce the risk of transmission of the virus.

The hospital offered free health talks to the public. These included talks on back and neck pain and foot and ankle conditions. These talks were currently taking place virtually over a social media platform due to the on-going COVID-19 pandemic. The general public were given the opportunity to have their questions answered during the talks.

The hospital's website had information about health topics. These included sharing patient stories and highlighting health topics such as back care awareness.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

There was a Spire Healthcare consent to investigation or treatment policy. This included, the training required to take consent, whose responsibility it was to obtain consent and when to use implied, verbal and written consent.

Patients were given information about their procedure both verbally and in writing by the consultants and nursing staff to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.

Consent forms we reviewed within the patients' records were fully completed and detailed the procedure planned and the risks and benefits of the procedure. The hospital consent forms complied with Department of Health guidance. The service had a two-stage consent process. Patients' records showed consent was reviewed on the day of their surgery as part of their pre- operative checklist.

Staff followed their internal process for seeking consent from patients when providing care and treatment in line with legislation and guidance and this was clearly recorded. We observed staff asking patients' verbal consent prior to examinations, observations and delivery of care.

Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process to determine whether they could be admitted for treatment at the hospital. Patients were risk assessed on an individual basis and adjustments put in place to deliver safe care to the patient if needed.

The hospital admitted patients living with dementia. The service had a dedicated dementia pre-assessment pack. This included a form for taking consent, a mental capacity assessment form and a '*This is me*' leaflet. The leaflet provided staff with information about the patient to help enhance the care and support given whilst the patient was in the unfamiliar environment of the hospital. The hospital had a dementia lead who liaised with patients and their families on how the

hospital could best support the patient. In addition, each department had a dementia champion who could provide support for patients, their families and staff in the areas where they worked. Staff we spoke with told us they had dementia training, took into consideration patients' wishes and followed guidance to ensure decisions were made in patients' best interest.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The surgery service had a compliance rate of 97% at the time of our inspection.

Are Surgery caring?

Good

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

Compassionate care

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

Staff throughout the surgery service put patients at the centre of what they did. During our inspection we saw pleasant interactions between staff and patients. We saw staff treat patients with warmth and care, they were courteous, professional and demonstrated compassion to all patients.

We saw theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious. For example, we saw theatre staff ensured that patients were not left exposed unnecessarily.

Staff were discreet and responsive when caring for patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Peoples' privacy and dignity was always considered. Staff always knocked before entering a room.

Patients we spoke with during our inspection commented positively about the care and treatment they had received.

The hospital monitored patient feedback from their patient satisfaction survey and the NHS Friends and Family Test (FFT). The FFT is a tool that gives people that use the service the opportunity to highlight both good and poor patient experience. From October 2020 to September 2021 the hospital had received an average satisfied rating of good or very good of 96%. Due to the COVID-19 pandemic the Patient Led Assessment of the Clinical Environment (PLACE) assessments had been cancelled for 2020. The 2019 PLACE privacy, dignity and well-being score was 93%. The patient satisfaction survey showed from July 2021 to September 2021 showed 95% of patients rated their care as excellence and 97% of patients who completed the survey felt they were in safe hands.

Emotional support

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

Good

Surgery

When talking to staff, it was clear how passionate they were about caring for their patients and how they put patients' needs at the forefront of everything they did.

Staff working in the surgery service showed sensitivity and support to patients and those close to them. Staff understood the emotional impact of them having surgery. Staff told us they sometimes saw patients who appeared anxious due to the nature of their visits. They understood the need to give patients appropriate and timely support and information to cope emotionally with their care, treatment or condition. Theatre staff told us if needed they would give additional reassurance to a patient if they were anxious about their surgery. We observed this during the inspection.

During our inspection we saw staff giving emotional support to patients. They understood that each patient was an individual and took time to get to know their patients. This meant they could give the right emotional support for that patient when needed. Staff told us the care and support they gave to patients had increased as currently visitors were not being allowed into the hospital due to the COVID-19 pandemic unless prior-approved. Staff were aware this could lead to patients feeling isolated and vulnerable.

The service offered a chaplaincy service who could offered emotional, psychological and spiritual support to patients, relatives and staff of all, any or no faith. We saw posters telling people of this service on notice boards. The ward had a quiet room which provided patients with a quiet space if needed.

The patient satisfaction survey showed from July 2021 to September 2021 showed 94% of patients felt staff understood their needs and 95% of patients felt staff were attentive.

Understanding and involvement of patients and those close to them

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

Patients told us they felt involved in the planning of their care. They told us they had received full information about their diagnosis and treatment and the care and support which would be offered following the procedure. Staff provided written information to support the verbal information given.

Patients told us staff clearly explained the risks and benefits of treatment to them before admission. Patients we spoke with told us they had opportunity to ask questions about their treatment. This meant that patients were involved in making shared decisions about their care and treatment.

Staff told us that costs and payment methods were discussed with patients before admission. Patients we spoke with confirmed this and said written information was provided to them.

The patient satisfaction survey showed from July 2021 to September 2021 showed 91% of patients felt they were fully informed, 95% of patients were satisfied with their experience with the treatment and 91% of patients felt discharge was organised and efficient.

Good

Surgery

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services to meet the needs of those who chose to use the service. Admissions to the surgical ward were all elective and planned in advance. The hospital had an admission criteria which meant the hospital only admitted patients whom the hospital had facilities to care for.

There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this.

Most patients who attended the hospital were privately funded or insured patients. In addition, the hospital also participated in the NHS e-Referral Service for certain procedures. Through this service, NHS patients who required an outpatient appointment or surgical procedure were able to choose both the hospital they attended and the time and date of their treatment.

The hospital had supported the local health community during the COVID-19 pandemic. They had worked closely with the local clinical commissioning group (CCG) and NHS trust to provide a range of services and specialities. This included identifying how the hospital could be used to provide COVID-19 safe environments to services that had been paused at the local trust. Feedback from the local trust was positive and mentioned how safe patients felt having their treatment at the hospital and how the logistics ran smoothly. Some of the staff in the surgery service had worked at their local trust during the pandemic and the team were proud of this.

Meeting people's individual needs

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

Surgical patients' individual needs were discussed during booking and pre-admission assessment. Staff used this information to provide safe care and treatment and mitigate any possible risk to the patient. If during pre-admission assessment staff identified the service could not meet the patient's needs, staff would not treat the patient at the hospital and refer the patient to an alternative health care provider who could support the patient. The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted following the appropriate risk assessments had been carried out.

Good

Surgery

Patients received information explaining about their surgical procedures and what to expect throughout their hospital visits. This information was designed to address patients' questions about their forthcoming procedures. Information included details on preparing for hospital, what to bring with you and what to expect following their treatment. This information was also available to patients on the hospital's internet webpage.

Nurses gave patients detailed explanations about their admission and treatment in addition to written information. We observed clear explanations being given during pre-assessment appointments and reassurance being given to patients who were anxious about their care treatment.

Staff completed equality and diversity training annually as part of their mandatory training. At the time of our inspection training compliance across staff working in the surgery service was 93%.

The hospital had measures to meet the Accessible Information Standard (AIS). A standard which aims to make sure people who have a disability, impairment or sensory loss can access information they can understand and receive the communication support they need from health and care services.

Staff working on the surgical ward used coded discs on their patient board to identify patients who needed additional support. Staff told us this was a good visual reminder for them that they might need to use a different communication style when caring for the patient. For example, if a patient had a needle phobia or was hard of hearing. Staff showed us communication aids they used to help interact with their patients if needed.

The service had access to an interpreting service for patients whose first language was not English and signers if needed. We were shown posters in different languages which explained services the hospital offered such as verbal translation and interpreter services and how to make a complaint. The hospital could translate any information leaflet on request as they had a same day turnaround service level agreement with a translation service to provide this. The hospital displayed posters throughout the hospital to promote this service to patients.

Access and flow

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

The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.

The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their treatment, subject to consultant and nurse availability.

The hospital had established a clear booking process for appointments and hospital admissions. Patients told us the hospital had a good and efficient booking process.

The surgery service could conduct their patient pre-assessment either over the telephone or face-to-face dependent on the type of surgery they were having.

Good

Surgery

The hospital offered either day-case or inpatient surgical procedures. Day-case surgery did not require an overnight hospital stay. Inpatient surgery required the patient to remain overnight or longer after the surgery was completed, for care or observation. Day-case patients were told to bring an overnight bag with them just in case they were required to stay overnight. For example, if the patient was nauseous after surgery or had no support at home. We were given examples by staff when this had happened.

The booking team added patients to the hospital's patient information management system. This meant staff working throughout the hospital could track patient details and appointments.

Patient feedback was positive, saying they had access to timely appointments, care and treatment which met their specific needs.

As per NHS guidelines, NHS patients attending the hospital had their referral to treatment time (RTT) recorded. From October 2020 to September 2021 the hospital reported an average RTT of 83% for NHS surgical patients. This meant the hospital did not always meet the target of 92% of NHS admitted patients beginning treatment within 18 weeks of referral. However, targets were reached between October 2020 and April 2020, with an average of 99%. Senior staff told us targets were not met during May 2021 to September 2021 due to the impact of COVID-19, which had restricted their capacity as they had been supporting the local NHS trust with chemotherapy and outpatient services. The hospital told us RTTs were now recovering as the hospital was no longer needing to support the NHS trust.

The hospital reviewed the clinical need of patients who had their treatment delayed due to elective work being put on hold. Higher risk patients or patients whose condition had worsened were re-referred to their consultants, signposted to other healthcare providers, or re-prioritised for elective surgery when the hospital re-opened.

Patient feedback was positive, saying they had access to timely appointments, care and treatment which met their specific needs.

The hospital cancelled three procedures from October 2020 to September 2021 for non-clinical reasons which was less than 0.04% of the total number of procedures performed at the hospital. The service monitored cancellations to look for trends, themes and contributing factors. During this time period the highest factor in non-clinical cancellations was patients' choice not to have the operation.

Learning from complaints and concerns

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

The hospital followed the Spire Healthcare complaints policy which gave clear processes and timeframes for dealing with complaints. The hospital director had overall responsibility for the management of complaints. The hospital had a key performance indicator (KPI) to close complaints within 20 days. The target for this KPI was 80%. Data supplied by the hospital post inspection showed 97% of complaints were closed within this timeframe between October 2020 and September 2021.

All staff we spoke with were aware of the complaint procedure. Clinical staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge in the first instance.

Good

Surgery

Patients could make complaints in various ways, verbally, by telephone and in writing by letter or email. We saw posters throughout the surgery service explaining how patients could make a complaint. The hospital's webpage had a detailed page explaining the complaint procedure and how to make a complaint or raise a concern.

The hospital received 63 complaints between October 2020 and September 2021 with seven complaints relating to the surgery service. This was 0.09% of all surgical admissions at the hospital. Complaints in the surgery service tended to be due to lack of communication. None of these complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

We saw evidence that hospital complaints were discussed and addressed at the clinical governance meetings, in the medical advisory committee and departmental meetings. Any complaint themes or trends were analysed and actions put in place to stop them occurring again.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings, emails and notice boards. Complaints were also discussed at the daily communication meeting meaning heads of departments heard about complaints from elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.

Are Surgery well-led?

Good

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

Leadership

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

The hospital had a clear management structure with clear lines of responsibility and accountability.

The hospital was led by a hospital director, who had overall responsibility for the hospital and was the registered manager. They were supported by the director of clinical services, the operations manager, business development manager and the finance and commercial manager. The heads of departments, which included the theatre and the ward managers and the pre-operative lead were managed by the director of clinical services.

The senior management team supported staff to develop their skills. Staff had been provided with development opportunities to grow their leadership and communication skills. For example, the ward manager was undertaking a leadership course. This was equipping managers with the necessary tools to run and support their teams.

The surgery service had strong, effective leadership. When we spoke to the managers in the surgery service, they were organised, had a good understanding of the challenges to quality and sustainability in each of their areas and were able to tell us the actions needed to address them. They told us they felt supported by the senior management team and the other departmental managers. They were able to discuss any issues with them, were listened to and their views respected.

Good

Surgery

Staff working in the theatre and the inpatient wards spoke highly about their managers and felt supported and valued. Managers were highly visible and approachable and we saw evidence of this on the inspection.

Vision and Strategy

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

Spire Healthcare had a philosophy of care with its purpose of 'making a positive difference to our patients' lives through outstanding personalised care' and was underpinned by the companies values of driving clinical excellence, doing the right thing, caring is our passion, keeping it simple, delivering on our promises and succeeding and celebrating together.

The hospital had developed its own vision and strategic objective to deliver the company's philosophy. The strategic objective was split into five domains which aligned with the CQC's five key questions of, are services safe, effective, caring, responsive and well-led. Each domain was split down further into clinical/quality, operation, safety/risk and financial elements.

The strategy set out how the hospital would deliver and monitor progress against the strategy. This included the use of audits, effective incident reporting and training of staff. These objectives were monitored at the clinical governance meeting and sub-committees to make sure the hospital was delivering against its strategy.

The surgery service displayed the strategic objective on notice boards in their departments. Staff we spoke with during our inspection believed in the Spire Healthcare philosophy and were working as a team to deliver the vision and strategic objective.

Culture

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

Staff were welcoming, helpful and professional in their communication with each other, patients and visitors. Staff described good teamwork and respect amongst their colleagues, and we could see this in practice when we inspected the theatre and ward areas.

Staff we spoke with felt supported, respected and valued in their working environments. Staff told us they felt supported as individuals in their roles but also as part of the wider hospital too. Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and responsibility for everyone.

The 2021 hospital staff survey showed 90% of staff who completed the survey were proud to work for Spire Healthcare and 84% would recommend Spire Healthcare to friends or family as a place to work.

Good

Surgery

Staff told us the senior management team were approachable and visible and had an open door policy to discuss concerns. The hospital had a freedom to speak up guardian to ensure staff could raise concerns in a safe and supportive way. Management celebrated success with the wider team and we saw this demonstrated during our inspection when a compliment letter was shared during the daily communication meeting.

Spire Healthcare collected and published data relating to the Workforce Race Equality Standard (WRES). This was a programme that supported continuous improvement through robust action planning to tackle the root causes of discrimination. Independent healthcare providers have been required to publish their WRES data since 2017.

Spire Healthcare and the hospital used the WRES data to gain a greater understanding, put action plans in place and to drive equality and diversity in the workplace. Post inspection we reviewed the action plan that had been developed from the 2020 – 2021 WRES data.

The hospital and surgery service promoted equality and diversity in their daily work. The 2021 staff survey showed 74% of staff believed Spire Healthcare treated people as equals regardless of difference which had improved 11% since the 2020 survey.

Governance

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

The hospital had a governance framework through which the hospital was accountable for continuously improving their clinical, corporate, staff and financial performance.

There were 12 committees which held quarterly meetings where specific operational issues were discussed, such as infection prevention control and medicine management. Each meeting had a purpose, a set agenda and there were clear lines of accountability. We reviewed minutes from these meetings and saw, they were effective and included the set of decisions, outcomes and next steps or actions taken.

Information from these operational meetings, plus addition information such as patient outcomes and audit results, fed into the quarterly hospital clinical governance committee meeting. We reviewed these meeting minutes and could see they were planned, structured and followed a set agenda. They were thorough in their content with evidence of quality issues of safety, risk, clinical effectiveness and patient experience being discussed and actions taken if needed and the lessons learnt. The minutes from these meetings demonstrated the hospital management team had thorough oversight of the hospital's performance, challenges and successes.

The hospitals information and data from the clinical governance meeting was reported to the Spire Healthcare national corporate governance meeting and then to the Spire Healthcare board. This gave the board oversight of the quality and safety of care and treatment from the hospital and other hospitals in the group, which they used to make corporate strategic decisions.

Department managers attended the hospital's clinical governance meetings and discussed how their departments were performing. They could see the key quality issues of safety, risk, clinical effectiveness and patient experience for their

departments and hospital wide. It was up to the department managers to disseminate this information to their teams and to act on any issues arising. We were told by departments managers information would be shared with their teams in many ways including, at handovers, on notice boards and in departmental meetings and this was backed up by conversations had during our inspection with staff working in the surgery service.

Post inspection we reviewed minutes from the theatre and ward departmental meetings. Meetings had a set agenda which included standard agenda items such quality, staffing, risk management and other issues needing to be discussed, such as staffing levels. This showed that information was shared, discussed and actions acted upon within the department teams.

Governance was discussed at the medical advisory committee (MAC) with information from the clinical governance committee reported to the MAC. The MAC's role was to ensure clinical services, procedures or interventions were provided by competent medical practitioners at the hospital. This involved reviewing consultant contracts, maintaining safe practicing standards and granting practising privileges. The MAC would also discuss new procedures to be undertaken to ensure they were safe, equipment was available and staff had relevant training. The MAC minutes showed discussions including key governance issues, such as incidents, complaints and practising privileges were discussed.

There were arrangements to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

Management of risk, issues and performance

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

There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospital followed the Spire Healthcare risk management policy. This policy detailed the aim of risk management, explained what risk was and how to identify, record, review and mitigate risk.

The hospital operated a hospital risk register which was reviewed at the quarterly risk committee. Any new risks were added to the risk register and risks already on the register were monitored and appropriately managed. The risk register was also reviewed at the clinical governance meeting

The departments had their own risk registers which were managed by the department managers and fed into the hospital risk register. We reviewed the risk register from the theatre and ward departments and saw risks on the register reflected what staff had told us during the inspection. For example, staffing levels and impact of COVID-19

From talking to staff and reviewing documentation we saw evidence the surgery service and senior hospital managers were able to recognise, rate and monitor risk. This meant the hospital and surgery service could identify issues that could cause harm to patients and staff and threaten the achievement of their services.

There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes in Spire Healthcare hospitals. During our inspection when we spoke with staff and reviewed documentation we could see that the surgery service carried out these audits and, identified and took action where required.

Good

Surgery

Information Management

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

The hospital had clear service performance measures, which were reported and monitored by the hospital, Spire Healthcare and the local commissioners. Data collection was detailed and included data on a range of performance measures and quality indicators, such as audit results and patient feedback. We saw evidence that areas of good and poor performance were highlighted and used to challenge and drive forward improvements.

Where relevant, performance was tracked over time to highlight unexpected variations in performance which warranted investigation. This meant staff could immediately identify areas of increased performance or performance trends and areas that required investigation and improvement.

The hospital used information technology (IT) systems to effectively monitor and improve the quality of care. For example, there was a computer system where incidents, near misses and complaints were recorded. The hospital employed specialist staff to manage the IT systems and to collect, monitor and analyse patient safety data. It was their role to make sure data collected was accurate, valid, reliable, timely and relevant.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance.

Staff had access to a range of policies, procedures and guidance which was available on the hospital's electronic system. Staff also told us they used IT systems to access the e-learning modules required for mandatory training

Information governance was included as part of mandatory training for staff. Staff understood the need to maintain patient confidentiality and understood their responsibilities under the General Data Protection Regulations. The hospital had appointed a hospital data protection officer and a Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Engagement

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

The hospital and surgery service actively encouraged patients to give feedback about their experience to help improve services. For example, through patient satisfaction questionnaires, feedback and suggestion cards, and to complete reviews on search engine websites. The hospital reviewed and monitored patient satisfaction through their clinical governance committee and used the information to inform improvement and learning and to celebrate success.

The hospital had a presence on social media which included an informative website for people wanting to find out about the hospital and the services that it offered. The importance of this website was demonstrated during the COVID-19 pandemic keeping the public up to date on how to access services or when some services had needed to close or change due to government restrictions.

Good

Surgery

The hospital engaged with all staff in many ways. For example, a monthly newsletter and noticeboards in the hospital. Staff we spoke with during our inspection in the surgery service said the senior management team engaged well with them and their views were sought. There was a staff forum which gave employees an arena to discuss and seek practical solutions to improving their working experience.

Staff were invited to take part in the annual staff survey. In the 2021 survey 77% of staff working at the hospital had responded. The hospital had analysed the results and was working with staff in the departments to deliver a local action plan and next steps. The hospital was passionate in improving the hospital to make it a better place to work.

The service worked with the local health community to meet the needs of the local population. This had increased during the COVID-19 pandemic when they had provided a range of services and specialities to help support the local NHS trust and clinical commissioning group.

Learning, continuous improvement and innovation

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

The hospital was committed to improve the quality of services offered to patients. There was a focus on continuous learning and improvement.

The hospital and the surgery service offered apprenticeships and training opportunities which helped to develop the skills and offered career progression to individuals in the team. In addition, it meant the service could grow their own talent which helped with staff retention.

The hospital used the approach of identifying a problem, using a team approach to find a solution, trial the solution, monitor, refine if necessary. During our inspection, staff gave examples how they implemented this way of problem solving in the surgery service, for example:

- Since the last inspection the surgery service had worked hard to optimise fluid fasting for patients. A sub-meeting at the end of the bed meeting plans the fluid times for patients on the theatre list on the following day. Fluid times are issued to patients and this is relayed to the clinical teams. This practice was now embedded and the service was seeing increased optimisation of patients' fluid prior to surgery. This approach saw compliance raise from 50% to 95% of patients each month meeting best practice guidelines around fluid fasting times.
- The hospital had refined its bed meeting to ensure the hospital was utilised to its maximum potential whilst also providing a safe environment for the patient. All teams at the hospital had collaborated to create the bed meeting. The team met daily with representatives from pharmacy, wards, theatres, physiotherapy and diagnostic imaging to book patients in for their surgery. This daily meeting meant clinical discussions were carried out at the time of booking that centred round the needs and priorities of the patient and the level of service they may require prior to their admission with all teams having an input. The meeting was overseen by the director of clinical services. The team also discussed short notice bookings and whether they were possible and safe. We were told the bed meeting had improved patient experience as each team was prepared for the patient at each step of their journey.
- The hospital had undertaken an orthopaedic improvement programme. The programme was devised to monitor and reduce length of stays of joint replacement patients as clinical studies have shown better outcomes associated with reduced length of stay. The hospital had used data gathering to show where patient length of stays had been longer,

the same as or shorter than expected. They had then drilled down into the data to see if they could predict the factors that were resulting in the length of stay. For example, age, fitness of the patient or consultant. The hospital was in the next stage of programme and seeing where improvements could be made and to develop an orthopaedic forecasting tool to predict the length of stay needed for the patient.

A member of the day case clinical team was developing an animated film to inform patients in an inventive and entertaining way about the patient's journey. They had been inspired by an article in a nursing journal and decided to replicate and make it relevant for the patients who attended the Spire Gatwick Park Hospital.

Good

Services for children & young people

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

Are Services for children & young people safe?

Good

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

Mandatory training

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

The hospital had a corporate training policy which defined the mandatory requirements of staff working at the hospital.

Staff working in a Spire Healthcare Hospital were required to complete mandatory training such as fire safety, health and safety, information governance, equality and diversity, infection prevention and control, manual handling, managing violence and aggression, safeguarding children and adults.

Additional mandatory training was required for staff working in the children and young people's (CYP) service depending on their role in the department, this included paediatric basic life support, safeguarding and european paediatric advance life support.

Nursing staff received and kept up-to-date with their mandatory training. Staff we spoke with told us there were no barriers to accessing mandatory training.

We reviewed the training logs for CYP staff and found compliance was 100% for paediatric immediate life support, data protection and manual handling.

The children's lead monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Good

Services for children & young people

The Spire Healthcare corporate policy for safeguarding and the procedure for the care of children and young people in Spire Healthcare provided staff with guidance about safeguarding children and young people and the level of training required by staff working with children and young people at the hospital. The safeguarding policy followed relevant national legislation and guidance, for example the Royal College of Paediatrics and Child Health and provided guidance on female genital mutilation and domestic abuse.

Nursing staff received training specific for their role on how to recognise and report abuse. The director of clinical services, who was the safeguarding lead for the hospital was trained to level 4 in safeguarding for children. The children and young people lead nurse was trained to level 3. The three paediatric nurses who supported the service were also trained to a level 3 in safeguarding for children and adults. All staff working in the CYP were up to date with their training.

All staff we spoke with were aware of the signs of abuse and demonstrated an understanding about safeguarding children and young people processes. They knew who the safeguarding leads were at the hospital and how to escalate if they had concerns. We were given an example when staff had needed to raise concerns and the actions they had taken.

Non-clinical staff at the hospital received training specific for their role on how to recognise and report abuse. They completed level two for safeguarding children and young people. This was in line with national guidance.

The hospital followed safe procedures for children visiting the hospital and provided chaperoning service to patients. Access to the children's dedicated area was via a keypad.

Cleanliness, infection control and hygiene

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

All areas where children and young people (CYP) were seen were clean and had suitable furnishings which were well-maintained, chairs were wipeable and the sinks were Health Building Note, (HBN) compliant.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff in clinical areas were "bare below the elbows", had their hair tied back and wore clinically appropriate clothing.

The service provided appropriate and adequate quantities of PPE for staff including gloves and aprons in a range of sizes. Staff were able to access PPE at the point of use. There was easy and constant access to hand washing facilities throughout the hospital which were used by staff.

Cleaning records were up-to-date and demonstrated that all areas where CYP patients were seen were cleaned regularly. Staff completed daily cleaning routines and cleaning records. We reviewed these records during the inspection and found them to be up-to-date and complete.

Throughout the hospital and the CYP areas, hand sanitiser gel was available.

The hospital had an infection prevention and control (IPC) lead in place and held quarterly IPC meetings where discussions around building estates/development plan, waste management, water testing and incidents relating to IPC with actions took place.

Good

Services for children & young people

All hospital staff completed infection prevention and control training as part of their mandatory training. Staff working in the CYP department were 100% compliant with their training.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We found equipment to be clean. Staff used "I am clean" stickers to indicate they had cleaned the equipment recently and it was ready for use by another patient.

The hospital carried out monthly hand hygiene and PPE audits where children and young people were treated. Hand hygiene audits for October and November 2021 demonstrated a compliance of 100%.

The waiting area in outpatients did not have any toys due to COVID-19.

Environment and equipment

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

The hospital had a dedicated CYP ward with three individual bedrooms and a shared bathroom. This area was secure and protected by locking doors and an electronic keypad entry. Staff working in the ward had access to this.

All beds had an emergency oxygen and suction points which were checked daily and recorded as checked. Equipment and televisions at each bedside had relevant safety checks. These checks were also recorded on the nursing admission notes.

The service had enough suitable equipment to help them to safely care for children and young people. Resuscitation equipment specific for children of all age ranges was available and records showed these were checked daily and monthly.

We observed a number of pieces of equipment including resuscitation and breathing apparatus which was marked as available for use. The equipment had stickers clearly indicating they had been serviced and subjected to the required testing to remain safe for use.

The CYP team completed an environment assessment prior to admitting CYP patients to the hospital, with details recorded in the patient's care record. These included checks to ensure toys that were available complied with national standards and checked for health and safety issues and all medicines and cleaning products were stored away and not left unsupervised.

The hospital carried out quarterly COVID-19 environmental checks which included the areas children were treated and cared in. These checks covered COVID-19, IPC requirements and staffing in hospital theatres, and ward departments. These covered the staffing, safeguarding aspects of children in these areas as well as environmental risks.

Within theatres, there was an area in theatre recovery that was interchangeable between adults and children. In order to mitigate this, the area had child friendly curtains that could be drawn around, and a screen that could be pulled out. Ceiling and walls had child friendly images on them.

Staff disposed of clinical waste safely. During the inspection we saw the correct management of waste and the use of coloured bags to correctly segregate of hazardous and non-hazardous waste. This was in line with the Health Technical Memorandum 07-01: Safe management of healthcare waste.

The service had an effective system to manage waste disposal. Across the service sharps bins were correctly assembled and labelled to ensure traceability. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations).

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks.

The booking standard operating procedure (SOP) set out the safe and agreed criteria for the admission of children to the hospital. Once a patient was booked for surgery, they had a pre-assessment to ensure they met the inclusion criteria for surgery. This assessment was carried out face to face by a registered paediatric nurse for CYP patients up to 16 years of age and followed the Spire Healthcare pathway for CYP.

There was a risk based approach to nurse staffing for young people aged 16 to 18 years. Pre-admission assessment identified whether the young person was appropriate to follow the adult pathway. This meant they would be cared for by adult nurses. This process included considering the wishes of the young person.

Staff completed risk assessments for 16-18 year olds using a recognised tool which was completed prior to admission to assess young people for their suitability for care under adult/children services. All 16-17 year olds who required a surgical procedure or an interventional procedure in imaging had a risk assessment carried out by a children's nurse prior to the procedure to ensure they were suitable to follow the adult pathway.

Information from the pre-admission assessment was recorded in the patients' care record. This was used to help evaluate and highlight any potential patient risks. This contained two sections which highlighted if the child had any psychological or social needs. Any concerns were discussed with the multidisciplinary team and the child's children and young people's mental health service liaison or social worker. In some cases, the hospital also involved the school to gather more information.

We observed one face to face pre-assessments and found that all questions were covered and recorded in the patient's care records and any potential risks identified. Any risks identified were flagged to other teams for input.

The risk assessment we reviewed was thorough and screened patients for other illnesses and potential care issues that could lead to complications. The risk assessment provided instructions for where to book all children and young people if they were unsuitable for treatment at the hospital.

The hospital used five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is a recognised tool developed to help prevent the risk of avoidable harm and errors during and after surgery and should include safety-briefing, sign in, time out, sign out and debriefing. We observed that this was used correctly.

Good

Services for children & young people

A child and young person's health and wellbeing was monitored using the nationally recognised paediatric early warning system (PEWS). This identified if a child or young person was at risk of deteriorating and identified when a child or young person's condition needed to be escalated to a medical practitioner. There were different scoring charts for children of differing ages, to support early detection of a deterioration in their condition.

Our review of PEWS charts for one patient showed that patient observations were completed according to the guidance detailed on the PEWS observation chart.

All clinics were consultant led. All outpatient staff had trained in paediatric life support, basic or intermediate level. The resident medical officer was available on site.

Resuscitation simulations were practiced within the hospital. Paediatric emergency scenarios were followed up with an action plan detailing any areas for improvement.

The service had a standard procedure which outlined the process to safely and effectively manage children and young people that may require transfer to another healthcare facility due to deterioration in their condition. All staff were aware of this and were able to detail how they would transfer a critically ill patient, via ambulance to the nearest NHS emergency department.

The hospital had a children's transfer agreement with a local NHS trust in the event a transfer to their care was required.

The hospital also had a children's paediatric retrieval service agreement with another NHS trust in the event a transfer to their care was required.

Nurse staffing

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

The hospital employed a CYP lead nurse who had accountability for all the children's services, including outpatient services. This met with the Royal College of Nursing guidance on defining staffing levels for CYP people's services. This stated there must be a registered children's nurse identified and available with responsibility and accountability for the whole of the children's pathway, including their pathway through outpatient departments.

The hospital had three permanent and four bank paediatric nurses who supported children and young people. In addition, some nurses worked within the NHS and other private hospitals to ensure that they retained their clinical skills. The hospital had a nurse on call to cover sickness.

Services provided by the hospital were elective and staffing was planned to support the service required. The hospital had a registered nurse working in outpatients when they ran children and young people clinics.

During surgery, a children and young people nurse was always at the hospital. The hospital reviewed staffing rota to make sure there was always a children's nurse when children were at the hospital.

At the time of the inspection, the children and young people team had no vacant positions to fill.

Good

Services for children & young people

The hospital ensured that any child under the age of 16 was cared for by nurses or operating department practitioners with care of children and young person competencies and the european paediatric advance life support qualification (EPALS) within the recovery area.

Medical staffing

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

All consultant surgeons, paediatricians and anaesthetists had to complete an application for paediatric admitting rights. This information was used by the hospital management team to determine whether the person had the required skills and experience to carry out paediatric treatments at the hospital. Medical staff who could not demonstrate they had the relevant skills were not granted practising privileges.

Each child was admitted to the hospital under the care of a named consultant with paediatric experience. Staff told us consultants and anaesthetists made themselves available to provide advice over the telephone or attended the hospital when required.

There were 65 clinicians with practising privileges who provided a service for children. This included consultants, an allergist, anaesthetists and radiologists.

There were robust processes in place prior to medical staff being granted practising privileges at the hospital. A medical advisory committee (MAC) was in place which ensured consultants were competent to perform the procedures included as part of their practising privileges and they were working within their normal scope of practice.

There was a registered medical officer (RMO) on-site 24 hours a day/ seven days a week. The RMO had paediatric experience and EPALS training.

Records

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

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

We reviewed three set of patient records and found them to include the relevant assessments of care needs, risk assessments and were patient centred and personalised. Notes also clearly identified when a patient had any allergies.

The CYP service had an audit programme to assess the quality of completion of patient care records. Records were checked each month. We reviewed audit information from July 2021 to September 2021 and saw from the results records were 100% completed correctly.

CYP notes were kept at the nurses' station and were stored securely.

Medicines

Good

Services for children & young people

The service followed best practice when prescribing, giving recording and storing medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medicines prescribed on the medicine chart were dated and signed by the prescriber. Prescriptions detailed the dose and the time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the CYP patient.

The hospital carried out a medication audit tool to ensure correct documentation on prescription charts. We reviewed audit information from July 2021 to October 2021 which showed 100% compliance.

Patient care records and medicine charts we checked showed staff were documenting the information required and prescription charts were completed correctly.

Information collected during pre-assessment included medications, allergies and medical problems.

This information was used to accurately calculate medicine doses for children and young people. We observed a CYP patient outpatient clinic and saw that CYP nurses routinely took and recorded weight and height measurements from children prior to seeing the consultant. CYP patient's weight and height was also routinely measured when they arrived at the CYP ward as part of their inpatient checking in procedures.

Incidents

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

Staff knew what incidents to report and how to report them. All clinical and non-clinical incidents were reported and logged directly onto the hospital's incident reporting system. Staff of all levels were confident to report incidents and knew how to escalate concerns.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff said they received good feedback on incidents and the sharing and learning from incidents.

The service had no never events. 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.

In the last 12 months there had been 33 incidents reported relating to the CYP service. None of these resulted in severe harm to the patient. The hospital reviewed these and did not identify any themes or trends. Learning from this was shared. Staff understood the duty of candour. Staff within the service demonstrated an understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to those persons.

Good

Services for children & young people

Are Services for children & young people effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a selection of policies and guidelines related to children and young people and found they were within their review date.

Staffing of the CYP service followed the guidelines set out in the Royal College of Nursing; defining staffing levels for children and young people's service to ensure all staff caring for children and young people had the necessary skills and competencies.

The hospital undertook audits and reviews relating to the care of children at the service. Some of these included theatre starve times, paediatric early warning score (PEWS), consent and safeguarding risk assessment with good results.

The CYP service audit results were used to benchmark the hospital against other hospitals in the Spire Healthcare group which delivered paediatric services.

The hospital did not hold any accreditation relating to the care of children.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Nursing staff asked CYP patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary requirements. This information was passed to the catering team who prepared the meals. The hospital provided suitable meals and drinks for children and young people and offered meals for the family member staying with the patient.

CYP patients and their patients or guardians were advised about pre-surgery fasting (that is omitting food and fluids except water before operation) times during the pre-assessment process. Written information about pre-surgery fasting times was also sent to the patient and their patients or guardians.

The Spire Healthcare corporate children and young people in hospital policy stated that CYP patients should be placed at the beginning of the theatre list to ensure minimal fasting times and maximum recovery time whilst the anaesthetist and consultant were on site. The CYP lead nurse confirmed this happened.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

The hospital had local procedures for paediatric pain management which was based on guidance from the Department of Health and Department for Education and Skills core standards, National Service Framework for Children, Young People and Maternity Services, October 2004.

Nursing staff discussed pain and pain relief with CYP patients and their parents or guardians during the pre-assessment process. This was documented in the patient's care record.

We observed a face to face pre-assessment and heard pain and pain relief post-surgery discussed with patients and their family.

We reviewed CYP care records and saw that pain was assessed, documented and managed well throughout the patients' care. Staff used a nationally recognised age appropriate tool coupled with behavioural and clinical observations to help estimate the severity of pain and recognise visual expressions of pain. The most common tools adopted were smiley faces, FLACC (face, legs, activity, cry, consolability) or the verbal descriptive such as none, mild, moderate or severe.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

The hospital participated in a national audit tool, T-14 which was implemented to monitor patient outcomes in relation to ear, nose and throat patients. This was one of the highest numbers of surgery that was performed at the hospital for children and young people.

The T-14 audit tool monitored the patient outcomes following a tonsillectomy or adenotonsillectomy. Over the last three years, the hospital successfully obtained data and reported quarterly on the individual patient scores. The service reviewed this data and it was discussed at the children and young people committee.

Competent staff

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

The children and young people service had a comprehensive induction programme for all new staff recruited. We saw evidence of this when we reviewed staff records.

Nursing and health care assistants in outpatients completed paediatric competencies which were signed off by the children's lead demonstrating staff could complete specific tasks. Nursing competencies included children's safeguarding, consent, anaphylaxis adult/children and care of the adolescent and paediatrics phlebotomy.

During the inspection, all staff in outpatients had completed their competencies in safeguarding children and young people and care of children and young people.

The hospital had a paediatric competency framework which was completed by all children and adult nurses which included all the essential skills needed for looking after children. Staff were signed off by the CYP lead nurse.

Good

Services for children & young people

Information provided by the hospital showed that all of the children's nurses' appraisals were within date. Appraisals enabled staff to consider their clinical practise and any learning opportunities they considered would be of benefit.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

Doctors, nurses and other healthcare professionals supported each other to provide good care.

The children's nurses took full responsibility for communicating the needs of all inpatient CYP patients under their care with the general nursing staff, medical staff and other healthcare professionals as appropriate.

Staff we spoke with in the CYP service and the wider hospital told us there was effective working between all staff groups. When children were admitted the CYP lead nurse met with theatre staff to discuss the needs of the specific child. All staff we spoke with told us staff in the hospital worked as a team to support children and young people.

During the inspection we observed effective, friendly and helpful interactions between all staff working at the hospital.

Seven-day services

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

The hospital held outpatient clinics and admitted patients for procedures Monday to Saturday.

The RMO was on site 24 hours seven days a week and was therefore available at night and at weekends.

Staff could call for support from doctors and other disciplines, including mental health services.

The hospital pharmacy service was available between 9am and 5pm Monday to Friday, 9.30am to midday Saturday.

Health promotion

Staff promoted health promotion well.

There was no formal health promotion programme for CYP patients. However, we saw a range of age appropriate health promoting leaflets and posters displayed in prominent CYP areas, such as the waiting area in outpatients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The hospital had a children and young people policy which contained guidance on consent to ensure that assessment, care and treatment were carried out in line with legal and professional requirements relating to consent. This was in date and due a review in 2023.

Good

Services for children & young people

Staff understood the use Gillick guidelines in relation to children. This is a legal ruling whereby clinicians may accept consent from a child under 16 years of age, who has been assessed as competent to understand the implications of consent and who cannot be persuaded to involve their parents in care and treatment decisions. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not to others.

Verbal consent was taken for checking vital signs and phlebotomy. Written consent was taken for any minor procedures on the day it was carried out. We checked three patient records and saw that consent had been obtained in all cases.

Are Services for children & young people caring?

Good

We did not rate caring in the previous inspection as we did not have sufficient evidence to rate. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness.

Children, young people and their families said staff treated them well and with kindness. Throughout the inspection, we observed medical and nursing staff talking kindly to the child as well as parents. Staff were friendly and treated patients and their families with respect.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Doors were kept closed during consultations so that conversations could not be overheard.

Patients told us that all staff introduced themselves and said they had been kind, attentive and caring. We spoke with five patients, one of whom commented, “very satisfied with the service and staffs’ caring and helpful attitude”.

The hospital provided chaperones during clinics. We saw posters of this displayed in the ward.

The hospital launched an online feedback portal in May 2021 across all Spire Healthcare sites in treating children. This allowed parents to feedback anonymously through the rating statements and provide free-text comments. Majority of the feedback received were positive.

The inpatient survey from July 2021 to September 2021 showed 93% of patients commented the service met and exceeded expectations, and 89% of patients would choose it as a first choice next time.

Staff talked with children, young people and their families in a way they could understand.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people’s personal, cultural and religious needs.

Good

Services for children & young people

The pre-admission assessment process was used to help relieve CYP patients and their families of anxieties about coming to the hospital. Children and young people and their parents were told what to expect during their admission to the hospital. It also gave them the opportunity to visit the hospital, view the ward and other areas and meet the staff who would be looking after them during their stay which helped relieve anxieties.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff told us they had time to spend with patients to reassure them and provide emotional support.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. The hospital had a quiet room for distressed patients to maintain their privacy and dignity.

Staff told us if patients needed support services, they had relevant signposting information to give to them.

Parents, if they wanted to, could accompany their child to the anaesthetic room staying with them until they were anaesthetised. They could also be taken into the recovery area when their child woke up.

To help CYP patients feel more comfortable they could wear their own night wear to theatres.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Patients told us they were involved in their care planning and they were given the opportunity to ask questions about care and treatment. Patients commented that consultants explained procedures to patients in a way that was understood and they had been provided with clear information about their treatment and care.

Staff supported children, young people and their families to make informed decisions about their care. Patients felt that they had been fully supported in making decisions and had all the information they needed to know regarding their treatment.

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

Are Services for children & young people responsive?

Good

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

Service delivery to meet the needs of local people

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

Good

Services for children & young people

Children and young people attended the hospital for planned surgical procedures, outpatient appointments, X-ray services and physiotherapy. Following national guidance, inpatient surgical services and outpatient services were only offered to children aged three and above.

There was no dedicated children's waiting room in the outpatient department. Instead the outpatient's waiting area had a designated area for children and their parent. Due to recent development of COVID-19, toys had been removed from the area until further notice.

Staff told us, and patients we spoke to confirmed, that the hospital was flexible with appointment dates and offered earlier dates when these became available.

Within the inpatient ward, the CYP service had its own dedicated ward with three individual bedrooms and a shared bathroom.

Patients had access to drinking water in the waiting area. Baby changing facilities were also available in the toilets at the waiting area.

WiFi was available throughout the hospital and was free to use for all people on the premises.

The service ran a weekend gastro clinic to provide a 'one stop service' for all gut related issues. Medical cover for this included gastric consultant, psychologist, dietician, consultant radiologist, consultant allergist and a consultant anaesthetist.

The clinic saw on average 15 to 20 patients a month. The service in 2017 had 15% of patients outside the catchment area and has now increased to 36% outside catchment area.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.

Staff told us that outpatient appointments and surgical admission dates were planned with the families to meet the needs of the children. Parents of patients we spoke with told us they did not have to wait long for appointment dates.

The CYP patients' individual needs were discussed during booking and pre-admission assessment. Staff used the information to provide care and treatment in a safe way and mitigate any possible risk to the patient. If during pre-admission assessment, staff identified the service could not meet the child or young person's needs, staff would not treat the patient at the hospital and refer the child to an alternative health care provider who could support the child and their parent. The hospital did not have the facilities to support the care of children with high complex needs. Therefore, this patient group was not admitted to the hospital. However, children who had a learning disability could be admitted but only after the appropriate assessments had been carried out.

The service did not admit children who had known mental health diagnosis. However, there was clear guidance for staff about how to contact the local children and adolescent mental health services if they had any concerns about a CYP patient's mental health.

Good

Services for children & young people

Staff told us, if needed, interpreting facilities were available to support children and parents whose first language was not English. The need for interpreting services would be established at the time of booking.

The children's area was designed to meet the needs of children, young people and their families. The hospital site was entirely accessible by wheelchair. Passenger lifts were in place between floors and corridors throughout the hospital were wide enough to accommodate wheelchair access.

Due to the nature of the service and exclusion criteria, the hospital only treated children with a minimum of co-morbidities.

In order to ensure that they meet the needs of the child and provide exceptional care, the service asked parents to complete a "Hospital Passport" booklet. This gave staff an insight on how to best communicate with the child. This is an assessment for children with learning disabilities. It included contact details, communication such as Makaton, pain response, food, nutrition and hydration, likes and dislikes, toilet requirements and medication.

Access and flow

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

CYP patients attended outpatients or planned procedures as self funded, funded by insurance or through NHS referrals.

The hospital preferred CYP patients and their families to attend the pre-assessment appointment in person but nursing staff could complete this by telephone, if more convenient and suitable.

Children's surgical procedures were booked at the beginning of theatre lists, which meant children and young people could recover and return home the same day. A registered children's nurse was always on duty when a child was admitted as an inpatient. We saw evidence of this during the inspection.

The hospital monitored referral to treatment times for the children's services. None of the patients we spoke with complained of long wait times for appointments.

The hospital did not have a waiting list for outpatient appointments as these were made at the point of contact for a date and time suitable for the patient. Most patients were seen within a few days of their request, and always at their convenience.

Learning from complaints and concerns

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

The hospital followed the Spire Healthcare corporate complaint policy when investigating and responding to complaints or concerns. The registered manager had overall responsibility for the management of complaints.

Good

Services for children & young people

The hospital's website showed they were aligned to the Independent Healthcare Providers Network (IHPN) and the Patients Association. The website contained a short animation clip which explained to patients their rights around being treated safely and receiving the highest professional standards of care.

The hospital's website also directed complainants to an email where they could raise their concerns.

Staff in the CYP service told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team.

The hospital received three complaints relating to the care of children, from September 2020 to October 2021. These were related to staff behaviour, visiting policy and not receiving test results on the same day. All three of these complaints were responded to and actioned.

We saw evidence of hospital complaints being discussed in the minutes of the hospital's quarterly medical advisory committee meetings which the CYP consultant lead attended.

Parents/guardians we spoke with told us they were unaware of the formal route to raise a complaint but had not had cause to do so. They told us they would speak to the staff, telephone the hospital's reception or view the hospital's website if they felt they had a concern or complaint they wished to raise.

Are Services for children & young people well-led?

Good

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

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The children and young people (CYP) service was run by the CYP lead nurse who had accountability for all the children's services at the hospital, including outpatient services.

There was a lead paediatrician who represented the CYP service on the medical advisory committee (MAC).

The CYP lead held overall responsibility for quality, safety and safeguarding children and young people within the hospital.

Staff spoke highly of the local leadership within the children and young people service and commented they were approachable and welcomed feedback about the service.

Staff said that senior managers were visible in the department and around the hospital. They spoke of positive professional relationships with the senior leadership team and felt there had been an improvement in oversight alongside the freedom and support to develop staff and the department.

Staff at all levels felt they could escalate concerns to senior managers where necessary.

Vision and strategy

The service had a vision for what it wanted to achieve.

There was a clear vision for the hospital which was to be the market leader and recognised as the number one private provider of quality healthcare in Surrey and Sussex. They intended to do so by achieving examples such as having strong leadership and delivering first class health care, to be forward thinking and work collaboratively with clinicians.

The hospital's strategic objectives for 2021 was to provide high rated elective healthcare services to a defined population for all adults, children and young people, achieving health improvements for patients using our services.

Staff we spoke with were committed and enthusiastic about improving the service, patient care and outcomes at the hospital

Culture

Leadership of the children and young people's service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with said they felt respected, supported and valued.

The service had an open culture where patients, their families and staff could raise concerns without fear. Patients we spoke with said they were comfortable to raise any concerns or issue with staff.

Staff spoke of and we observed positive working relationships between staff within the CYP service and other staff at the hospital. Staff told us that peers would readily give advice and support as and when needed.

Governance

The service used a systemic approach to continually improve the quality of services.

The hospital had a governance framework through which the senior management team was accountable for continuously improving their clinical practice, staff and financial performance. The hospital had various sub-committees such as infection prevention and control and medicine management committees that fed into the quarterly clinical governance meeting.

The clinical governance meeting looked at the key quality issues of safety, risk, clinical effectiveness and patient experience from the CYP service and wider hospital.

The CYP lead represented the service at the quarterly governance meeting and other sub-committees. We reviewed meeting minutes post inspection and saw CYP issues were discussed and there was a CYP representative present.

Information from the clinical governance meeting fed into the medical advisory committee (MAC) meeting. There was a lead paediatrician consultant who represented the CYP service on the MAC. The MAC's role was to ensure clinical services,

procedures or interventions were provided by competent medical practitioners at the hospital. This involved reviewing consultant contracts, maintaining safe practicing standards and granting practising privileges. We reviewed minutes from the quarterly MAC meetings and saw there was a set agenda, including practising privileges review, consultants' appraisals and quarterly clinical governance report.

The CYP lead disseminated information from governance meetings to the CYP team and acted on any issues arising.

Managing risks, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

The hospital held a risk register which was regularly reviewed to ensure risks were monitored and appropriately managed. Head of departments managed departmental risk registers that fed into the hospital risk register. Risks and issues were discussed at the hospital and clinical governance and health and safety committees.

During the inspection, there were no direct issues relating to children and young people on the risk register.

Managing information

The service managed and used information well, using secure electronic systems and paper records.

The hospital used computer toolkits and dashboards to collect and monitor data throughout the hospital including the CYP service. Data on staffing, quality and safety was collected and reviewed.

Patient information and records were stored securely in all areas we visited in the CYP service. Staff received information governance awareness training and followed a policy to keep patient information safe and secure.

Leaders used information in reporting, performance management and delivering quality care. Staff undertook audits to make sure information they used was accurate, valid and reliable.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

The hospital held CYP nurses' meetings every quarter where any important updates were shared including incidents, complaints and patient feedback. We reviewed minutes and saw evidence of discussions around incidents, complaints, IPC taking place.

The hospital director sent a monthly newsletter to keep staff aware of hospital developments. This included information on events happening, wellbeing and mental health and COVID-19.

The service engaged with staff and undertook a staff survey. Results from this showed that 90% of staff were proud to work for the hospital; this had improved 15% from last year and 77% of staff were excited about the future which had improved 24% from last year.

Good

Services for children & young people

The hospital collected patient feedback and organised a patient forum day where patients and their families were invited into the department. Feedback from these were collected and improvements made as a result of this.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

There was evidence of learning from when things had gone wrong.

All staff involved with the CYP service were passionate about developing the service and giving the best care and treatment possible to their patients. When issues arose, they worked with the hospital's management team to come up with solutions. During the inspection we were given examples where changes had been made to improve their services. For example, feedback collected from the patient forum included adding more variety to the children's menu which the service took into account.

Staff were keen to learn and sought learning opportunities, both internally and externally, to increase their own skill set. We were given examples of training and courses staff had attended to aid their personal development, which in turn enhanced the services they could offer their patients.

The service provided evidence from an incident which was related to an injury sustained during the removal of a plaster cast. As a result of this, the service started inviting orthopaedic staff to the CYP committee meeting for learning to be shared.

Good

Medical care (Including older people's care)

Safe	Good
Effective	Good
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Good

Are Medical care (Including older people's care) safe?

Good

We have not previously inspected safe. We rated it as good.

Mandatory training

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

Staff accessed most of their mandatory training using an eLearning system accessible via the intranet. The mandatory training programme was comprehensive, Spire Gatwick Park staff were expected to achieve 95% compliance with this programme.

The operating theatre staff group, which included the endoscopy team fell slightly below this standard in one of the 12 elements, competition law (94%). However staff had until the end of March 2022 to complete all of the required training.

Resuscitation training was one of the mandatory training elements completed and the theatre group included staff who were trained to immediate and advanced life support skills levels as well as basic life support.

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

Safeguarding

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was evidence of staff understanding of the principles of safeguarding; notice boards displayed actions to follow if staff needed to raise concerns.

The staff received training in adult safeguarding and child protection at levels appropriate to their role. All staff working in the operating theatre were trained to level 2 minimum with approximately half trained to level 3 in adult safeguarding and approximately a third trained to level 3 in child safeguarding.

At the time of our inspection 96% of theatre staff were compliant with the expected adult safeguarding training and 92% with the expected child safeguarding. All staff had until the end of March 2022 to complete the required training.

For our detailed findings on safeguarding, please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

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

All areas we visited displayed information about infection prevention and handwashing.

Staff followed national and hospital guidance to minimise the risk of infection including policies and procedures introduced in response to the COVID-19 pandemic. This included the use of personal protective equipment (PPE) and we saw the correct use of PPE such as disposable gloves and aprons. PPE was readily available in all clinical areas and staff wore masks at all times. All staff undertook lateral flow testing twice a week and results and results were recorded via a government application, as well as locally via a Spire portal and local spreadsheet.

Staff took steps to address the control of risk from legionella; for example, they maintained a water flushing log for the taps in the theatre which was up to date.

The flow from dirty to clean areas was well designed and managed; the area was fully compliant with the Department of Health best practice guidance Health Building Note 00-09 'Infection Control in the Built Environment'.

The endoscopy procedure room had been refurbished to very high standard with excellent air exchanges, 10 per hour, minimising the risks of airborne microbial contamination and subsequent infection.

The hospital used environmental audits and observational hand hygiene audits to promote cleanliness and control infection. Recent results showed the theatre staff to be 100% compliant in both elements.

For our detailed findings on cleanliness, infection control and hygiene, please see the Safe section in the surgery report.

Environment and equipment

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

The endoscopy service had a designated AED [Authorising Engineer (Decontamination)] who had undertaken a review of flexible endoscope decontamination facilities in July 2021 as part of preparation for Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation. The review followed the Institute of Healthcare Engineering and Estate

Good

Medical care (Including older people's care)

Management tool. The outcome report of the review showed the facilities to be satisfactory in all but one minor element. The service was compliant with the Health Technical Memorandum HTM 01-06 which relates to the decontamination of flexible endoscopes. We saw decontamination was tracked and traced using a gold standard method for tracing scopes. There were two deep cleaning sinks and guidance for endoscope cleaning readily available.

All scopes had an up to date servicing report dated August 2021.

The service had a new washer and new laser drying cabinets which were tested in accordance with manufacturer's guidance; we reviewed the daily/weekly 'drying cabinet clean' log, signed and dated. The general endoscopy area daily cleaning schedule was clearly signed and dated.

The hospital had existing maintenance and repair contracts for all equipment used in endoscopy. There were lockable cupboards for the storage of hazardous cleaning chemicals, which met the Control of Substances Hazardous to Health regulations 2002 (COSHH).

For our detailed findings on environment and equipment, please see the Safe section in the surgery report.

Assessing and responding to patient risk

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

Staff completed a pathway document for patients attending for an endoscopy procedure. This comprised of a detailed pre-operative assessment including; patient's medical and anaesthetic history, previous hospital admissions, any medication they were taking, and daily living arrangements.

Staff in endoscopy completed a five steps 'surgical safety checklist for endoscopy' for each patient. This is a recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. Audits of the five steps showed the service to be 99.8 % compliant in the year to September 2021.

For detailed findings assessing and responding to patient risk, please see the surgery section.

Staffing

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

The staffing for endoscopy was provided by the wider operating theatre team with four designated staff for endoscopy procedures. At the time of our inspection there was one vacancy. The absence rate for the staff in endoscopy was 7.7 % for the year to the end of September 2021; this had not been impacted by COVID-19.

For our detailed findings on nursing and medical staffing, please see the Safe section in the surgery report.

Records

Good

Medical care (Including older people's care)

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

Staff had access to patients' records including results of tests to provide safe and effective care. Patients' records were detailed and included diagnosis, and treatment plan. The patients' records included the completed care pathway, past medical history, risk assessment, consent form, details of the procedure undertaken, clinical observations, medicines and arrangements for discharge.

Staff kept accurate endoscope tracking records in line with national guidance. This was to ensure all the items used during the procedure could be tracked in the event of a suspected disease transmission.

For our detailed findings on records, please see the Safe section in the surgery report.

Medicines

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

Patients attending for endoscopy may have a procedure under sedation. The hospital had a sedation policy, and staff ensured medicines were available in case a patient had an adverse reaction to sedation.

There were no patient group directives (PGDs) used in the endoscopy service. PGDs provide a legal framework that allows some registered healthcare professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

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

Incidents

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

Staff reported incidents through an electronic system in accordance with the Spire Healthcare incident reporting policy. There was an internal process to report, record and seek advice as needed. Incidents were reviewed monthly, and actions were taken to mitigate any risks identified. Examples of actions taken included reviewing procedures and lessons learned were shared with the staff.

There was an established process for the management of safety alerts relating to medicine and equipment.

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

Are Medical care (Including older people's care) effective?

Good

Medical care (Including older people's care)

Good

We have not previously inspected effective. We rated it as good.

Evidence-based care and treatment

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

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

The endoscopy service had procedures and policies which were available to the staff to ensure that care and treatment was delivered in line with national guidelines such as the National Institute for Health and Care Excellence (NICE).

Patients were given information and staff followed fasting guidelines in line with the Royal College of Anaesthetists and National Institute for Health and Care Excellence (NICE).

The staff in endoscopy completed an annual audit cycle as part of the operating theatre programme; this included the National safety standards for invasive procedures (NatSSIPs) audit. Results showed the service to be 99.8% compliant with these audits.

The endoscopy service was actively working towards the Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation. At the time of our inspection, the service was well prepared with operating procedures, job roles and induction pack up to date. A training needs assessment was completed and gaps identified. The service aspired to achieve accreditation within a year of our visit.

Nutrition and hydration

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

Patients were advised about pre-investigation fasting times (that is omitting food and fluids except water before a procedure) during the pre-assessment process. The service followed the Royal College of Anaesthetists guidance about pre-operative fasting to ensure patients fasted for the safest minimal time possible.

Patients undergoing an endoscopy procedure that required bowel preparation or sedation were given appropriate fasting advice as part of the pre-assessment. Patients due to attend for a colonoscopy were given detailed advice on how to prepare for the procedure.

For our detailed findings on nutrition and hydration, please see the Effective section in the surgery report.

Good

Medical care (Including older people's care)

Pain relief

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

Staff monitored patients' pain during procedures and were supported to communicate their pain and discomfort. In endoscopy, patients were offered an anaesthetic throat spray prior to their procedure to ensure patients' comfort during the procedures.

For our detailed findings on pain relief, please see the Effective section in the surgery report.

Patient outcomes

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

The hospital had an action plan in place to meet the requirements set out in the JAG accreditation framework which included a feedback process for gastro-intestinal surgeons about their technique and patient outcomes. Performance was reviewed at the clinical audit and effectiveness committee, at the clinical governance committee and at the medical advisory committee (MAC).

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

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and Staff were experienced, qualified and had the skills and knowledge to meet the needs of patients.

Staff were supported to complete further training relevant to their role and specific to the needs of the people they cared for.

Managers identified staff's training needs and supported them to develop their skills and knowledge. The service supported staff to undertake training to remain on the professional register and meet their revalidation requirement. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the register. The service also checked staff had current registration to allow them to practice.

Prior to consultants practising at the hospital their credentials were reviewed by the MAC which also then monitored their right to continue to practice at the site.

Staff working in endoscopy had training and were competent in clinical aspects of endoscopy which included for example, the support of patients through a procedure, management of specimens and the decontamination of endoscopes, endoscopic mucosal resection, management of gastro-intestinal bleed.

Good

Medical care (Including older people's care)

All staff received an annual appraisal; competencies were reviewed and training needs were discussed and staff found them useful for their development.

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

Multidisciplinary working

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

To ensure effective services were delivered to patients, different teams and health professionals worked together as a multi-disciplinary team. The consultants, registered nursing staff and healthcare assistants took part in a safety huddle prior to the start of lists.

Patients had their care pathways reviewed by the relevant clinical staff and consultants.

The MAC met quarterly and was attended by a range of medical consultants from most specialities. These meetings were an opportunity to discuss incidents raised, complaints about service, same day cancellations and all issues affecting service provision at the hospital.

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

Seven-day services

All patients attending the hospital for endoscopy procedures followed the elective pathway and admissions were booked in advance. Operating theatres were available six days a week.

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

Health promotion

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

Staff assessed each patient’s health at attendance and provided support for any individual needs to live a healthier lifestyle. Patients were given advice on diet and fluids following treatment, to help ensure they maintained a healthy dietary intake.

The endoscopy team had developed a pathway to promote safe care.

The hospital had health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of social distancing and washing hands to reduce the risk of transmission of the virus.

Leaflets to support healthier lifestyle were available online or could be printed as requested.

For our detailed findings on health promotion, please see the Effective section in the surgery report.

Good

Medical care (Including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The service had a consent policy, and specific consent forms were used for all patients undergoing endoscopy procedures. At the pre- assessment stage, patients were given information about the procedure in order to assist them in making informed decisions about their care and treatment.

The guidance for staff on obtaining valid consent, paid due regard to the Mental Capacity Act 2005. Staff had access to the policy and had received training in completing consent in line with hospital's guidance. As part of the policy, failure to obtain consent prior to examination or treatment would require staff to report this as an incident in line with the hospital's incident management process.

The hospital audited consent processes every quarter to ensure standards remained high.

For our detailed findings on consent, please see the Effective section in the surgery report.

Are Medical care (Including older people's care) caring?

Insufficient evidence to rate

We have not previously inspected caring. We did not rate it at this inspection as we did not observe any patients receiving endoscopy procedures.

Compassionate care

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

Emotional support

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

Understanding and involvement of patients and those close to them

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

We reviewed information available to patients before and after undergoing their endoscopy procedure. This was comprehensive and written in a style which most people would understand.

For our detailed findings on caring, please see the Caring section in the surgery report.

Good

Medical care (Including older people's care)

Are Medical care (Including older people's care) responsive?

Good

We have not previously inspected responsive. We rated it as good.

Service planning and delivery to meet the needs of the local people

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

Managers planned and organised services so they met the needs of people accessing the service. The hospital provided planned endoscopy procedures for insured and self-pay patients. The hospital pre-planned all admissions to allow staff time to address any issues that may be identified for further investigation.

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

For our detailed findings on service delivery to meet people's needs, please see the Responsive section in the surgery report.

Meeting people's individual needs

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

Patients received written information ahead of their appointment which included specific instructions and information about what to expect as part of their care and treatment. Patients received information relevant to their procedure prior to their attendance. For patients having an endoscopy procedure, the information included guidance on preparation, arrival time, the procedure and aftercare.

The day-case procedure pre-admission questionnaire included an assessment of people's individual needs, which included a question to check if any additional support was needed, to support effective communication and understanding.

Staff in the endoscopy service understood the needs of people living with dementia, and there were dementia champions on the wards to support staff and patients as needed.

For our detailed findings on meeting people's individual needs, please see the Responsive section in the surgery report.

Access and flow

Good

Medical care (Including older people's care)

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

Managers monitored waiting times and made sure patients could access services when needed and receive treatment within agreed time frames and national targets. Following a GP referral for an endoscopy procedure, consultants assessed patients in the outpatient department. They reviewed patients to see if they met the admission criteria, carried out assessments and discussed a plan of treatment. Consultants carried out endoscopy procedures at a date and time to suit patients.

For our detailed findings on access and flow, please see the Responsive section in the surgery report.

Learning from complaints and concerns

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

In the year 1 September 2020 to 1 October 2021 there were two complaints relating specifically to the endoscopy service. No themes were identified.

For our detailed findings on learning from complaints and concerns, please see the Responsive section in the surgery report.

Are Medical care (Including older people's care) well-led?

Good

We have not previously inspected well-led. We rated it as good.

Leadership

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

The endoscopy service was managed by the leadership team for surgical services. The designated endoscopy team were focussed on processes to achieve the Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation, and staff understood the requirements for success.

For our detailed findings on leadership, please see the Well led section in the surgery report.

Vision and Strategy

Good

Medical care (Including older people's care)

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

The endoscopy service had a mission statement and set of values that aligned with the hospital strategic direction. The service was working towards achieving the JAG accreditation . By participating in accreditation, the service had enrolled on an ongoing programme of service and quality improvement.

For our detailed findings on vision and strategy, please see the Well led section in the surgery report.

Culture

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

For our detailed findings on culture, please see the Well led section in the surgery report.

Governance

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

There was a well-developed and effective governance structure at the hospital. The governance, performance and quality meetings were structured around the clinical dashboard and discussions were focussed on this. All meetings within the governance framework were well attended and there were clear lines of accountability. The endoscopy service was represented at these meetings by the managers within the overarching surgical services team.

For our detailed findings on governance, please see the Well led section in the surgery report.

Management of risk, issues and performance

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

The Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation programme featured on the hospital's corporate risk register. The endoscopy suite had been refurbished to ensure it met expected standards, and progress against successful achievement of accreditation was monitored regularly.

For our detailed findings on managing risks, issues and performance please see the surgery report

Information Management

Good

Medical care (Including older people's care)

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

Leaders proactively collected information and analysed it to drive improvements in care. Staff completed training in information governance, and staff we spoke with understood their responsibilities regarding information management.

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

For our detailed findings on managing information, please see the Well led section in the surgery report.

Engagement

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

Staff were proactive in harnessing patient feedback on their services. Feedback we saw online was positive and questionnaires returned by patients following their procedures reflected the comments seen on the hospital website.

Staff received a monthly newsletter which kept them informed of issues relating to topics such as pay reviews, health and well-being matters, vacancies and new starters and local events.

For our detailed findings on engagement, please see the well led section in the surgery report

Learning, continuous improvement and innovation

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

Staff in the endoscopy service were fully engaged in the process to achieve JAG accreditation; this included a focus on refurbishment of the facilities, upgrading equipment and reviewing all policies and procedures to reflect the highest standards.