Spire Harpenden Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit on 12 and 13 April 2016 and an unannounced inspection on 25 April 2016.

Our key findings were as follows:

Overall the hospital was rated as good.

Are services safe at this hospital?

- There was access to appropriate equipment to provide safe care and treatment.
- The environment was visibly clean and there were systems in place to maintain the safety of equipment used across clinical areas. However in surgery we found that 'I am clean' stickers were not always dated.
- Staff were encouraged to report incidents and were aware of the duty of candour regulation. There was evidence of learning from incidents and complaints and effective processes were in place to reduce risk.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- Systems were in place for the prescribing, storage and administration of medications.
- Staffing levels were appropriate to the needs of the clinical areas and flexed according to the demands of the service, ensuring flexibility to meet patient demands.
- There were clear escalation processes in place, which included escalating to the resident medical officer (RMO) and the patient's consultants.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. However, not all staff had been trained to the right level.

Are services effective at this hospital?

- Care and treatment was delivered in line with evidence based-guidance.
- Policies were accessible, current and reflected professional guidelines. The hospital monitored adherence to policies with the use of local audits.
- Patient outcomes were audited in surgery; however we found that they were not always formally captured in medical care.
- Pain was well-managed and pain management was audited.
- Patients' nutritional status was assessed.
- An induction programme was provided to all new staff.
- There was a process in place for checking professional registration.
- The Medical Advisory Committee (MAC) ensured consultants were competent to practice and practising privileges were reviewed annually.
- Consultants were on call for 24 hours a day and seven days a week for their inpatients and day case patients. There was an RMO providing medical cover for patients and clinical support to staff.
- There were arrangements to ensure staff were able to access all necessary information to provide effective care.
- Staff were aware of their role with to regards to the Mental Capacity Act and Deprivation of Liberty and had received training.
- Multi-disciplinary teams worked well together to provide effective care. Multi-disciplinary team working included hospital staff, local acute trusts, clinical commissioning groups and general practitioners.
- Staff had received an up to date appraisal and identified individual training needs. Staff had the right qualifications, skills, knowledge and experience to do their job.

Are services caring at this hospital?

- Patients were treated with dignity and respect. Their preferences were taken into account with treatment planning and they were given the time and information required to make informed decisions about their care.

Summary of findings

- Feedback from patients and those close to them was positive about the way staff cared for them and the treatment they had received.
- The Friends and Family Test response rates across services were better than the national average. The percentage of patients that would recommend the hospital to family and friends varied between services.
- Staff recognised the need to provide patients and their families with emotional support and the hospital had a list of multi-faith contact details should patients require these.

Are services responsive at this hospital?

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- Services included other organisations and general practitioners in planning patient care to ensure a holistic approach.
- Appointments were scheduled according to the patient's condition and could be arranged as telephone appointments if preferred.
- Appropriate facilities were provided to meet the needs of patients requiring wheelchair access and hearing loop. Interpreters were available to support patients if necessary.
- Patients could access the service at times to suit them.
- The services had protocols and procedures in place to manage patients with complex needs, including those living with a learning disability and dementia.
- Staff had awareness and had attended training in caring for patients living with dementia.
- Information on complaints or how to raise a concern was available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner. There was evidence of actions taken to address issues raised in complaints and staff were informed of changes required in response to complaints.
- Patients received and had access to appropriate written information about their condition and treatment.
- There were no toys or books available in the waiting areas specifically for children when they attended outpatients, physiotherapy or diagnostics appointments.

Are services well led at this hospital?

- The hospital had a vision and a set of values. The hospital also had a clear governance structure and a clinical governance committee that met monthly to discuss a range of hospital issues.
- There were defined routes for cascading information to hospital staff.
- The hospital had a robust risk register.
- Senior management staff at the hospital were visible, supportive and approachable.
- Staff were generally proud to work at the hospital and said they felt supported and valued.
- Clinical leads had a shared purpose and motivated staff to deliver services and succeed.
- Services were being actively progressed through the development of Joint Advisory Group (JAG) accredited endoscopy department and planning palliative care services within chemotherapy.

We saw an area of outstanding practice including:

- Oncology services offered a high standard of personalised care for a variety of patients. This included bespoke appointments, support out of hours and access to specialists. Treatment options were inclusive of new medications and not limited by clinical commissioning. Patients experience was individualised and supportive of their decision-making.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Summary of findings

- Staff who have responsibility for potentially assessing, planning, intervening and evaluating children's care, must be trained to level three in safeguarding.

In addition the provider should:

- Although there were clinical hand basins in utility areas, there were no clinical hand basins in patients' rooms. Therefore staff were using these patient sinks at the point of care when it was necessary to wash their hands. Clinical sinks should be available at point of care.
- The floor coving in patient bedrooms and bathrooms was not compliant with infection control guidelines.
- Medicine cupboards in theatres were being left unlocked for convenience when theatres were in use.
- Medication was found to have been prepared in advance and stored in an unlocked fridge.
- When changes were made to theatre lists, the lists were reprinted and the wards informed of the changes. However, the lists were not reprinted on different coloured paper, which is not best practice. This meant that there was an opportunity for errors to occur if there had been multiple changes in list orders. By the time of our unannounced visit, work was underway to rectify this.
- Medical representatives visiting theatre did not have their identification routinely checked, as they and the companies they represented, were well known to the theatre staff.
- Patient outcomes in oncology were not formally captured.
- Consider the effective management processes required for out of hour endoscopy emergencies.
- Although there was some participation in national audits, this was not comprehensive, particularly in medical care and the hospital should consider formally collecting patient outcomes and participate in national audit programmes to enable benchmarking against national standards.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Outstanding ☆	Overall, we rated the service as good for safe, effective and outstanding for caring responsive and well led. We found that: Both endoscopy and chemotherapy services had a small established team that flexed working days and staffing numbers to meet the demands of the service and ensure patients' treatments were provided according to their condition and any demands on their work/life balance. The clinical environment was suitable to the demands of the service, with Macmillan accreditation in place on Heartwood ward, and Joint Advisory Group Gastroenterology Society accreditation being applied for in the endoscopy unit. There were robust processes in place to maintain equipment and facilities and nursing staff were aware of their responsibilities to ensure patient safety. There was evidence of learning from incidents and complaints and effective processes in place to reduce risk. The hospital used paper records, which were held locally and were readily accessible for patient attendances at the hospital. Patient records were found to be comprehensive and inclusive of specialist advice, notifications to general practitioners and evidence of multidisciplinary discussions. Heartwood ward had participated in an organisational pilot in electronic records and this was planned to be rolled out nationally following a successful trial period. Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Staff had information they needed before providing care and treatment. Staff were able to access additional support and advice from clinical leads. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal. Consent was obtained before care and treatment was given.

Summary of findings

During the inspection, we saw and were told by patients, that the staff were kind, caring and compassionate at every stage of their treatment. Patients we spoke with during our inspection were positive about the way they were treated and felt able to gain support at any time. The oncology team provided a 24-hour advice line for all patients to assist with any concerns with symptoms or treatment.
There were systems to ensure that services were able to meet individual needs, for example, appropriate decorations for those with visual impairment. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.
Staff were familiar with the organisational vision and values and felt part of the team as a whole. Nursing staff told us that they felt supported by their immediate line managers and that the senior management team were visible within the departments.
There were effective systems for identifying and managing the risks at the team, hospital and organisational levels. Teams were benchmarked against organisational hospitals.
Regular governance meetings were held and staff were updated and involved in the outcomes of these meetings. There was a strong culture of team working across the areas we visited.

Surgery

Good

Overall, we rated the surgical services as good for caring, effective, responsive and well-led. Safety required improvement. We found that:
There was appropriate equipment to provide safe care and treatment. Incidents were reported and dealt with appropriately and themes and outcomes were communicated to staff. Action was taken to ensure harm free care.
Children aged 16 years and above were cared for, however not all staff were trained to level 3 in safeguarding.
Patient areas were visibly clean, tidy and appropriately equipped. Patients were assessed, treated and cared for in line with professional guidance. There were effective arrangements in place to monitor and manage pain.
Patient surgical outcomes were monitored and reviewed through formal national and local audit.

Summary of findings

Patients' nutritional status was assessed and nutritional needs were met. There was sufficient competent medical and nursing staff on duty to meet the needs of patients.
Patients were treated with dignity and respect. Nursing, medical and other healthcare professionals were caring and patients were positive about their care. Patients were given appropriate written information on what to expect from their care and treatment. Staff were able to recognise the needs of patients and relatives and gave emotional support.
The booking system offered some flexibility to patients. There was appropriate discharge planning.
Complaints were acknowledged, investigated, and responded to in a timely manner. Information about the hospitals complaints procedure was available for patients and their relatives.
The hospital had a clear governance structure. Information was cascaded to all staff. The service reviewed and acted on feedback about the quality of care received. There was strong leadership and staff felt valued.

Outpatients and diagnostic imaging

Good

Overall, we rated the outpatients and diagnostics service as good for safe, caring, responsive and well-led; effective was inspected but not rated. We found that:
Safety concerns were identified and addressed. Staff were clear with regards to the process to report incidents. Staff were fully aware of the Duty of Candour regulation.
There were good infection control procedures in place and the areas were generally visibly clean and well organised. However, we found some areas did not comply with the Health Building Notes for flooring and sinks in a clinical area.
Records were accessible and completed accurately.
Staffing levels were appropriate for the service provision with minimal vacancies. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
Consent was obtained before care and treatment was given.

Summary of findings

Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. However staff employed by the hospital, who were responsible for assessing children's care in outpatients, did not all have the correct level of safeguarding training. Staff had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.
There were systems to ensure that services were able to meet individual patient needs, for example, for patients living with dementia.
Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. Patients could access the right care at the right time.
The imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice. Staff had the right qualifications, skills, knowledge and experience to do their job.
The learning needs of staff were understood. Staff were supported to participate in training and development.
Multi-disciplinary teams worked well together to provide effective care.
Referrals to treatment times were in line with the national average and appointments could be made easily and quickly if required.
Patients were positive about the way staff treated them in all outpatients and diagnostic areas. They were involved in decisions around their care and treatment and found leaflets informative regarding any potential surgery. Patients were informed about relevant fees for their consultation before they attended their appointment.
Complaint information or how to raise a concern was available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner.
Staff had knowledge regarding the vision for the hospital. There was good staff satisfaction. Staff felt supported and valued. There was a strong culture of team working across the areas we visited.

Summary of findings

Contents

Good

Spire Harpenden Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Spire Harpenden Hospital

Spire Harpenden is a private hospital in Harpenden, Hertfordshire. It has 79 registered beds including four extended recovery beds. The hospital was opened in 1983 and, is purpose built over two floors. During this period the hospital has seen a number of changes, including a major development and expansion in 2014.

The registered manager has been in post for over five years.

The hospital provides inpatient services to adults and outpatient services to both adults and children. The outpatient department comprises of 22 consulting rooms. The hospital offers imaging and physiotherapy services in addition to a pharmacy department providing services for both inpatients and outpatients. All outpatient services are situated on the ground floor of the building.

The inpatient services are situated on the ground and first floors. There are four wards and an extended recovery unit which comprise of 58 inpatient beds, which have ensuite facilities and 21 day case beds.

The operating facilities include five theatres and an endoscopy suite. Four of the five theatres have laminar flow and two offer integrated laparoscopic services.

The hospital undertakes a range of surgical procedures and treats adults. The hospital suspended its inpatient and day case surgical service for children and young people in January 2016 following a review of paediatric services.

The hospital is managed by Spire Healthcare and is part of a network of over 35 hospitals. The hospital provides care for private patients who are either covered by their insurance companies or are self-funding. Patients funded by the NHS, mostly through the NHS referral system can also be treated at Spire Harpenden Hospital.

Our inspection team

Our inspection team was led by:

Inspection Lead: Kim Handel, Inspection Manager, Care Quality Commission

The team of eight included CQC inspectors and a variety of specialists: theatre nurse, chemotherapy nurse specialist and a governance specialist.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 12 and 13 April 2016 and an unannounced inspection on 25 April 2016. We spoke with a range of staff in the hospital, including nurses, allied health professionals, support staff and consultants. During our inspection we reviewed services provided by Harpenden Hospital in the ward areas, operating theatres, outpatients, pharmacy and imaging departments.

During our inspection we spoke with 15 patients and 47 staff, including consultants, who are not directly employed by the hospital. In addition, we spoke with six family members/carers from all areas of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and reviewed personal care or treatment records of patients.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of this inspection

Information about Spire Harpenden Hospital

The hospital has 79 beds, most with en-suite facilities, 21 of these are used for day patient cases currently. There are five operating theatres, four with laminar flow, 22 consultation rooms and an endoscopy unit.

Spire Harpenden provides an inpatient and outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery, diagnostic imaging and urology. There were 10,235 inpatient episodes between January 2015 and December 2015. 7,483 were day cases and 2,752 stayed one or more nights in hospital. In total, there were 9,149 procedures carried out between January 2015 and December 2015.

Between January 2015 and December 2015, 74,216 people were seen in outpatients. There were 2,258children attended outpatients between January 2015 and December 2015.

Between January 2015 and December 2015 around 20% of the patients having day or inpatient treatment were funded by the NHS, the remaining patients were self-funding or paid for by their insurance companies. In outpatients around 9% of patients funded by the NHS, the rest by other means, either via insurance companies or self-pay.

337 doctors have practising privileges and their individual activity is monitored. In addition, there is 374 whole time equivalent employed staff.

Spire Harpenden has the following accreditations:

- CPA Accredited pathology satellite unit
- MacMillan Accredited Oncology Unit
- Registered Pharmacy
- Sterile Services –ISO 13485:2003, EN ISO 13485:2012, Directive 93/42/EEC.

The hospital is working towards Joint Advisory Group accreditation.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day by an onsite resident medical officer. Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital.

The hospital accountable officer for controlled drugs is the registered manager.

Spire Harpenden was last inspected by the Care Quality Commission in January 2014. There are no outstanding non compliances.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Outstanding ☆

Medical care

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

Information about the service

Spire Harpenden medical services comprised of a seven bedded adult chemotherapy suite and an endoscopy unit.

The chemotherapy suite is located on Heartwood ward on the ground floor of the main hospital site and is open 8am to 8pm Monday to Friday. The unit managed on average 20 patients per month, with multiple attendances per patient. Attendance was for a variety of treatments and investigations, with patients often attending the department weekly. The nursing staff also administered complex medications to patients with other medical conditions including rheumatology specialities and osteoporosis. Attendance figures were recorded for attendance to the department and are not split into clinical conditions, or tumour sites. These patients numbered, on average, less than ten per month.

Both the endoscopy unit and chemotherapy suite comprised of a head of department who led registered nurses and care support workers. Locally, the Head of Clinical Services/Matron and Hospital Director supported teams. Medical cover was provided directly by the patient's consultant and the resident medical officer (RMO). Additional support was available through the organisational leads for clinical specialities.

We carried out an announced inspection on the 12 and 13 April 2016 and an unannounced inspection on the 25 April 2016. We inspected both clinical areas.

During inspection, we spoke with five nurses, a pharmacist, one consultant and four patients and relatives. We reviewed medical and nursing records of seven patients and trust data relating to both services.

Summary of findings

Overall, we rated the service as good for safe and effective and outstanding for caring responsive and well led.

- Medical services had a small established team that flexed working days and staffing numbers to meet the demands of the service and ensure patients' treatments were provided according to their condition and any demands on their work/life balance.
- The clinical environment was suitable to the demands of the service, with Macmillan accreditation in place on Heartwood ward, and Joint Advisory Group Gastroenterology Society accreditation being applied for in the endoscopy unit.
- There were robust processes in place to maintain equipment and facilities and nursing staff were aware of their responsibilities to ensure patient safety. There was evidence of learning from incidents and complaints and effective processes in place to reduce risk.
- The hospital used paper records, which were held locally and were readily accessible for patient attendances at the hospital. Patient records were found to be comprehensive and inclusive of specialist advice, notifications to general practitioners and evidence of multidisciplinary discussions. Heartwood ward had participated in an organisational pilot in electronic records and this was planned to be rolled out nationally within the Spire hospitals group, following a successful trial period.

Outstanding ☆

Medical care

- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Staff had information they needed before providing care and treatment. Staff were able to access additional support and advice from clinical leads.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal. Consent was obtained before care and treatment was given.
- During the inspection, we saw and were told by patients, that the staff were kind, caring and compassionate at every stage of their treatment. Patients were positive about the way they were treated and felt able to gain support at any time. The oncology team provided a 24-hour advice line for all patients to assist with any concerns with symptoms or treatment.
- There were systems to ensure that services were able to meet individual needs, for example, appropriate directions for those with visual impairment.
- There were systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.
- Staff were familiar with the organisational vision and values and felt part of the team as a whole. Nursing staff told us that they felt supported by their immediate line managers and that the senior management team were visible within the departments.
- There were effective systems for identifying and managing the risks at the team, hospital and organisational levels. Teams were benchmarked against organisational hospitals.
- Regular governance meetings were held and staff were updated and involved in the outcomes of these meetings. There was a strong culture of team working across the areas we visited.

Are medical care services safe?

Good

Overall, we rated the service as good for safe because:

- Medical services were open and transparent and staff were aware of their responsibilities, understanding the need to raise concerns and report incidents. Staff felt fully supported when doing this.
- Effective processes were in place and performance data showed that when things went wrong, appropriate investigations and actions were taken and learning was shared across the team, the hospital and the Spire group.
- Effective systems were in place to maintain the cleanliness of the environment and maintain the safety of equipment used across clinical areas.
- The environment was appropriate to the needs of the patients including those with additional needs for visual impairment or reduced mobility. Heartwood ward had achieved Macmillan accreditation for the services and environment provided.
- Systems were in place for the tracking and monitoring of medications used. Administration processes were in line with national guidance and reflected in patient pathways.
- Staffing levels were appropriate to the needs of the clinical areas and flexed according to the demands of the service, ensuring flexibility to meet patient demands.
- The national tools used to monitor and assess patients' conditions were audited to ensure compliance.
- There were clear escalation processes in place, which included the use of the resident medical officer and escalation to consultants.
- Staff were aware of major incident planning and able to demonstrate actions that they would take.

Incidents

- Staff were able to discuss their responsibilities to raise concerns and the correct process for reporting safety incidents and near misses, internally and externally.
- Staff told us they knew how to report incidents using the hospitals electronic incident reporting system. Staff on duty during the inspection demonstrated this.

- There were 250 incidents reported across the hospital from January to December 2015. There were no serious incidents reported for either the endoscopy of chemotherapy departments. There were several minor incidents, however these had been dealt with immediately.
- Teams discussed learning from incidents that occurred both locally and organisationally. We observed evidence of discussions at clinical governance meetings and within team newsletters during inspection.
- Nursing staff told us they felt informed of any outcomes of concerns raised.
- There were no never events reported by medical services from January to December 2015. A never event is defined as a wholly preventable incidents, 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.
- The service reported two deaths of patients who had undergone chemotherapy. One incident was expected and the patient had an appropriate end of life pathway in place. The second was an unexpected death, which was under investigation at the time of inspection.
- The hospital reported no serious incidents within the medical services that required an investigation from January to December 2015. A serious incident is described as: An event where patients and service users have died or sustained avoidable harm or have been exposed to a significant risk of avoidable harm as a result of a failure by the registered person to provide safe care or treatment that result in patient harm.
- From November 2014, all providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were able to describe their responsibilities when something went wrong and demonstrated openness with patients and their relatives. They were able to describe experiences when they had used duty of candour principles. We saw evidence of investigations and action plans associated with learning from incidents during inspection. The hospital followed the organisational policy relating to complaints and offered apologies and completed investigations within an agreed timescale. The standard response time was 20 days, but was extended with complex cases following discussion with the complainant. The hospital reported 98% compliance with response time from January to December 2015.
- The service discussed incidents and related actions and learning at the Medical Advisory Committee meetings. The organisation discussed any deaths, both expected and unexpected, via both the MAC and clinical governance committees. In addition, incidents where patients' condition deteriorated and required transfer to acute trusts were examined and scrutinised by both these committees.

Safety thermometer or equivalent

- The safety thermometer is an audit completed within inpatient areas on a monthly basis. This system monitors risks associated with pressure ulcers; catheter associated urinary infections, falls risks and blood clots (venous thromboembolism, VTE). Audit results were captured centrally to identify trends and results displayed locally.
- Medical services did not capture safety thermometer data; however did collect similar data in number of falls, infections, VTE compliance, mandatory training and completion of patient assessments. This information was displayed on Heartwood ward was collated and showed 100% compliance for VTE risk assessments from January to December 2015.
- The hospital reported no pressure ulcers of category two or above during 2015. Pressure ulcers affect an area of skin and underlying tissue and are categorised according to severity. Category one being discolouration of skin and category four being full thickness skin loss with underlying damage to muscle, bone or tendons.
- Compliance results from audits were benchmarked against other hospitals in the organisation and staff used this to share learning and experience. The hospital was noted as performing about the same as other hospitals on the organisation scorecard for January to March 2016.

Cleanliness, infection control and hygiene

- All areas visited were visibly clean and cleaning schedules were in place to prevent and protect people from a healthcare-associated infection.

- We saw signatory sheets demonstrating regular cleaning of equipment on Heartwood ward.
- All equipment was clean and "I am clean" stickers were used across all areas inspected. Staff were observed cleaning equipment after use.
- Waste was handled appropriately with separate colour coded arrangements for general waste, clinical waste, chemotherapy waste and sharps, clearly marked. All bins were foot pedal operated lids and were not overfilled.
- The endoscopy unit had effective processes in place to ensure the cleanliness of equipment and to prevent contamination. This included separate dirty and clean rooms, and the use of a designated staff member for equipment cleaning during busy scheduling.
- Endoscopy cleaning and decontamination equipment had been recently replaced and an additional sink unit planned for installation. The new sink unit was planned to facilitate an improved cleaning system, as accurately measured cleaning fluids would be dispensed by foot pump, instead of current manual measurement by nursing staff.
- The endoscopy team completed weekly water sampling for contamination. We saw evidence of sampling, results and action taken for "rogue" results. Any incident of contamination was managed by resampling and "closing" the unit until confirmed as clear of contaminants. The hospital engineer and ward sister monitored this process.
- Decontaminated endoscopy equipment was stored for up to 72 hours in ultraviolet cabinets within the department. Endoscopy staff tracked all equipment to ensure effective decontamination.
- There were processes and procedures in place for tracking equipment used for each patients investigation, including sterile equipment used for biopsies and details of staff members operating and decontaminating.
- Patients attending endoscopy appointments identified as having suspected communicable infections were placed at the end of treatment lists to allow additional cleaning times between patients.
- Staff were observed using appropriate personal protective equipment such as aprons and gloves, when undertaking tasks.
- Endoscopy staff had trialled several types of aprons to use during decontamination and identified a type which was suited to the environment and for ease of use.
- Staff were noted as being bare below the elbow and appropriately washed their hands or used sanitising hand gel between patient contacts.
- The medical services reported no incidence of Clostridium Difficile, MRSA or Methicillin-susceptible Staphylococcus Aureus (MSSA) from January to December 2015.
- We found that appropriate sharps bins were in use across medical services and labelled correctly to identify date opened and ward area and hospital.
- There were monthly organisational infection control meetings, which were chaired by the matron. Information was shared between heads of departments and then cascaded across teams locally at ward level. Staff were able to escalate concerns to the senior management team at this forum.
- Infection control link nurses from each clinical area attended monthly meetings. We reviewed evidence of these meetings during the inspection and found them to be comprehensive.
- Infection control risk assessments were in place across medical services. Risk assessments identified risks associated with chemotherapy medication, decontamination and cross infection.
- An infection control audit was in place with quarterly requirements for compliance with uniforms, handwashing and clinical equipment such as mattresses. Some audits were completed by external staff members to promote non-biased data collection. Compliance was noted as being in line with organisational targets.
- In addition to the handwashing audit, medical services had also complete monthly audits of sanitising hand gel usage. Data for February 2016 identified that on average hand gel was used 20 times per day, proving that gel was being used.
- Medical services completed audits on insertion and removal of specific intravenous devices, used for the administration of intravenous medications. The results for 2015 showed that of 11 devices, none became infected.
- There was a policy and procedure in place for the management of cytotoxic spillages and nursing staff were able to demonstrate awareness and equipment used.

Environment and equipment

Medical care

- The service had essential systems, processes and practices in place to keep people safe; this included, a comprehensive maintenance programme and competency checks for equipment used, for example for safe administration of intravenous medication.
- The design of the chemotherapy unit was in line with Department of Health guidance HBN 03-02, with adequate space and facilities to meet the needs of both patients and clinical staff.
- Chemotherapy services opened at Harpenden hospital in 2009 and were previously located on Roundswood ward. Services were relocated to Heartwood ward in 2015. The ward consisted of seven en-suite rooms equipped with emergency equipment such as call bells. The service had been reviewed by the Macmillan Cancer Support charity in 2011 and achieved Macmillan Quality Environment Mark (MQEM) accreditation. In 2015 the hospital was re-accredited with this award. The MQEM is an assessment of services provided for patients living with cancer, which is based on an assessment of the environment ensuring it is welcoming and accessible, that patients are treated with dignity and respect and are given choices in their care and treatment. Accreditation standards are reassessed three yearly to ensure continued compliance.
- The endoscopy unit was located between theatres and the day case ward on the first floor of the hospital site. The department consisted of one treatment room with adjoining dirty and clean utility areas and a small office area. Patients attending the unit were collected by endoscopy staff and escorted into the treatment room for the procedure. Once completed, the patient would either return to their room on the day case ward or to theatre recovery if they took longer to wake following sedation. Nursing staff attended to the patients at all times and ensured accurate handover between theatre and ward staff.
- All nursing staff reported an effective maintenance programme for equipment. We saw evidence of portable equipment being serviced, maintained and tested appropriately to ensure it was safe and fit to use.
- The in house maintenance department completed regular visits to the clinical areas and checked equipment. The department worked closely with the endoscopy unit to ensure equipment was safe to use and maintained.
- The hospital maintenance team were responsible for the hospital asset record for all equipment. Nursing staff reported that the maintenance team were proactive in addressing any concerns and regularly attended the clinical areas to check equipment.
- Specialist equipment was appropriately maintained by manufacturers who attended the hospital to service equipment. The hospital had a small workshop located on the ground floor of the main building to enable equipment review on site. Manufacturers also provided specialist training on equipment and this was observed during inspection.
- Equipment was stored in appropriate locked store cupboards either within or adjacent to clinical areas.
- We checked resuscitation equipment and found it to be clean and well maintained. There were secure tags in place and records detailing that equipment had been checked daily. Staff were trained to use the equipment provided by the organisation and demonstrated knowledge during inspection.
- All rooms were fitted with emergency call points and appropriate equipment for the management of a clinical emergency.
- Dirty utility rooms were inspected and found to be clean and tidy.
- The service had systems in place to ensure that samples and medications were contained in protective bags during transfer between departments.
- Staff had access to appropriate protective equipment such as aprons, gloves and visors as necessary.
- Staff reported that they had adequate supplies of clinical equipment used for administering medication and received training directly from the manufacturers.
- Clinical waste was segregated from the clinical areas and processes were in place to remove waste at regular intervals from the departments. This was observed during inspection.

Medicines

- There were effective arrangements in place to monitor and track the receipt, storage and disposal of medications.
- We reviewed seven prescription charts and found that there were no omissions and patient demographics, weight and allergies were clearly recorded. All prescriptions were legible and signed in line with best practice.

Medical care

- Staff were aware of and able to access guidance and policies relating to the safe administration of medications through the hospitals intranet.
- The hospital had a pharmacy on site that provided daily cover between 8am and 5pm. Nursing staff reported that the pharmacy team were flexible and always assisted before or after duty to ensure medication was available for patient treatments.
- Out of hours medication, for urgent use, was accessible through the pharmacy department as the keys were located in a safe on Ambrose ward. Nursing staff reported that, in conjunction with the resident medical officer, they completed appropriate organisational documentation to confirm medications taken for which patient and notified the pharmacist in person the following day.
- Pharmacy staff were not allocated to specific wards or departments however, they regularly attended clinical areas to maintain agreed stock levels and ensure stock rotation.
- Heartwood ward had weekly meetings with a nominated pharmacist to review patients attending for treatments the following week. A discussion confirmed date and time of appointment, medication due and dosage required. Any blood results or complications were discussed to ensure all risks were identified.
- Chemotherapy was purchased ready mixed via an approved supplier and delivered to the pharmacy department. This was then transferred to Heartwood ward in individually sealed bags containing prepared medication and the prescription chart. The medication was tracked and signed for at all stages of transfer between pharmacy and ward.
- Chemotherapy was stored on the ward in a locked fridge for a maximum of 24 hours, which enabled patients to receive treatment promptly, in the morning.
- Medical services had a robust system in place for the management of chemotherapy spillages. Staff were able to access the appropriate policy and procedure detailing their actions.
- Nursing staff reported that unlicensed medication was not administered in the unit, but they did have access to any licensed medication that was not approved by the local commissioning group. This enabled patients to have access to a wider range of medications earlier in their treatment phase than NHS patients. For example, effective anti-sickness medication, which was usually only available for end of life care, was readily available to all patients.
- Treatment room temperatures were recorded daily. The temperatures varied but were within the correct range for the safe storage of medicines. There were clear instructions on actions to be taken if the temperatures were noted as being out of range.
- Fridge temperature checks were completed daily, they were within an acceptable range and no gaps in recording were identified.
- Administration of chemotherapy medication was completed following guidelines and competence. Patients confirmed that all nursing staff used the same process of administering medications, confirming the patient's identity and ensuring cleanliness throughout.
- The endoscopy unit used a limited number of medications, which were stored in a locked cupboard.
- The endoscopy nursing team were able to prescribe and administer preparatory medications for planned procedures that were in line with the hospitals patients' group direction. These are instructions for the supply or administration of medicines to groups of patients who would not be individually identified before presentation for treatment. For example, all patients attending for a colonoscopy required specific medication for bowel preparation.
- Nursing staff reported that the type of sedation used during endoscopy varied according to the consultant's preference and patent's need; however, this was administered in line with national guidance. The hospital medication policy detailed guidance on the use of sedation.
- Endoscopy staff reported that safe sedation guidelines were adhered to during clinical procedures and patient pathways reflected this.
- We saw controlled drugs were stored, managed and reconciled appropriately.
- Nursing staff reported knowledge of and the safe administration of controlled medication in line with the Nursing and Midwifery Council- Standards for Medicines Management.
- The use of controlled medication was audited by the hospital. The 2015 audit in endoscopy showed that there were two missing data entries relating to medication administered in November 2015. The

clinical team reviewed this and the consultant responsible for the administration signed for this retrospectively. The stock level was found to be correct and daily checks completed.

- The pharmacy team completed medicines optimisation audits monthly to capture compliance of medication charts and administration. Audit results for November 2015 did not detail charts relating to specific clinical areas and charts were picked randomly. However, overall compliance was very high across all ten reviewed charts. Noted omissions included one chart without a weight recorded, two charts with admitting nurse signature missing and one chart with a prescription which was illegible. Omissions were dealt with and discussed at clinical governance meetings to effect improvements.
- We saw safe administration of antibiotics in line with national guidance. Out of hours, antibiotic or unusual antibiotic prescribing was reported to the matron who reviewed the patients' details and discussed treatment with the consultant.
- Medical services had access to a microbiologist for advice and confirmation of treatment. The consultant was usually contacted by telephone, however was able to attend the hospital to review patients if necessary.
- We saw patient's notes relating to an admission for suspected sepsis, and found that the sepsis guidelines had been followed with the patient receiving all appropriate treatment within one hour of admission to hospital.
- Patients who needed to take medication home with them were provided with a supply of medication and received a clear explanation of safe use and management by the nursing staff. This included oral chemotherapy medications. Details of any medications and treatments completed or planned were shared with the patient's General Practitioners by letter.
- Nursing staff reported that national safety alerts were cascaded to all staff through the hospital intranet and discussed locally if affecting their practice.

Records

- The hospital staff predominantly used a paper based records system for recording patients care and treatment. These were stored in the medical records department on site. The notes were found to include copies of referrals, clinic notes completed by consultants and copies of nursing records and clinical results.
- On Heartwood ward, medical records for all patients with an active treatment plan were stored in locked cupboards situated at the nurses' station.
- Medical records for patients undergoing endoscopy procedures were kept with the patient on the day case ward. These were transferred to the endoscopy unit with the patient at the time of procedure.
- Heartwood ward used an electronic notebook to record patients' treatment and nursing records and were the trial site for this system. This was an electronic copy of the care pathway, which could be uploaded to a central database to enable auditing. Electronic notebooks were password protected. The plan was for nursing staff to use the devices at home to access patient information when contacted out of hours. This also meant that records and treatment plans were available for patients attending as an emergency.
- The endoscopy care pathway included a modified version of the World Health Organisation's (WHO) five steps to safer surgery checklist that was completed at the time of the procedure.
- Any equipment used during a clinical procedure in endoscopy was recorded in the patients' records and in the departments' treatment log. This ensured that all equipment was tracked.
- Medical notes were legible with clear plans in place. Data entries were clearly labelled with author, date and time of entry.
- Nursing and medical staff had access to electronic reporting of blood tests and investigation results. Investigations completed outside the organisation were reported using recognised secure systems to protect patient identity.
- Consultants were supported by secretarial services on site.

Safeguarding

- Staff were aware of their responsibilities regarding safeguarding practices and told us the local policy was accessible on the intranet.
- Although the services were used by adults only, all staff completed mandatory child protection, level 2 safeguarding children and safeguarding adults training. Compliance for all subjects was 96.7%.

- Organisational compliance for mental capacity training was 45%, which was below target of 50%. This included online training and/or classroom based training and was for all staff involved with decision making regarding patients care and treatment, in line with Spire policy. Nursing staff confirmed they were aware of the training need and had scheduled training to update.
- There were clear systems, processes and practices in place to keep people safe. Nursing staff reported no recent incidents regarding safeguarding, however were able to describe the processes of escalation.
- Medical services had reported no safeguarding concerns from January to December 2015.
- Posters identifying contact details for the safeguarding lead were visible in all ward areas.

Mandatory training

- Nursing staff spoken with reported full compliance with mandatory training. Hospital data showed a consistent increase in compliance for all staff training over 2015 with 86% compliance in March 2016. This was above the organisational target of 80%.
- The hospital used online training which nursing staff reported was convenient as they could complete it when they had time.
- Online training was available in eight standard modules which included fire safety, health and safety, infection control, level 2 safeguarding children, safeguarding adults, manual handling, compassion in practice and equality and diversity. Additional subjects were dependent on role and included managing violence and aggression, controlled drugs, incident reporting and mental capacity act training.
- Training was completed off site or by an external person for practical aspects such as basic life support.

Assessing and responding to patient risk

- Medical services had clear eligibility criteria for patients accessing the service, with clear pathways for referrals to alternative providers for patients who did not meet the required eligibility.
- Medical services did not provide 24-hour inpatient cover. Out of hours, provision was through the inpatient ward area and the resident medical officer. Patients undergoing chemotherapy who became acutely unwell were admitted to the main inpatient area for treatment.
- The nurse assessed patients admitted to Heartwood ward prior to agreeing a treatment programme. Patients would attend an outpatient appointment and then be accompanied by the consultant to the ward to be introduced to the nursing staff. They would then agree an appointment slot for a pre-chemotherapy assessment. This included a physical examination and the completion of risk assessments. Following the assessment, patients were offered a treatment plan, which they could agree to following discussion with the consultant. Nursing staff would complete a similar assessment prior to any treatment on every admission to hospital.
- Similarly, the nursing staff reviewed patients admitted for an endoscopy procedure prior to an appointment being scheduled. This enabled nursing staff to ensure the patients were fit for the treatment planned. Any concerns were escalated to the consultant and staff discussed treatment options. For example, nursing staff told us that patients identified as having any risk factors, were discussed with the consultant prior to the planned treatment to ensure the patient was appropriately risk assessed. Risks relating to the procedure were discussed with patients prior to treatment and confirmed during consent processes.
- High-risk endoscopy patients were not treated within the department and it was arranged that their care be taken over by the local NHS trust.
- There was no emergency on call provision for patients who had undergone endoscopy; however, the endoscopy sister reported that theatre staff were able to complete procedures if necessary. It was reported that out of hours endoscopy had not been required for several years.
- Heartwood ward offered a 24 hour on call service for patients who were currently undergoing treatment. Nursing staff would rotate an on call telephone service, which patients could call at any time with any queries or concerns. Nursing staff had an assessment template based on national guidance, which promoted safe decision-making. This resulted in either urgent admission to the hospital; review the following day or discussion at next appointment. Nursing staff would use the information gathered using the tool, to discuss possible admissions with the resident medical officer to arrange admission to the inpatient ward. A flow chart describing out of hours actions was available and displayed for all staff to confirm the process.

Medical care

- We saw patient's notes relating to an admission for suspected sepsis, and found that the sepsis guidelines had been followed with the patient receiving all appropriate treatment within one hour of admission to hospital.
- Patients who became clinically unstable during their appointment were reviewed by the resident medical officer and as soon as possible by the responsible consultant. Emergency transfers to the acute NHS trust were completed via a call to ambulance services. The hospital had a strategic plan in place to address the need of emergency transfer to acute hospitals under a local service level agreement. There had been 13 during the previous year, but none had related to chemotherapy or endoscopy.
- All treatment plans within Heartwood unit were in line with national guidance and were evidence based. We saw evidence that guidelines were updated regularly to meet changes in recommendations.
- Patient observations were completed using the national early warning score (NEWS) system. This is a numeric scoring system enabling identification of deterioration in a patient's clinical condition. Completion of NEWS scores was regularly audited by the hospital to ensure compliance and showed that these were at 100%.
- Care pathways on Heartwood ward contained a formal risk assessment in nutrition, but this was monitored through weekly weighing and discussion of nutritional needs at each attendance at hospital.
- Nursing risk assessments were integrated into care pathways and included nutritional, skin integrity and mobility assessments. These were repeated at every attendance to hospital to monitor trends or deterioration in clinical condition.
- Heartwood ward staff were aware of the policy for extravasation (the process where fluids such as drugs leaks into surrounding tissue causing swelling) which was based on the United Kingdom Oncology Nursing Society guidance. The policy was observed during inspection.
- Nursing staff reported that they had completed or had attendance planned for intermediate life support training events. Training figures for this were not available.

Nursing staffing

- The hospital used a staffing tool based on the analysis of patient dependency and activity within a period in September 2015. Nursing staff completed an activity and dependency study, which was analysed to indicate appropriate staffing levels across all clinical areas. Both the endoscopy unit and Heartwood ward had small nursing establishments based on this analysis. Both departments were fully recruited.
- As both departments provided planned procedures and treatments, staffing levels were adjusted according to the daily needs. Heartwood ward reported between 50-60 patient attendances per month, with busy days seeing seven patients. Endoscopy reported between 120-130 procedures per month, with busy days seeing up to ten patients.
- The number of staff on duty varied according to activity planned for that day. In Heartwood ward, there was always two qualified nursing staff on duty with an additional qualified nurse for high activity periods. Nursing staff on Heartwood ward flexed their hours to meet the demands of the service, and as a result, agency staff were not required in the department. In addition, the ward sister flexed hours and clinical time to suit the needs of the department and support the team.
- Similarly, the ward sister and a qualified nurse, with additional care support worker hours, staffed the endoscopy unit.
- During inspection, we reviewed four weeks previous off duty, which showed that actual staffing numbers were in line with numbers planned.
- Due to staff sickness during 2015, the endoscopy unit reported using agency staff frequently from January to December 2015. The theatre manager who arranged this assured that appropriately qualified staff were used. The endoscopy ward sister ensured the staff member was supported by a substantive member of staff and orientated to the unit. The post had been recruited to at the time of inspection. Staffing numbers were not displayed on the wards, however the nurse in charge was displayed and this was found to be accurate during both the planned and unannounced inspection.
- Due to the working patterns, medical services did not provide daily handovers; however, staff discussed care and treatment planning daily to ensure all staff were aware of any issues. An example of this was the handover of a patient's previous reaction to

chemotherapy. We observed nursing staff discussing the patient's previous experience and all staff were then aware of what actions to take if the administering nurse called for assistance.
- Students were not allocated to medical services, but did attend planned days during their placement at the hospital. Students would attend on days with high activity to promote learning and experience. The learning varied according to activity on the day, but included introduction to therapies and treatments.

Medical staffing

- All consultants had practising privileges, which were managed by the hospitals management team. Practising privileges meant that consultants were required to be contactable at all times when they had a patient at the hospital. They were also required to be able to attend within a designated timescale for advice with medical emergencies.
- Practising privileges were reviewed annually and an electronic system used to monitor expiry. The consultant reviews included aspects of performance, such as appraisal, volume and scope of activity and review of complaints and incidents.
- Nursing teams reported that the consultants who used the services were easily accessible and usually liaised directly with them when planning patients' care.
- Consultants were responsible for the patients for the duration of their treatment. Nursing staff reported that consultants would plan treatment and appointments with patients to ensure that they had regular clinical reviews during their treatment.
- To ensure adequate consultant cover for leave or sickness, consultants planned cover with colleagues already established as part of the team.
- Nursing staff could access the resident medical officer, available 24 hours per day, for any urgent issues. The RMOs in place during inspection were trained in advanced life support (ALS).
- Nursing staff told us that any concerns regarding consultants practice was escalated through the clinical lead for the department, and then through the Medical Advisory Committee (MAC). Minutes from this meeting were reviewed during inspection and confirmed shared learning, update on changes to best practice and safety alerts.
- The organisation liaised closely with the base hospitals through a nominated person, this enabled the hospital to keep up to date with any concerns or changes to individual consultants' practices.
- Consultants received a copy of the hospital "consultant handbook" which detailed hospital processes and procedures. This included expectations of practice and behaviour.
- Formal ward rounds were not in place on Heartwood ward; however, patients were reviewed by the responsible consultant at least daily, in line with individual treatment plans and their obligation under the practising privilege arrangements.

Major incident awareness and training

- Nursing staff reported awareness of the major incident policy and their roles in the event of an incident. The policy was accessible on the intranet.
- Nursing staff reported that they had recently managed a situation whereby the wards were evacuated because of a fire alarm. This incident was reported as being well managed, with staff acting appropriately in line with policy. Staff were able to access a debriefing session relating to this incident and learning shared amongst the teams.
- The organisation had an appropriate business continuity plan in place and staff were aware of processes and actions required in the event of an emergency, such as loss of power or adverse weather conditions for business continuity. Nursing staff were able to inform us of providers who would assist with the management of patients in an emergency.

Are medical care services effective?

Good

Overall, we rated the service as good for effective because:

- There was a holistic approach to assessing, planning and delivering care and treatment. This included the effective management of pain relief and nutrition.
- New evidence-based techniques were being used and technologies were supporting delivery of high quality care.
- Staff skills and competence were seen as a priority and integral to quality care.

- Where appropriate, national guidance was used to form the basis of policies and procedures.
- The services were benchmarked against other hospitals to identify areas of improvement and shared good practice.
- Competency within oncology was maintained by external assessment processes and in line with national guidelines.
- Multidisciplinary team working included local acute trusts, general practitioners and specialist nurses to ensure that care was seamless across all aspects of the patients care pathway.
- Chemotherapy service had links with specialist nurses and local hospices to ensure a seamless transition of care for patients.
- Medical and nursing notes were readily available for all attendances at hospital, processes were in place to enable access to reports and investigation results deemed essential to treatment planning.

However we also found that:

- Patient outcomes were not formally captured.
- Only 45% of staff had completed DoLS and Mental Capacity Act training.

Evidence-based care and treatment

- Policies were current and referenced according to the hospital clinical governance policy.
- All policies were accessible through the hospital intranet and based on national guidance from professional bodies such as the National Institute for Health and Care Excellence (NICE).
- We saw that chemotherapy guidelines and standard operating procedures used were based on United Kingdom Oncology Nursing Society guidance. This included all templates for treating and assessing patients.
- The endoscopy unit used national guidance for safe sedation and the five steps to safer surgery, and this was reflected in patient care pathways.
- Patients with acute conditions such as upper gastrointestinal bleeds were treated at alternative acute NHS hospital trusts.
- The hospital had a comprehensive audit calendar in place to monitor compliance against policy and in line with NICE guidance. This included consent processes, recording of multidisciplinary meetings and clinical practice such as intravenous long line device infections.
- Additional audits planned included the monitoring of sepsis and was scheduled to be completed between April to June 2016.

Pain relief

- Pain was managed in line with the Faculty of Pain Medicine Standard 6.4, with individualised pain control plans according to the patent's clinical condition and managed by consultants, specialist nurses and palliative care specialists.
- Staff reported that they had access to a visiting palliative care consultant who assisted with appropriate prescribing of pain relief for patients living with cancer.
- Patients reported that pain relief was well managed and nursing staff responded quickly to requests for pain control.
- Medication charts evidenced that appropriate pain medication was in use and administered regularly.
- Nursing staff reported that pain scores were recorded on the national early warning system (NEWS) charts and this was observed during inspection.
- The service used a pain trigger to action tool to assess patients' level of pain and requirements for analgesia, which was scored one to five. The score was recorded on the patients NEWS chart. Compliance with appropriate pain management was audited and results discussed during the clinical audit and effectiveness meetings. The audit results for 31 March to 14 April 2016 showed that 13 patients reported a pain score greater than two (across the hospital). The audit showed that pain control was provided immediately apart from one instance, which was resolved within ten minutes.

Nutrition and hydration

- A nutritional assessment was completed on each admission to hospital. This included an assessment of the patient's weight, any problems experienced with food and drink, and issues with swallowing and nausea. This enabled staff to make referrals for nutritional support as necessary.
- Patients undergoing endoscopy were informed of the dietary requirements prior to the procedure. Nursing staff liaised with the ward staff to ensure that patients were appropriately prepared for procedures and "starved" for the appropriate duration.
- Intravenous medications and fluids were prescribed and available where necessary.

- Patients could be referred for nutritional assessment or support from a dietician if necessary.

Patient outcomes

- The hospital used a clinical scorecard to benchmark against other hospitals within the organisation. The scorecard recorded key performance indicators, which contributed to patient outcomes, such as completion of accurate patient observations, venous thromboembolism (VTE) monitoring, evidence of multidisciplinary team meetings in medical notes and mandatory training compliance. On review of the scorecards for 2015-2016, we saw that the hospital consistently met organisational targets for the medical services components.
- Patients attending medical services had a care pathway defined by the treatment planned. These identified actions and assessments to be completed at every stage and were based on national guidance for the specific condition or treatment.
- Heartwood ward did not formally record patient outcomes; however, the ward sister maintained a database of all patients detailing treatment types which could be used to provide data if requested.
- Patients requiring palliative or end of life care were involved with discussions with the nursing and medical team to decide on favoured location for treatment. This included liaison with the Macmillan services, GPs and local hospices.
- All patients diagnosed with cancers were seen and commenced treatment within two weeks of referral.
- Medical services did not participate in national audits. Local audits included review of blood transfusions administered, recording of early warning scores (NEWS), pain management, documentation compliance, waste management and recording of multidisciplinary team meetings.
- There was a comprehensive action plan regarding the standards required to achieve Joint Advisory Group Gastroenterology Society accreditation (JAG), which included the annual review of policy and guidelines and a number of audits in clinical practice. The audits required were review of consultant specific completion rates, intubation of the caecum, pain scores, timeliness of procedure list and annual review by clinical commissioning.

Competent staff

- All nursing staff within Heartwood ward had completed annual updates and assessments in chemotherapy. This was completed externally at another specialist provider. Competence was maintained through regular practice and staff observed each other to ensure compliance. Patients reported that the process of administration did not change between staff or episodes of treatment, suggesting compliance against procedure.
- Nursing staff in Heartwood ward had regular updates from the local oncology centre, which was also cascaded to ward staff to assist with the management of chemotherapy patients admitted to the ward.
- Oncology specialist consultants were included in the planning of patient care and treatment, and were usually accessed through a telephone referral. Nursing staff reported that specialist consultants were easily accessible offering advice and support as necessary.
- Nursing staff in endoscopy reported that they regularly reviewed guidance from the British Society of Gastroenterology (BSG) and received regular updates on best practice from one consultant who was part of the BSG ethics committee.
- The hospital provided an induction and learning programme for all new staff. This was reported by all nursing staff as being thorough and including an overview of the organisational aims and objectives as well as clinical skills required for roles.
- In addition to training, staff were offered regular appraisals. The staff spoken with reported completed appraisals and clear objectives for learning. Organisational data confirmed 100% compliance with annual appraisal.
- Nursing staff reported that the hospital had support mechanisms in place to assist nursing staff with revalidation. This included practical advice with assistance in compiling evidence and emotional support through the process.
- Medical revalidation was completed by consultants' base hospital. If they were independent of the NHS, this was completed by Spire's medical director.
- There were processes in place for checking registration with the GMC and NMC. The management team maintained this.
- The management team and MAC reviewed competency of the consultants and checks were in place with the consultant's trust to ensure practice was current. There was 100% compliance with this at the time of inspection.

- Consultants requesting to complete new procedures were required to apply for permission from the senior team. This was reported as being a robust process and required consultants to complete a protocol and policy relating to the new procedure. This was then reviewed by the MAC who agreed to the procedure following confirmation of competence and ensuring that procedures were in line with NICE Guidance.
- Nursing staff in Heartwood ward reported that they were due to attend advanced life support training, with training booked for completion in 2016. Both Heartwood ward and Endoscopy had 100% compliance with basic life support.

Multidisciplinary working

- Medical and nursing staff reported good working relationships. Nursing staff reported that they would contact consultants directly to discuss patients care and felt that this was always responded to positively. Consultants openly promoted the department and the quality of care the nursing team provided.
- Consultants attended Heartwood unit regularly to discuss possible referrals to the service, and nursing staff felt that they were well supported and listened to during these discussions.
- Patients referred with suspected breast cancers were discussed as part of local acute trusts multi-disciplinary team (MDT) meetings. The trusts medical team, breast nurse specialists and clinical leads attended these meetings. Nursing staff reported that they were able to attend the MDT meeting to discuss their patients.
- There was evidence of MDT discussions within all medical records reviewed. This was also audited by the hospital. Data showed that compliance varied from 42 to 67% between April to December 2015. Organisational target was 65% and consultants were reminded to ensure accurate documentation was in place following identification of poor compliance.
- Endoscopy nursing staff reported that they had a positive relationship with consultants and felt they valued their skills and knowledge.
- We observed effective team working amongst clinical and management teams with clear escalation processes and open discussion in place.
- GPs were kept informed of treatments provided; follow up appointments and medications to be taken on discharge. Nursing staff reported that some local GPs were involved with the planning of patients care and treatment.
- Patients undergoing chemotherapy had their care transferred to either the community palliative care team or the local hospice if their condition deteriorated. This was provided following discussion between the patients' general practitioner and consultant.

Seven-day services

- Both endoscopy and Heartwood ward provided an 8am to 8pm Monday to Friday service, with flexed hours to meet the demands of the service at the time. For example, the endoscopy unit remained open late on a Wednesday as the consultant provided an afternoon and evening clinic.
- Theatre staff were responsible for assisting with emergency endoscopy procedures out of hours. However, it was reported that no emergency procedures had needed to be conducted from January to December 2015. This was discussed during inspection and the hospital informed us that they were in the process of reviewing the need for emergency endoscopy cover.
- Nursing staff reported working out of normal working hours for planned procedures, which involved an endoscopy prior to an operation. This was to ensure that appropriately trained and competent staff were available for the procedure.
- Out of hours chemotherapy services included a helpline for patients who were concerned about symptoms, with all clinical emergencies being managed by the inpatient area.

Access to information

- Treatment records for 'active' chemotherapy patients were maintained on Heartwood ward. All archived records were stored centrally in the hospital medical records department. After a period of three months these records were transferred off site to a secure facility in line with the hospital and Spire policy.
- Patients in Heartwood ward reported effective communication and correspondence between the hospital, consultant and GP, which enabled effective management of their condition and treatment.

- Endoscopy reports of findings or treatment plans were recorded in the patient medical records, which were also stored in the medical records department. When patients attended for treatment, patients' notes were maintained by the inpatient ward and were sent to the endoscopy unit with the patient.
- Copies of endoscopy reports were supplied to patients and retained by the consultant for medical notes. A copy of the report was shared with patients' general practitioners with discharge letters.
- Medical notes included all information pertaining to assessment and treatment plans including details of multidisciplinary team meetings. Copies of all external communications (such as GP letters) were also stored in the patient's notes enabling tracking of patient care.
- The hospital had access to medical records for NHS patients and results reporting systems through secure networks.
- Investigation results were emailed directly to consultants to speed up processes of investigations and treatment planning. This included histology results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for chemotherapy was completed by the consultant and then checked by the nursing staff on Heartwood ward prior to any administration. Nursing staff reported that the pre-chemotherapy assessment was used to discuss complications regarding treatment plans and the intent of treatment; this was evidenced in patients' notes and during patient discussions.
- Nursing staff were aware of their responsibilities in relation to gaining consent for all procedures within both endoscopy and Heartwood ward.
- Consent processes within endoscopy had been audited February to March 2016 by the nursing staff and showed that individual consultants had differing processes of gaining the patient's consent. This related to consent being obtained for the procedure in the treatment room, prior to the procedure or in the patient's room before the list commenced. The audit results were shared with the consultants during a team meeting and the team agreed a standard process for all staff to follow. The nursing team were planning to repeat the audit to monitor compliance.
- All staff reported that they were aware of the consent policy and how to access this on the organisation's intranet. They also explained that any concerns would be escalated to the head of department or matron for further advice or assistance. All clinical staff reported compliance with Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training and had completed appropriate training. However, hospital compliance data stated that only 45% of staff had completed Mental Capacity Act training, which was below the organisational target of 50%. This figure related to all staff including administrative and support staff. Staff had been reminded of training requirements through the clinical brief, which was sent electronically to all staff.
- Nursing staff reported limited experience and exposure to patients with capacity or safeguarding concerns but were able to inform us of escalation processes and the appropriate clinical leads.
- Patients attending the service for chemotherapy were advised of possible side effects of treatments during the pre-chemotherapy assessments and prior to attending for treatments. This ensured that patients had time to consider the impact of medications prior to agreeing to the treatment.

Are medical care services caring?

Outstanding ☆

Overall we rated the service as outstanding for caring, because:

- Patients were treated with dignity and respect.
- Everyone, including non-clinical staff, involved with patients and their families were involved in treating the patient as an individual.
- Staff felt they had time to interact with patients and build effective relationships, which were inclusive.
- Patients stated they felt genuinely cared for.
- Patients' cultural and religious needs were genuinely considered.
- All staff were observed being kind and caring and there were incidents where they went the 'extra mile' for patients in their care.
- Patient feedback was positive.
- Patients' preferences were taken into account with all treatment planning and appropriate time was given to patients to make decisions in an informed way.

- Feedback from patients and those close to them was positive about the way in which they were treated and cared for.
- Further support networks were available which included psychological support.

Compassionate care

- Interactions between staff, patients and relatives were observed to be inclusive, polite and respectful.
- Nursing staff were observed confirming with patients how they wished to be addressed.
- Staff gained permission and consent prior to completing treatment or attending to tasks.
- We saw staff maintaining patients' dignity at all times.
- Endoscopy staff escorted patients to the department and ensured dignity was maintained by providing additional gowns to protect modesty.
- Patients informed us that they were happy with the care provided and would return for further treatment as their experience had been so positive.
- All patients felt informed of care and treatment plans, with adequate provision of time for questioning or discussions regarding treatment. Patients on Heartwood ward felt they were included in all planning and decisions regarding treatment options.
- Heartwood ward had achieved Macmillan accreditation, which meant that patients had appropriate environment and support networks for their clinical condition.
- Organisational patient satisfaction audits were completed every month and all patients who attended the hospital were asked to complete a survey regarding care provided. Organisational data showed that patients considered the care and attention of nursing staff, pain control, privacy and dignity and involvement in decision making to be excellent by 80-100% of patients during January and February 2016. In addition to the organisation audit, staff captured patient satisfaction through the friends and family test. Results from July to December 2015 showed that 97-100% of patients would recommend the hospital to their friends and families. The response rate of completed surveys varied between 30%and 60%, an average of 45%, which was better than the England average of 25%.

Understanding and involvement of patients and those close to them

- Heartwood ward nursing staff reported that patients were introduced to the ward and staff prior to deciding if they were to have treatment in the hospital. To facilitate this, consultants accompanied patients to the department following their outpatient appointment to introduce staff and review the facilities.
- Patients once agreeing to treatment at the hospital were offered a pre-treatment appointment, where all aspects of care were discussed and appointment scheduling was planned.
- Nursing staff reported that they felt able to build effective patient nurse relationships because the environment and facilities enabled them to spend time with the patients in a non-rushed manner. Patients confirmed this stating that staff always had time to speak to them, offering support and advice
- Nursing staff on Heartwood ward informed us that due to patients attending the ward regularly over long periods, they became familiar with them, building relationships with them and their families. Staff felt this enabled them to identify when patients' needs changed.
- Patients were involved with decision making around stopping chemotherapy. In addition decisions were discussed across the multidisciplinary team. Nursing staff told us patients often had reduced chemotherapy doses according to their frailty and were referred to the palliative care consultant for symptom control. Patients were often supported at home by the NHS end of life community teams rather than as an inpatient.
- Patients told us that staff were kind and caring. They felt involved and in control of their treatment plans.
- Due to small nursing teams being in place, patients regularly saw the same nurse, which promoted continuity of treatment and an effective patient nurse relationship. Patients told us they felt that staff genuinely cared about them.
- Patients were informed of all charges and costs for treatments in a sensitive manner and patients confirmed this during inspection who explained that they were told of all charges in advance of treatments during private consultations. Patients were also provided with information relating to charges prior to agreement of treatment.
- Nursing staff discussed treatment options and planned end of life care with patients and families to ensure that

patients received the care they would prefer. This included admission to the inpatient area for acute conditions and planning of end of life treatment and location with the patients GPs and local hospice.
- Nursing staff on Heartwood ward were observed offering newly diagnosed patients additional time and support to discuss the diagnosis and treatment options. We saw one patient and their relative being given time to look around the department and speak to patients and staff regarding the services provided. Patients reported that the additional time spent with them enabled them and their families, to acknowledge their illness and come to terms with it.

Emotional support

- Staff felt that they had time to spend with patients and their relatives supporting their needs. Patients confirmed this.
- All patients identified as requiring additional emotional support at the pre-chemotherapy assessment session were referred for psychological support following discussion with the consultant.
- Patients' family members informed us that they were able to accompany patients to appointments and felt included in conversations and planning.
- We were told that nursing staff had attended funerals of patient who had passed away to support family members. This continued as long as required, with relatives making regular contact with the nursing team for up to several months after bereavement.
- We saw thank you messages from relatives and patients detailing how staff had provided specific support for something. For example, one patient was noted as being very upset about the loss of hair, and thanked nursing staff for assisting with hair styling, advice regarding wig services and assisted with diversional therapy.
- Nursing staff referred patients with complex conditions or needs, for individual counselling and support.
- Patients told us that nursing staff continued to support them even when in remission from their cancer. This included telephone advice and support to discuss treatments currently in place and any symptoms, irrespective of whether they remained a patient within the service or not.
- We saw that relatives of patients attending the service were offered the opportunity to discuss their concerns and nursing staff were attentive to their needs.
- Patients reported that they attended the department to see staff regularly, even when they were not scheduled to attend for appointments, just to remain in contact with them. They stated that nursing staff were always happy to see them, offering supportive comments regarding how they looked, how they were managing or enquiring if they required any additional support.
- Endoscopy staff assisted consultants with discussions with patients regarding findings during investigations. Nursing staff reported that they often attended the ward to accompany consultants with breaking bad news. They then spent time with the patient discussing the results to ensure patient understanding.

Are medical care services responsive?

Outstanding ☆

Overall, we rated the service as outstanding for responsive because:

- Appointments were flexed and tailored to meet the needs of the individual and offered flexibility and choice in appointments.
- Patient individual needs were central to the planning and delivery of the services.
- Services included other organisations and general practitioners in planning patient care to ensure a holistic approach.
- All patients were assessed prior to treatment planning to ensure that all risks were identified to enable staff to manage them effectively.
- Oncology patients were able to access support out of normal working hours including those who were not receiving current treatment.
- Appointments were scheduled according to the individual's condition and could be arranged as telephone appointments if preferred.
- The service provided appropriate facilities to meet the needs of patients requiring wheelchair access and hearing loop. Interpreters were available to support patients if necessary.
- A small number of complaints were received and there were effective process in place to address any concerns with evidence of actions taken to address issues raised. Staff were informed of changes required in response to complaints.

Medical care

Service planning and delivery to meet the needs of local people

- Both the chemotherapy and endoscopy service reflected the needs of the local population needs and ensured flexibility, choice and continuity of care.
- Nursing staff on Heartwood ward reported that terminally ill patients whom they had treated for several years were required to receive care at the local hospice, as this facility was not provided on the ward. This was despite patients preferring to attend the hospital for their end of life care. The service was therefore planning to implement a palliative care service to enable patients to be cared for within a familiar environment by staff that they knew.
- Oncology patients received additional support from specialist nurse practitioners according to their diagnosis. For example, a breast care specialist nurse assisted with support networks. Nursing staff liaised directly with specialist nurses and services to ensure that patients received the appropriate level of support for their condition. The team reported that they held a local directory of specialist services which were easily accessible for the team.
- Due to the extended skills of the nursing staff on Heartwood ward, medical services offered additional facilities for patients with conditions related to gastroenterology, rheumatology and osteoporosis. These patients were able to attend the ward for the safe administration of medication, which required the nursing staff's skills. The same referral process was used for all patients. Patients attending the service for non-chemotherapy treatment were not identified, or treated differently by the nursing team. Patients reported a high level of service from all nurses within the department.
- Consultants within endoscopy offered set dates for appointments, but these could be flexed to suit specific patient needs or requirements. For example, one patient had the appointment changed to allow for a holiday to be taken, prior to treatment.
- The theatre scheduling team booked endoscopy appointment dates with nursing staff who arranged the time of appointment based on their clinical assessments. This enabled more complex cases or patients with infections to have appropriately placed slots to facilitate additional time or post treatment cleaning.
- Patients were seen in preadmission assessments prior to commencement of any treatment to identify any risks and to ensure they were aware of the processes being undertaken.
- Scheduling of appointments was completed in line with requirements for the procedure, for example availability of equipment and specialists.
- Heartwood ward and the endoscopy unit were clearly signposted from the entrance of the hospital and all areas were within a short walking distance. Staff were observed assisting patients who appeared to be lost or had limited mobility.
- Patients and relatives were able to access the hospital café if they wished for alternatives to ward based provisions.

Access and flow

- The service had a robust policy in place relating to the admission and discharge process. This was in date and detailed processes for all aspects of admission and discharge, including risk assessments to be completed, preparations of rooms, discharge checklist and transfers in and out of the hospital.
- The nursing teams managed availability of appointments locally and patients were admitted from home for appointments.
- All patients diagnosed with cancers were seen and commenced treatment within two weeks of referral
- Patients unable to attend the departments for the appointment were offered alternative slots following discussion with the heads of department. Each clinical area had a ward diary, which enabled logging of activity. We saw nursing staff discussing attendance to the unit with a patient over the telephone. The patient had forgotten what time the appointment was scheduled for and nursing staff rearranged an appointment for later in the day to ensure that treatment was received in line with the treatment plan. This was despite the patient planning to attend the clinic several hours after the scheduled appointment.
- Nursing staff reported that patients referred for cancer treatments were assessed in outpatients, reviewed as pre chemotherapy patients by nursing staff and commenced treatment within two weeks of referral.
- The hospital monitored referral to treatment times for inpatient services only. This did not include oncology or endoscopy.

- We were told that patients received chemotherapy within Heartwood ward only and any inpatient would be transferred to the unit for their treatment. This ensured that appropriate staff were responsible for the administration of medication and allowed nursing staff to monitor the patients' condition.
- Heartwood ward patients were offered bespoke appointments to meet the needs of the patient in line with treatment. For example, patients were able to pick times of attendance on the day treatment was due.
- We were told that patients attending appointments who then required diagnostic investigations were offered the choice of attending the relevant department during that visit. This was not observed during inspection.
- Within Heartwood ward, consultants would discuss appointment scheduling with both the patients and nursing staff as some appointments were coordinated for when the consultant was on site to monitor and track effectiveness of treatments or results from investigations.
- Chemotherapy patients who became unwell were admitted to the inpatient area within the hospital. The nursing team following initial assessment usually arranged this. They would attend the hospital out of normal working hours if necessary to assist with patient care and treatment.
- The service worked closely with the patient, GPs and the local hospice to determine the best location for the delivery of end of life care. This was predominantly provided within the hospice setting; however nursing staff reported that they continued to be involved with the patients and their families, providing emotional support after discharge from their service. Patients who were deteriorating were transferred rapidly to local acute NHS hospital trusts in line with a service level agreement.
- The responsible consultant led on the arrangements of this to ensure continuity of care. An incident report was completed for all transfers to acute trusts using the hospital incident-reporting tool. There had been no incidents requiring transfer to the acute trust from Heartwood ward or endoscopy unit in 2015.
- Endoscopy appointments were scheduled and letters sent to patients detailing the procedure details and preparation required concerning oral nutrition, fluids and any medication. The unit also provided contact details to facilitate patients' ability to access the team completing the investigations.
- Nursing staff within endoscopy kept patients informed of procedure delays by attending the ward and notifying them individually. Staff reported that this assisted to reduce patient anxiety, as they felt informed of the reasons for any delays.
- Although nursing staff reported sufficient equipment to complete planned endoscopy procedures, they explained that sterilisation time sometimes affected the availability of equipment. To prevent delays the nursing staff tracked equipment against planned procedures to ensure adequate cleaning could take place between cases.
- Patients discharge was planned and patients attending for appointments were informed of treatment duration and likely recovery periods.
- Endoscopy patients were treated as day cases and were informed of time of procedure and if any delays occurred.
- During inspection, we observed that patients were attended to immediately upon arrival in departments. Nursing staff were observed accompanying patients to their rooms and explaining the process for that day's treatment.

Meeting people's individual needs

- The hospital offered an on call service for patients, which enabled them to contact a nurse 24 hours per day. Patients were able to speak to a nurse with any concerns regarding their condition or treatment, and gained advice on whether they needed to be seen urgently or whether they needed to see their consultant. One patient explained they had used the service and gained advice, despite not receiving treatment on the unit at that time. The patient explained that staff were responsive and offered advice based on their knowledge of the current treatment.
- The chemotherapy services were inclusive of patients' general practitioners in the management and planning of patient care. Patients stated that their GPs, consultant and nursing team collectively planned for all stages of their clinical condition, which enabled patients to understand treatment options prior to reaching the change in condition. Patients we spoke with stated that this enabled them to understand what would happen with treatments and know what the alternatives were. This included planning of medication, care at home and admission to hospice. Nursing staff on Heartwood

confirmed that this was the usual process for all patients who were terminally ill, although the level of engagement varied according to the individuals concerned.

- The chemotherapy nursing staff reported that they had not treated any patients with a known diagnosis of dementia or a learning disability. Nursing staff confirmed patients attending the department could have extended appointments and be accompanied during treatments and appointments if additional support was required, whatever the reason may be.
- The environment was appropriate to the needs of the patients including those with additional needs for visual impairment or reduced mobility.
- Patients treatment plans were arranged on an individual basis and medical records showed discussion between nursing and medical staff to identify the individual's pathway.
- Outpatients offered a one-stop breast clinic, where patients were offered a consultation, diagnostic investigations and treatment planning in one visit.
- Any patients identified as having complications associated with their chemotherapy were discussed with the responsible consultant and arranged either telephone consultation or face-to-face appointment for the following day.
- Endoscopy staff provided patients with detailed letters of post-operative care, including advice regarding driving, contact numbers and follow up care.
- All areas of the hospital were easily accessible for patients and relatives who had mobility restrictions. All departments were able to accommodate patients in wheelchairs, with sufficient space for manoeuvring safely.
- Clear signage was in use across the hospital and staff were readily available at reception areas to assist patients with directions and assistance to appointment areas.
- The wards were decorated which considered people who had a visual impairment. This included contrasting wall and door colours and large signage.
- An interpreting service was available for patients who did not speak English and staff were aware of how to access this if necessary. Leaflets were not routinely available in non- English languages; however, staff reported that these were accessible on the intranet.
- Hearing loops were available throughout the hospital.
- Patients' meal preferences were observed on Heartwood ward. Patients were offered a variety of meals and any specific dietary requirements were discussed with the catering manager/chef. Staff provided appropriate catering for patient with meal preferences or smaller appetites. This included additional meals or snacks.
- Patients and their relatives were able to access refreshments from the hospital café if they wished.
- The hospital provided free car parking for visitors and patients. Nursing staff told us that transport could be provided for patients who were unable to attend hospital appointments using their own transport.
- Nursing staff were able to access information on a variety of topics relevant to individual patient conditions.
- During the inspection, it was noted that all call bells were responded to within a short timescale, with no delays.
- The hospital had recently built a dedicated multi faith room at the hospital in response to feedback provided from the February 2016 PLACE audit.

Learning from complaints and concerns

- The hospital had an effective complaints management procedure. Where possible complaints were managed locally and staff felt they were equipped to do this.
- There had been 124 complaints, both written and verbal made to the hospital between January and December 2015. These related to the whole hospital and were not specific to the medical service. The hospital followed the organisational policy relating to complaints and offered apologies and completed investigations within an agreed timescale. The standard response time was 20 days, but was extended with complex cases following discussion with the complainant. The hospital reported 98% compliance with response time from January to December 2015.
- Both departments reported few complaints. With endoscopy staff commented that the majority of informal complaints centred on delays in procedures and explained that these were usually resolved informally by explaining any delays in treatment times.
- The organisational complaints policy was accessible for all staff through the intranet and staff told us they knew how to access this. The policy was reviewed and found to be current.

Outstanding ☆

Medical care

- The medical advisory committee (MAC), clinical effectiveness and audit committee meetings reviewed complaints monthly to identify trends, which enabled issues to be addressed directly and in a timely manner. Teams were informed of any concerns following the reviews, which enabled them to take actions.
- We were told that any staff members named during feedback were assisted to identify any learning needs to promote continued individual development.
- Positive feedback was shared across the hospital. We saw that each ward area displayed the most recent complaints information and survey results.
- We found survey results displayed on the wards. At the time of inspection, it was noted that patients had complained about the teapots, which spilt when used. Nursing staff informed us that this had been taken into account and teapots had been replaced.
- Nursing staff reported that they received weekly organisational and hospital newsletters, which highlighted changes to practice, company and hospital news and updates.
- The hospital received seven comments on the NHS Choices website from January to December 2015. Six were likely to recommend services and one unlikely. However, it was not possible to identify if these comments relate specifically to medical services.

Are medical care services well-led?

Outstanding ☆

Overall, we rated the service as outstanding for well-led, because:

- The service had leadership, governance and a totally patent centred culture, which were used to drive and improve the delivery of care.
- Clinical leads had a shared purpose and motivated staff to deliver services and succeed.
- Governance and performance management were proactively reviewed and reflected best
- There was an inclusive management style which started with the hospital director, through the matron and the head of department.
- Staff morale was high.
- Audits and review systems were in place to ensure compliance and reflected changes to practice.
- Clinical leads were visible, approachable and integral to daily functioning of the service.
- Staff felt valued and respected by their medical colleagues.
- National leads were available to assist with the development of services and offer support.
- There were high levels of job satisfaction and individuals were proud to work for the hospital.
- Teams were well established and worked effectively.
- Medical services were actively progressing services through the development of JAG accredited endoscopy department and planning palliative care services within chemotherapy.

Leadership and culture of service

- The hospital was led by the Hospital Director and Matron, each department had a nominated head who was a clear leader. Guidance and leadership was evident within the chemotherapy unit, with the team observed to be working towards common goals to ensure effective treatment and patient satisfaction. Patients confirmed that the nursing staff could not do enough for them. Medical services were very positive about the services they offered and the level of care they provided.
- Each clinical area had a nursing lead/head of department whose role included the management of the unit, staff and worked clinically as the specialist nurse.
- Nursing staff reported that their direct line managers were supportive and kept them informed of day to day running of the departments. Within chemotherapy, the lead nurse was visibly engaging, with staff encouraged to complete tasks at continue to improve the service. Nursing staff were observed responding positively to the lead nurse.
- There were no nursing vacancies across medical services. Heartwood ward reported an established team, with staff working on the unit for several years. Nursing staff reported that they had left previous posts as a result of lack of time to provide quality patient care; however, the chemotherapy service enabled them to provide care at a high standard which gave them job satisfaction.
- The nursing team on Heartwood were dedicated to the service and were observed to be genuinely caring to patients and their relatives. For example, staff were pleased when a patient visited and informed them that their treatment had been successful.

- The endoscopy unit had been fully staffed since December 2015 and the team were in the process of expanding further with an additional staff member to assist with the JAG accreditation process. The newly recruited team member had previously been involved with achieving JAG accreditation at a local hospital trust, which meant that they had the experience and knowledge to support the team in the process.
- Nursing staff reported that the hospital director and matron were visible and easily accessible and they felt able to escalate any concerns to them.
- Staff reported that they felt motivated to develop themselves and the services. This was evident in the planning of extending services within Heartwood Ward to include other medical conditions for treatment and the implementation of palliative care services in the future. Staff within the endoscopy unit were also enthusiastic about developing the service and achieving accreditation.
- There were clear lines of accountability and responsibility and staff were aware of expectations.
- All staff stated that they felt there was a positive working culture and a good sense of teamwork. High team morale was evident across all areas. Nursing staff reported that they worked collaboratively; skills and knowledge were shared across all grades. The lead nurse was observed to be inclusive of all staff and encouraged the team to experience new tasks/ training in order to develop both the individual practitioners and the service. This was observed during inspection when training was directed at all staff that would have contact with the patients receiving the planned treatment.
- Staff told us they had annual appraisals and were encouraged to access training in relevant topics.
- Staff were proud to work at the hospital and were passionate about their role and the work that they did.

Vision and strategy for this core service

- The hospital had clear vision, mission and values embedded into all aspects of patients' care. Nursing staff were fully aware of these and detailed these in all interactions with patients. The organisational mission was: "To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care." Organisational values included: "Succeeding together, driving excellence, doing the right thing, and delivering on our promise". These were not monitored individually, but audits captured staff satisfaction and clinical compliance.
- The chemotherapy head of department informed us that to enable the service to expand, staff were required to develop additional skills in palliative care medicine. This included becoming a palliative care nurse specialist. The hospital senior management team was reported as being supportive of this process with additional training planned and processes in place to ensure competence.
- Heartwood ward had been chosen as a pilot site for the introduction of electronic patient records. This facility assisted with data collection and auditing processes. The nursing team volunteered to pilot/trial the services as they felt that this would assist with planning of patients' treatments and on call facilities.
- The chemotherapy nurses reported to the ward manager and were supported by Spire National Cancer Services Manager who reviewed the service, any incidents and offered support and development remotely to the manager and team.
- Endoscopy services were in the process of applying for Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation. This involved the development of policies, practices and procedures to an accredited standards framework, which would be assessed annually. The team had a comprehensive action plan in place, which was in line with JAG requirements. The theatre manager had recently appointed additional staff to assist with this process.
- The endoscopy unit was awaiting the provision of electronic reporting system, which would enable photographs of investigations to be printed directly into patients' notes. This was expected to be completed by July 2016.

Governance, risk management and quality measurement for this core service

- The hospital held weekly heads of department meetings where planned activity and any issues were discussed. The minutes from these meetings were shared electronically with all staff.
- Medical services had a robust governance structure in place, with monthly meetings taking place. Clinical effectiveness and audit committee meetings were completed against a set agenda. Minutes of these

meetings were reviewed as part of the inspection and found to be comprehensive. Items discussed included local actions to be completed regarding a breakdown of incidents, a review of medical equipment, national clinical guidance, audit results and a breakdown of complaints. Each department had a nominated lead who attended as a representative for their speciality. Information gathered was shared across the teams locally.

- Quarterly governance and medical advisory committee (MAC) meetings discussed patient outcomes as part of a structured agenda. Nursing staff reported that communication across the team was easy due to specialities having such small teams. All staff attended work on the same day at least once per week and this day was used to update the teams on any changes or issues. Ward sisters had not formalised this process with team meeting notes, however the endoscopy team used a book to write any important messages, which staff signed to confirm they had read the details.
- The hospital had risk registers in place and all risks were appropriate to the clinical speciality. This included exposure to spilt chemotherapy, patient medication reactions and administration device faults.
- Risk registers were reviewed during inspection and found to be updated regularly and accurately reflected the risks that staff told us they were concerned about. Actions were taken to mitigate risks and were detailed in risk assessments.
- Heartwood ward had a policy index, which demonstrated where policies could be located, initiated, reviewed and archived.
- Chemotherapy guidance on Heartwood ward was regularly updated and reflected the United Kingdom Oncology Nursing Society guidance.
- Medical services completed audits in line with the hospital audit calendar. Results were shared and displayed on wards and actions taken to address any issues. Audits completed included completion of NEWS score, pain management, VTE prophylaxis assessment, MDT compliance, risk assessments, hand hygiene and endoscopy trace and track.
- There were clear escalation processes in place for the transfer of patients to acute trusts.
- Endoscopy staff had completed an audit of patient satisfaction from February to March 2016. The audit was completed anonymously but consultants were identifiable. Results showed that consultant practices varied around consent processes. In response to this, the nursing team had discussed the process with consultants and a standard approach to consent agreed. The audit response was 50% of 50 distributed questionnaires.

Public and staff engagement

- The hospital sought patient feedback either through organisational, NHS or charity surveys. Heartwood ward used a Macmillan based patient feedback survey which was completed quarterly. Patients and relatives we spoke with were very positive about their experiences at the hospital and department, one patient stating that following diagnosis of a second condition had elected to return to the hospital for treatment, as the experience had been so positive during the previous treatment. The patient stated that staff were welcoming and obviously remembered them from previous attendances.
- Heartwood nursing staff assisted with training and education for local GPs and used the opportunity to promote the services provided.
- Patients' satisfaction was displayed on ward notice boards and discussed at all meetings.
- The 2015 staff satisfaction audit showed that staff were satisfied with engagement, line manager, the team and their work with satisfaction scores higher than 88%. Staff were less satisfied with senior leadership, quality of service and working together, with satisfaction scores between 70-79%. It is important to note that senior leadership changed in 2016 so results did not accurately reflect the management team at the time of inspection.
- Endoscopy nursing staff trialled a variety of clinical aprons to identify which would suit their needs and preferences. Staff were able to request the provision of an apron, which suited their needs.
- Staff sickness rates were generally very low with minimal turnover of staff.
- All staff enjoyed working within and were proud of their department and service.

Innovation, improvement and sustainability

- The chemotherapy unit maintained MacMillan accreditation compliance since 2011, with a dedicated chemotherapy unit and development of services to meet the demands of the patients.
- There was a plan in place to provide electronic devices to monitor chemotherapy patient conditions and access records from home to enable accurate out of hour

assessments and enable patients' records to be contemporaneous and reflective of their condition. However, no training or firm plans were in place for purchase of these devices.

- The development of chemotherapy services to include palliative care will enable patients' treatment to be completed in their place of choice by familiar staff.
- The hospital was working towards JAG accreditation which would enable the development of endoscopy services to facilitate the introduction of NHS patients. Currently, NHS providers require endoscopy units to have JAG accreditation for patient referrals as this denotes the standard of service required. In addition, processes within the JAG accreditation will enable benchmarking of practice against other providers and organisations.

Good

Surgery

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

Information about the service

Spire Harpenden Hospital provides surgical services for various specialties to both private and NHS patients. The hospital cares for adults and young people over 16 years of age.

There are two main inpatient wards offering mostly single ensuite rooms and a further eight-day case beds and six-day care 'pods,' a total of 79 beds. The hospital also has a seven bedded chemotherapy ward and a four bedded extended recovery unit.

Sterile services are provided on site and are International Organisation for Standardisation (ISO) accredited.

Within the outpatients department there is a pre-assessment area where patients are seen in preparation for their admission to hospital.

There are five theatres with associated anaesthetic rooms and a recovery area. There is also an endoscopy theatre used for urology, gynaecology, and gastro-intestinal procedures.

There were 9,149 visits to theatre between January 2015 and December 2015, mainly for elective surgery. The hospital offers a range of surgical procedures, including; orthopaedic, ear nose and throat, general surgery, cosmetic, gynaecology and urology procedures.

All patients are admitted and treated under the direct care of a consultant surgeon and medical care is supported by a medical consultant and a resident medical officer (RMO).

We carried out an inspection of the hospital and visited the main inpatient and day case areas, the extended recovery unit, pre-assessment clinic and theatres. We talked to four patients and acknowledged the views expressed by patients on Care Quality Commission comment cards. We also talked to 15 members of staff. We observed care and treatment and reviewed seven patient records. Prior to the inspection, we reviewed performance information about the hospital.

We also made an unannounced visit to the hospital on 25 April 2016.

Good

Surgery

Summary of findings

Overall, we rated the surgical services as good for effective, caring, responsive and well-led. Safety required improvement.

- There was appropriate equipment to provide safe care and treatment.
- Incidents were reported and dealt with appropriately and themes and outcomes were communicated to staff.
- Action was taken to ensure patients were protected from abuse. However, staff caring for children were not trained to the right level in safeguarding.
- Patient areas were visibly clean, tidy and appropriately equipped.
- Patients were assessed, treated and cared for in line with professional guidance.
- There were effective arrangements in place to monitor and manage pain.
- Patient surgical outcomes were monitored and reviewed through formal national and local audit.
- Patients' nutritional status was assessed and dietary needs were met.
- There was sufficient competent medical and nursing staff on duty to meet the needs of patients.
- Nursing, medical and other healthcare professionals were caring and patients were positive about their care.
- Patients were treated with dignity and respect.
- Patients were given appropriate written information on what to expect from their care and treatment.
- Staff were able to recognise the needs of patients and relatives and gave emotional support.
- The booking system offered some flexibility to patients.
- There was appropriate discharge planning.
- Complaints were acknowledged, investigated and responded to in a timely manner.
- Information about the hospital complaints procedure was available for patients and their relatives.
- The hospital had a clear governance structure.
- Information was cascaded to all staff.
- The service reviewed and acted on feedback about the quality of care received
- There was strong leadership and staff felt valued.

Are surgery services safe?

Requires improvement

Overall we rated the service as requires improvement for safety:

- Staff caring for young people aged 16 -18 years of age were not always trained to level 3 in safeguarding.
- The floor coving in patient bedrooms and bathrooms was not compliant with infection control guidelines.
- Medicine cupboards in theatres were being left unlocked for convenience when theatres were in use. However, on the unannounced visits this practice had stopped
- Medication was found to have been prepared in advance and stored in an unlocked fridge.
- When changes were made to theatre lists, the lists were reprinted and the wards informed of the changes. However, the lists were not reprinted on different coloured paper, which is not best practice. This meant that there was an opportunity for errors to occur if there had been multiple changes in list orders. However, this had been rectified by the time of our unannounced visit.
- Medical representatives visiting theatre did not have their identification routinely checked, as they and the companies they represented were well known to the theatre staff. But by the time of our unannounced visit a process had been put into place to capture these details.

However we found that:

- There was access to appropriate equipment to provide safe care and treatment.
- Staff told us they were encouraged to report any incidents, and serious incidents were discussed at team meetings and ward handovers. Staff were confident in reporting incidents and were aware of the importance of the duty of candour regulation.
- We observed the five steps to safer surgery checklists were being completed appropriately.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care.
- Nursing handovers were well structured within both the surgical wards.

- The environment was visibly clean and staff followed the hospital policy on infection control. Equipment was generally cleaned after use with an: 'I'm Clean' sticker placed on to it. However, these were not always dated. This meant that some equipment might have been cleaned several days prior to use.
- Staff had the appropriate training to be able recognise and respond to deteriorating patients.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally.
- The systems, processes and practices that were essential to keep people safe were consistently identified, put into practice and communicated to staff.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents; this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic system. There had been eight serious incidents reported between January 2015 and December 2015. One incident reported was a notification from the General Medical Council (GMC) of a fitness to practice investigation involving a consultant who had practising privileges at the hospital. This matter was referred to the Medical Advisory Committee (MAC) and the case was later closed by the GMC. Four of the incidents occurred in the wards. Three of these incidents involved deterioration in a patient's conditions and one was a patient fall.
- Two incidents were reported in theatres, one involving equipment found to be out of date and the other involving an combination of prosthesis, the MAC discussed this with the consultant and agreed he used the correct prosthesis. A small fire in the sterilisation unit due to a fault with equipment had also been reported.
- All these incidents had been investigated and there was evidence of actions taken. For example, following the patient fall a new procedure was implemented. If a patient fell during the night, an immediate x-ray was requested, even if this meant calling out an on call radiographer. This was in order to rule out fractures.
- All serious incidents were analysed at clinical governance meetings to ensure that lessons were learnt. This information was disseminated to staff via head of department meetings through ward handovers, meetings and safety briefings.
- In addition, a monthly bulletin was sent from Spire's head office outlining incidents that had taken place in other hospitals. There was a system of red, amber, green (RAG) rating them with regards to learning outcomes. This meant that learning was shared both locally and throughout the organisation, to enable procedures to be put into place so that similar incidents did not reoccur.
- There had been no never events reported in the last 12 months within surgery. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Duty of Candour

- From November 2014, all providers were required to comply with the Duty of Candour Regulation. 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.
- Staff were fully aware of the Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident. We saw examples of where duty of candour had been applied with regards to incidents and complaints.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The safety thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data is collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter urinary tract infections, and falls.

- The hospital audited and monitored avoidable harms caused to patients. Between October 2015 and April 2016 there were eight falls, one pressure ulcer and no catheter infections reported. This information was not displayed on the wards we visited.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare associated infection.
- The wards and theatres were visibly clean and tidy.
- The hospital had policies and procedures in place to manage infection prevention and control. Staff accessed policies via the hospital intranet and were able to demonstrate how these policies were easily available.
- Staff followed the hospital's policy on infection control, for example, we observed staff complying with 'bare below the elbow' and not wearing jewellery.
- We observed a lack of clinical hand washing facilities in ward areas. Clinical hand basins were provided in utility areas, but not in patient rooms. This meant that at the point of care, staff were washing their hands in patients' private bathrooms. Although the sinks in patient bathrooms had wrist operated taps, best practice would be to have dedicated clinical sinks within ensuite rooms. Department of Health Guidelines 2013 HBN009 state that: 'En-suite single bed rooms should have a general wash-hand basin for personal hygiene in the en-suite facility in addition to the clinical wash-basin in the patient's room'.
- The hospital did not carry out observed hand washing technique audits, therefore we could not be reassured that staff were complying with correct hand washing techniques. The hospital had conducted monthly audits of hand gel used in each patient room weighing the container at the beginning and end of the month. This did not however, give assurance that staff were washing their hands correctly and using hand gel appropriately. Instructions on hand hygiene were displayed next to hand gel dispensers.
- The flooring in patient rooms and bathrooms was not compliant with Department of Health (DH) 2013 HBN0010 part A. The coving from the floor did not rise far enough up to the wall. This meant that cracks could appear where the floor met the wall and be a source for bacteria to collect. This was raised with the senior management team at the time of our inspection.
- There were some newly refurbished rooms, however, the infection control lead had not 'signed ' them off, to ensure they were safe, fit for purpose and complied with Health Building Note (HBN0010, part A). We saw an action plan to address this; the issue had been raised at the infection control committee and with Spire head office. The action plan stated that future refurbishments would be brought to the infection control committee for final agreement.
- Personal protective equipment, such as gloves and aprons, were used appropriately and were available in sufficient quantities. We did not observe staff using the washbasins; this may have been because they were located in patient rooms. However, we saw staff using hand gel that was readily available throughout the ward.
- Equipment was cleaned after use with an; 'I'm clean' sticker placed on it. These were not dated, meaning that some equipment might have been cleaned several days prior to use.
- The trust's 2016 Patient Lead Assessments of the Care Environment (PLACE) indicator in cleanliness was 100% which was an improvement on the previous year (2015) of 63%
- There had been no incidents of MRSA or Clostridium difficile between January 2015 and December 2015.
- Housekeeping staff were dedicated to a ward area and followed a daily cleaning schedule. Checklists were completed and submitted to the housekeeping supervisor who conducted monthly audits. Audit results were discussed with housekeeping staff at weekly meetings. The hospital employed a night housekeeping team who attended to the outpatients and theatre areas whilst they weren't in use.
- There had been seven surgical site infections reported for January 2016 to April 2016. The patients involved had all undergone orthopaedic procedures. The hospital had a consultant dashboard, which recorded incidence of infection. From this, no trends had been identified, for example with particular surgeons, operations, theatres, or scrub teams.
- The hospital had its own central sterilisation service to clean and sterilise theatre instruments and equipment. The service had international organisation for standardisation accreditation (ISO) which is a global quality management standard. This meant all the machinery used to decontaminate and sterilise instruments were being maintained correctly and

cleaned consistently to an approved standard. In addition, the processes within the department meant that instruments were being decontaminated and sterilised correctly.

Environment and equipment

- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, were regularly checked and documented as complete and ready for use. The trolleys were secured with tags, which were removed monthly to check the entire trolley for expiry dates and integrity of contents. In addition, a full check took place if the trolley had been opened for use, and it was then retagged.
- There were systems to maintain and service equipment as required. Equipment had been tested appropriately to ensure that it was safe to use.
- The environment within the wards and theatre were well maintained, clean and tidy, although some storage areas within theatre were cramped.
- All equipment was recorded and tracked; an asset list was held by the engineering department and was updated regularly. The hospital had a contract with an external provider that completed most of the equipment maintenance in the hospital. Faulty equipment was reported and recorded. When equipment was urgently needed, the maintenance company were contracted to replace it within 24hrs to enable normal service to continue.
- Theatre staff had completed medical device competencies for specialist equipment used in particular procedures. The external medical companies that supplied the equipment assessed and sign off those competencies. This ensures that staff were able to use specialist equipment competently and ensured patient safety.
- The patient led assessment of environment (PLACE) for the hospital's condition, appearance and environment in 2016 was 96%.

Medicines

- There were effective arrangements for medicines. This included obtaining, prescribing, dispensing, recording, handling, storage and security, their safe administration and disposal.
- Unwanted medicines were managed by the pharmacist and disposed of safely.
- Medicines were stored securely in accordance with regulatory requirements. Ambient temperature of medicines storage rooms and fridge temperatures were checked and recorded daily, to ensure that stored medicines were safe for use. All temperatures were within the required ranges. There was guidance for staff about actions they should take if temperatures were found to be outside the specified range.
- Medicines were mostly contained in locked cupboards. However, during our inspection we found that medicine cupboards in anaesthetic rooms were being left unlocked whilst the associated theatre was in use, to provide quick access to medicines. The issue was raised with the senior management team during our initial inspection. On our unannounced visit on 25 April, we found that all medicine cupboards were locked. Risk assessments had been completed on the practice of leaving medicine cupboards open in working theatres. The theatre manager had ordered key pad locks for the main doors into the theatre complex to ensure only hospital staff had access.
- We found that one medicine had been prepared in advance and stored in the medicine fridge within theatres. The medication was not labelled with the medicine's name and therefore there was a risk that the incorrect medication could be administered. The issue was raised at the time of inspection with the theatre manager. On our unannounced inspection, we found that this practice appeared to have stopped. All staff had been sent an e-mail to remind them that this was unacceptable practice and an audit had been implemented to monitor compliance.
- There were separate cupboards in ward treatment rooms for patients' own medication. The hospital had a self-administration policy and patients were encouraged to self-administer where appropriate. An assessment of a patient's competence to self-administer their own medicines was conducted and prescription charts stamped to indicate this. Patients were not able to self-administer pain relief, as nursing staff need to conduct pain assessments and monitor its effectiveness.

- The management of medicines was audited, for example the number of occasions prescribed medicines were omitted and the correct storage and management of controlled drugs. We spoke with the hospital pharmacist who told us that the main issue identified on controlled drug audits was not clearly identifying errors and signing, according to hospital policy. The ward manager was sent a copy of the audit findings and delegated actions to the ward sisters. We saw evidence of these action plans in place. Staff were spoken to individually and if they then did not comply with the controlled drug policy, the ward manager informed them that their error would be recorded in their personal file. We did not see any evidence of additional training being offered to staff who did not comply with the controlled drug policy.
- We did not observe the administration of medication during our inspection. However, we checked five medicine charts which were all completed appropriately.
- Nursing staff were aware and were able to seek guidance from the hospital's medicines policy and British National Formulary (BNF), which was the latest edition. The BNF is a pharmaceutical reference book and contains advice on prescribing and pharmacology.
- Each treatment room had guidance available for nursing staff on management of prescription charts and controlled drug administration.
- The hospital pharmacist visited the clinical areas daily to check agreed stock levels and to ensure there was appropriate stock rotation. The pharmacy was open from 9am until 5pm during the week and from 9am until 12pm on Saturdays. There was a registered pharmacist on call on bank holidays and out of hours, to provide advice and support when necessary.
- There was a procedure in place for the senior nurse and the RMO to gain entrance to pharmacy if medicines were needed urgently. Each had a separate key. We looked at the records of out of hours access and it was clear that pharmacy was not accessed regularly.

Records

- The hospital used a paper based records system for recording patients' care and treatment.
- Patients' records were stored securely in a lockable trolley whilst in use on the wards, to maintain confidentiality.
- We reviewed six sets of patient records. Information was easy to access and the records contained information on the patient's journey through the hospital including pre assessment, investigations, results and treatment provided. There were pathway booklets for different types of procedures. These pathways ensured that the progress was made and any deviation from the prescribed pathway could be identified and an appropriate intervention made swiftly.
- Some patient records were kept at the patient's bedside. For example, observation charts and fluid balance charts.
- Theatre records were completed and included the five steps to safer surgery checklist. We saw that these were completed fully and appropriately.
- Patient records that were no longer required were secured in a locked box until being collected by the medical records team. They were stored securely on site for three months, and then archived off site in a secure storage facility.
- When changes were made to theatre lists, the list was reprinted and wards informed. However the lists were not reprinted on different coloured paper, which is best practice. This meant that there was an opportunity for errors to occur if there had been several changes in list orders. This issue was raised with the senior management team during our inspection. When we returned on our unannounced inspection, there had been a meeting to discuss this process. We saw that new lists were reprinted on different coloured paper and redistributed to all areas. The order of the list would also be changed on the electronic system so that there was an accurate record of the list order and assurance that the most up to date list was being followed.

Safeguarding

- The hospital had safeguarding policies available to staff on the intranet, which staff knew how to access. There were also hard copies of the policy kept in the ward area. We saw flow charts on staff information boards to remind staff of the process, so that they knew how to protect patients from abuse and avoidable harm.
- The hospital had safeguarding leads for adults and children. Staff were aware of who they were and how they could be contacted.

- Staff received training on safeguarding through electronic learning and had a good understanding of their responsibilities in relation to vulnerable adults and children. They were able to explain how to raise a safeguarding concern.
- Staff who were caring for young people aged 16-18 years were not always trained to level 3 in safeguarding. Although we saw no evidence of a failure to safeguard children, we were not assured that all staff who had contact with children or young people had received the appropriate level of safeguarding training. The provider should ensure that a process is in place to ensure clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns has received training to the appropriate level of competency as outlined in the Intercollegiate guidance Safeguarding Children.
- Staff we spoke with had undergone training in Mental Capacity Act 2005 (MCA) to ensure that they were competent to meet patients' needs and protect their rights, should a patient lack capacity. The training received included training of Deprivation of Liberty (DoLS). Staff had an understanding of when DoLS may be required.
- Training was provided as part of the hospital's mandatory training package. Information provided by the hospital indicated that 74% of ward nursing staff and 64% of theatre staff had completed all their mandatory training modules in MCA and DoLS.
- Medical representatives who were visiting theatre did not have their identification routinely checked, as the companies they represented were well known to the theatre staff. This was raised with senior managers during our inspection. When we returned on an unannounced inspection, the hospital were reviewing all medical representatives to ensure they were cleared and trained before being present in theatre. There was a standard confidentiality form that all visitors were asked to sign.

Mandatory training

- Staff received mandatory training to enable them to provide safe care. Some of the training was completed through e-learning and some, for example manual handling, was provided through onsite training.
- Mandatory training covered a range of topics such as infection control and basic life support training.
- Staff we spoke with said that they had completed all of their mandatory training for 2016. However, an audit of the first quarter of 2016 showed that hospital wide, 64% of staff had completed all of their training. It also showed that 74% of nursing staff and 64% of theatre staff had completed their mandatory training for 2016. The ward manager we spoke to was able to show us records of staff training, which showed which members of staff still had training had left to complete. The ward sisters were involved in ensuring staff completed their training by providing opportunities for e-learning to be completed and ensure staff had dates booked for face-to-face modules.

Assessing and responding to patient risk

- Preoperative assessment is a clinical risk assessment where the health of a patient is appraised to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. It also ensures patients are fully informed about the surgical procedure and the post-operative recovery period and can arrange for admission, discharge and post-operative care at home. Not all patients due for admission, attended a pre-assessment clinic before their admission for surgery. They were assessed according to their clinical needs by completing a preoperative questionnaire return it to the hospital. Patients were then triaged to determine who required a face-to-face consultation in clinic or a telephone call.
- All patients having planned major surgery, for example, a hip replacement attended a preoperative assessment clinic. Any preoperative investigations, for example blood tests, were carried out during the clinic. Preoperative assessments were carried out in line with National Institute of Health and Care Excellence guidelines.
- Patients who required testing for MRSA were swabbed prior to admission. If the patient had a positive MRSA swab, the admission date was deferred where necessary and treatment for MRSA was provided.
- The national early warning score (NEWS) was used to identify deteriorating patients. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored according to pre-determined parameters. There were clear directions for actions to take when a patient's

score increased. There were appropriate triggers in place to escalate care, which members of staff were aware of. We reviewed seven sets of patient notes and found that scores were added up correctly and escalation was carried out appropriately. This meant that patients who were deteriorating or at risk of deteriorating were recognised and treated appropriately.

- Risk assessments were completed using national recognised tools, for example the Waterlow score, to assess patients' risk of developing pressure ulcers.
- The five safer steps to surgery checklist was used. We observed checks as they were being carried out, both in the ward and operating theatre. The practice appeared embedded throughout the hospital.
- There was a four bedded extended recovery unit within the inpatient ward. If a patient was assessed as requiring a level of observation not able to be provided on the ward, they were booked into the unit. If a patient deteriorated during surgery, they were admitted to the unit postoperatively to be stabilised. The unit was staffed by ward sisters who had attended an external training course on the provision of level 1 care. If a patient suffered further deterioration and required transfer for level two or three care, the consultant made arrangements for transfer to the local NHS trust. There was a policy to support this process and a written agreement between the hospital and the local NHS trust. There had been 13 patient transfers to the local NHS Trust between January 2015 and December 2015, all of which had been investigated to ensure that no trends were identified.
- There was access to a minimum of two units of O Rhesus negative emergency blood. The hospital had a 'massive blood loss' protocol and all staff we spoke to were aware of where the emergency blood was stored and how to obtain it. Further blood for transfusion was obtained through the local NHS trust blood bank and the details of how they were contacted were included within the flow chart attached to the blood loss protocol. The hospital used a dedicated taxi company to transport blood for transfusion in and out of normal working hours.
- The practising privileges agreement required surgeons to be contactable at all times when they had patients in the hospital. They needed to be able to attend the hospital within 30 minutes, according to the level of risk to the patient. They had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover in the event that they were not available, for example when they were on holiday. Staff told us that they were made aware when consultants were on holiday and who would be covering for them. An e-mail communication was sent by the consultant's secretary to all clinical areas to advise staff of the consultant's holiday and who was providing cover.
- A senior member of nursing staff from each clinical area carried the cardiac arrest bleep for their period of duty. The RMO had advanced life support training (ALS) and all nursing staff had intermediate life support training (ILS). Some senior nurses we spoke with were also trained to advanced level. The hospital had eight staff trained to ALS level in addition to the RMO. A rota displayed in the theatre area listed each member of staff that were part of the cardiac arrest team on a given day and identified their role in the team. For example, if they were responsible for airway management or chest compressions in the event of a cardiac arrest. This meant that, should the team be called to a collapsed patient, the situation had been organised to enable the patient to receive timely care.
- All female patients of child bearing age were required to have a pregnancy test prior to undergoing any surgical procedure. This was audited, was part of Spire's clinical score car and compliance was 100%.

Nursing staffing

- The hospital used a staffing tool which was based on an analysis of the dependency of the patients and the subsequent nursing activity required to meet the patients' needs. From this, the required number of nurses and healthcare assistants were calculated for each shift.
- During our inspection, we saw that planned numbers of nursing staff had been met.
- The hospital used a team of bank staff to cover any shortfalls in ward staff to ensure they were able to provide safe care.
- Theatre reported that agency staff usage between January 2015 and December 2015 was less than 20%.
- We saw that staff rotas were planned six weeks in advance.
- We observed that nursing handovers within the surgical wards visited were well structured and gave clear concise information on each patient. Handovers were

recorded on a small electronic device by each named nurse. This meant that nurses could continue to care for patients whilst the next shift of nurses were listening to the handover. The recording could be repeated for clarity if needed. A printed handover sheet was used in conjunction with the recording. This did not however give an instant opportunity to ask nurses further questions about treatment plan and care. Staff we spoke with told us that they still had sufficient time to ask questions after handover and before the previous shift of nurses left the hospital.

Surgical staffing

- Patient care was consultant led. The hospital practising privileges agreement required the consultant to visit and review the patient daily and more frequently if necessary. Staff we spoke with confirmed that consultants did review patients when requested to do so.
- There was a registered medical officer (RMO) in attendance in the hospital 24 hours a day, seven days a week. The RMO provided medical support to wards and theatres and was easily accessible via the hospital bleep system.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the hospital.
- Staff told us that, should there be an interruption in normal services, each clinical coordinator communicated with each other to immediately manage the situation. In addition, there was a member of the senior management team on call who was contacted if necessary. For example, staff told us that there had been a recent fire alarm and they worked together to begin to evacuate the clinical areas.

Are surgery services effective?

Good

We found that surgical services were effective because:

- Policies were accessible, current and reflected professional guidelines.
- Care was provided in line with best practice guidelines.
- The hospital monitored adherence to policies by the use of local audits.
- Pain was managed well and pain management audited.
- Patients' nutritional status was assessed.
- Intravenous fluids were prescribed and administered as appropriate.
- PLACE audit scores for the quality of food were 95.9%.
- Patient outcomes were audited and showed results in line with those nationally.
- An induction programme was provided for all new staff.
- There was a process for checking professional registration.
- The Medical Advisory Committee (MAC) ensured consultants were competent to practice and practising privileges were reviewed annually.
- There was evidence of good multidisciplinary working.
- Consultants were on call for 24 hours a day and seven days a week for their in and day patients and visited them daily.
- There was a resident medical officer (RMO) providing medical cover for patients and clinical support to staff.
- There were arrangement's to ensure staff were able to access all necessary information to provide effective care.
- Staff were familiar with the consent policy.
- Staff were aware of their role with to regards to the Mental Capacity Act and Deprivation of Liberty and had received training.

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation had been identified and were used to develop how services, care and treatment were delivered.
- Policies were current and based on professional guidelines, for example, National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- Policies were available on the intranet and in hard copy in clinical areas.
- We saw the hospital had systems in place to provide care in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition of and response to acute illness in adults in hospital). For example, an early warning score was used to alert staff should a patient's condition deteriorate. The system used incorporated escalation actions that should be taken.
- Adherence to local policies and procedures were monitored with a schedule of local audits, for example,

medicines management, documentation and the five steps to safer surgery. Results for quarter one of 2016 (January to March) for patient documentation were 97%, the previous quarters audit showed a compliance of 98% which meant that documentation was consistently fully completed. Audit of the five steps to safer surgery for March 2016 showed 100% compliance. Clinical score cards were used to identify any potential issues to the organisation and hospital. These showed the hospital's performance in a range of clinical audits. For example, the percentage of cancer patients that had been the subject of a multidisciplinary team meeting, the percentage of patients having their records completed appropriately with signatures and dates and compliance with the use of NEWS charts audited. Data was recorded for all Spire Healthcare hospitals. This meant that the hospital's performance was benchmarked against their peers. The information gathered from this was presented at clinical effectiveness and audit meetings. Any persistent outliers were subject to scrutiny from senior clinical staff at Spire's head office.

- Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based, ensuring best practice in assessment and prevention.

Pain relief

- Pain assessments were being used effectively in the seven patient records reviewed.
- The hospital used a numerical pain score whereby zero was when a patient reported no pain, 2 for unpleasant pain and four for worst imaginable pain. A pain 'trigger to action' audit was conducted. A monthly sample of patients' notes who had a pain score of over two were audited to find out what trigger prompted action and how long after the pain score was recorded did action take place. In most records audited, there was an immediate action by nurses and pain relief medication was administered. Audit results and pain management issues were discussed at clinical audit and effectiveness committee meetings.
- Patients we spoke with said that their pain was well managed during their treatment.

Nutrition and hydration

- Staff completed an assessment of patients' nutritional status and their needs as part of their initial nursing assessment and updated this, if their condition changed, during the patient's stay.
- Intravenous fluids were prescribed, administered and recorded appropriately in the seven patient notes reviewed.
- Nausea and vomiting was formally assessed and prescribed treatment given.
- Pre-operative fasting guidelines were aligned to the recommendations of the Royal College The issue was raised at a clinical audit and effectiveness committee meetings of Anaesthetists, (RCOA). However, a recent audit showed that only 30% of patients were fasted within the Royal College of Anaesthetist guidelines in 2015. The length of fasting was becoming increasingly longer with patients waiting sometimes up to eight hours with no fluid or food prior to surgery. This meant that patients were at risk of becoming dehydrated. Following this, an action plan was put in place, whereby after the anaesthetist had reviewed the list each morning, the theatre administrator informed the concierge of the list order which was then communicated to the ward. The concierge and ward sister then agreed on the time that patients could drink until, prior to surgery. Fasting times continued to be audited and in March 2016 showed that 55% of patients were being fasted within RCOA guidelines.

Patient outcomes

- Between January 2015 and December 2015, there had been two readmissions to theatre and 13 unplanned transfers of patients to NHS hospitals. No trends had been identified with regards to, for example, types of surgery or surgeon.
- The hospital participated in the elective surgery, Patient Reported Outcome Measures (PROMS) national audit. The hospital received annual PROMS reports and data for April 2014 to March 2015 showed that for the Oxford knee score, 45 patients out of 49 reported an improvement in health after their procedure. Data for Oxford hip score showed that 71 out of 75 patients reported an improvement in health after their procedure.

Competent staff

- Registered nurses had completed intermediate life support training. Basic life support training was provided to support staff. This ensured that all staff were able to respond to a collapsed patient.
- Resident medical officers (RMO) were trained in advanced life support (ALS). Some senior nursing staff and operating department practitioners were also trained to this level. The hospital had eight staff trained to ALS level in addition to the RMO. The hospital provided an induction programme for all new staff. A newly appointed staff nurse that we spoke with was able to show us a competency document. It was comprehensive and covered essential training that ensured staff could work safely and effectively in their roles.
- The theatre manager was able to confirm that staff had completed specific competencies that were recorded in a competency booklet and we saw a sample of these. For example, theatre nurses had completed competencies in all areas including recovery, anaesthetic, and scrub techniques. All competencies were specific to each area and had been developed by Spire Healthcare, although specific competencies relating to Spire Harpenden had been added.
- Additional training was provided by the local university and staff were sponsored to attend relevant courses. For example, some had attended a radiation training course.
- All staff we spoke with told us that they had received an annual appraisal and found this a positive experience. Information provided by the hospital confirmed that all staff had undergone an annual appraisal for 2015. The majority of staff had also undergone their appraisal for 2016.
- Each staff member had a small pocket book, which included specific information as a quick reference in subjects such as dementia care, duty of candour and infection control. Staff told us they used the booklet for quick references for care and treatments.
- We saw evidence that all registered nurses and professional staff that worked in the wards and theatres had valid nursing and midwifery registration or were registered with the Health and Care Professions Council. This confirmed that nurses and other practitioners, such as operating department practitioners and physiotherapists, were trained and eligible to practise within the UK. There was an effective process in place to ensure these were updated.
- The role of the medical advisory committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document. The hospital checked registration with the General Medical Council the consultants' registration on the relevant specialist register, Disability and Barring Service (DBS) check and indemnity insurance.
- There were arrangements which required the consultant to apply to undertake a new technique or procedure not undertaken previously by the practitioner at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which may have taken specialist advice such as that from the National Institute for Health and Care Excellence or the relevant Royal College. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.
- Practising privileges for consultants were reviewed annually. The review included all aspects of a consultant's performance. The review included an assessment of their annual appraisal, volume and scope of activity, plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. The hospital used an electronic system to check when privileges were due to expire.

Multidisciplinary working

- Staff worked together to assess and plan ongoing care and treatment. This included in between teams or services, including referral and discharge.
- It was clear that departments and members of staff within them communicated well to ensure that the patients' journey through the hospital was as smooth as it could be.
- The pharmacist and physiotherapist attended a ward round each morning with the nurse in charge. Each patient was reviewed and their progress discussed in order that a plan of care for that day was agreed.
- Nursing staff we spoke to reported good working relationships within the hospital and with the local NHS hospital, GPs and local hospice.

- Discharge letters were sent to the patients' GPs immediately after discharge, with details of the treatment provided, follow up care and medications provided.

Seven-day services

- Consultants were on call seven days a week for patients in their care.
- There was 24 hour a day RMO cover in the hospital to provide clinical support to surgeons, staff and patients.
- The RMO dispensed emergency out of hours prescribed medicine, as they were able to access certain medications kept in a separate locked cupboard in the ward area. There was a system for recording medication, accessed by the RMO.
- There was an on call system for theatre staff, radiographers, physiotherapists and pharmacists. Staff we spoke with were aware how to access this information if they needed to call someone out of hours.

Access to information

- There were arrangements in place to ensure that staff were able to access all necessary information to deliver effective care.
- Computers were available in the wards and theatre areas, all staff had secure, personal log in details and had access to e-mail and all hospital systems. The ward manager was able to log on to the intranet system and show us how policies and procedures were accessed. It was clear they were familiar with this process.
- Staff had access to medical records for patients commissioned for treatment from the NHS. This meant when a patient was admitted for surgery clinicians had all the information they needed including test results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy that staff were familiar with.
- The hospital had three nationally recognised consent forms in use; there was a consent form for patients who were able to give valid consent, another for patients who were not able to give consent for their operation or procedure, for example if they lacked mental capacity, and one for young people (aged between 16 and 18 years).
- Staff were confident in managing the consent process for young people under 18 years and were aware of the Gillick competency, used to assess if a young person was competent to understand proposed treatment.
- All consent forms we saw were for patients who were able to consent to their operation/procedure and they were completed in full. We saw that they contained details of the operation/procedure and any associated risks benefits. The forms were carbon copied so that patients were also able to have a copy should they want one.
- Staff we spoke with were aware of their role with regards to the Mental Health Act (2005) and obtaining consent from patients who lacked capacity.
- Training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) was provided by the hospital. Staff we spoke to confirmed that they had received this training.

Are surgery services caring?

Good

We found surgery good with regards to caring because:

- Patients felt they were treated with compassion, dignity and respect.
- We saw examples of staff taking measures to ensure patients' privacy and dignity were respected.
- Patients told us they felt cared for.
- Patients understood their care and treatment and had opportunities to discuss any risks involved.
- Staff were observed introducing themselves to patients and giving verbal information.
- Staff spent time with patients and patients told us they felt listened to.
- Staff recognised the need to give patients and their families' emotional support.
- Information was available to staff so that they were able to contact ministers or clergy, to meet patients' spiritual needs.
- We observed care of a patient in theatre where staff made the patient feel relaxed.

However we also found that:

- PLACE scoring for 2016 for dignity and respect was 73%.

Compassionate care

Good

Surgery

- Patients told us that they were treated with compassion, dignity and respect during their hospital stay.
- The PLACE score for ensuring patients were treated with privacy and dignity was 72% and had been previously 82% in 2015. However, following the inspection, we were shown an action plan dated 2 April 2016 to address the reduction in this performance. This included the creation of a quiet/multi faith/prayer room.
- Staff took measures to ensure patients' privacy and dignity, for example, patient room doors were closed unless patients wanted them open. We observed staff asking patients permission to display their name outside the door.
- Patient feedback from comment cards included comments such as: 'I felt cared for'. Another said: 'The care was amazing,' and 'I found staff to be caring and compassionate at all times'.
- Patient satisfaction survey results for March 2016 showed 87% of all patients rated the care and attention received from nursing staff as excellent, with 11% of all patients rating it as very good.
- The friends and family survey results between July 2015 and December 2015 showed that between 94% and 100% of patients would recommend the hospital to family and friends. The response rates were similar to the England average of 36%.
- We heard staff talking to patients and relatives on the telephone; their manner was courteous and helpful.
- Patients in theatre had their privacy and dignity respected when being transferred onto the theatre table. Staff behaved in a sensitive manner ensuring that patients were not unnecessarily exposed.

Understanding and involvement of patients and those close to them

- Patients told us that they understood their care and treatment and had been given opportunities to discuss their surgery and the risk and benefits involved with their consultant.
- Consultants visited their patients throughout the day and were available to answer any questions they had. In addition, they were able to inform patients on what to expect and their plan of treatment.
- Named nurses were allocated to patients, this meant that patients knew who was caring for them and who to approach if they had any questions or needed any assistance.
- We observed the care of one patient in theatre. Staff introduced themselves to the patient and gave information on what would be happening and what to expect.

Emotional support

- Staff spent time with patients and families and were able to provide emotional support. Patient comments included: 'Nurses listened to me and gave me their time.' Another said: 'Nothing was too much trouble'.
- A nursing sister we spoke with explained that staff provided emotional support to family members as well as patients. She was able to give an example of a patient who was expected to be admitted for day surgery that was living with dementia. They had found the experience of coming into hospital upsetting, which made them very anxious. The patient's family became emotional on seeing their loved one's distress. Staff provided one to one nursing care for the patient whilst their family was supported to take a short break. Staff sat with the patient's family and reassured them.
- There was information available to staff on how to contact members of the clergy to meet patient's different spiritual needs.

Are surgery services responsive?

Good

We found surgery services to be good in relation to responsive because:

- The booking system for patients offered some flexibility.
- All NHS patients were seen in preoperative clinic and therefore unnecessary cancellations were minimised.
- Discharge planning began during the preadmission process.
- All areas were accessible to patients with mobility problems.
- An interpretation service was available for patients that did not speak English.
- Patients discharge plans took account of their individual needs, circumstances and on-going care.
- Hospital staff we spoke with had an awareness of dementia and had attended training in the care of patients with dementia.

- A medical consultant who had practising privileges at the hospital was readily available to accept referrals from patients with medical needs, so that they could be cared for appropriately.
- The hospital had links to a palliative care consultant and hospice.
- The hospital had a corporate complaints policy.
- All complaints were reviewed by MAC and clinical governance committees. Actions and learning from complaints was shared with all staff.
- Staff we spoke with were aware of the complaints policy and knew what action to take if a patient or relative raised a concern.
- Nursing staff carried pagers, which was linked to the nurse call system, so that they were aware when a patient was ringing for attention.
- There was an open visiting policy at the hospital.
- Patients were given appropriate written information on what to expect from their care and treatment.

Service planning and delivery to meet the needs of local people

- The booking system was flexible, allowing patients where possible to select times and dates for treatment to suit their family and work commitments.
- Consultants had planned, dedicated theatre lists. This enabled patients to be booked onto these lists. In addition, staff with specific skills and competencies to meet the needs of the patients could be allocated to particular theatres, for example staff that could assist with ophthalmological surgery.
- The hospital restaurant menu provided a range of choice to patients and the quality of food in the PLACE audit from 2016 scored 95.9%.
- One patient told us: 'The food was excellent'.

Access and flow

- The hospital's pre admission policy and local contracts ensured that all patients were assessed at the pre-operative assessment clinic. This meant that patients who had co-existing conditions were identified, so that any pre-operative work up, for example blood tests, could be done. This minimised unnecessary cancellations.
- Staff began planning the patient's discharge during the preadmission process where they gained an understanding of the patient's home circumstances and daily care needs.
- The hospital's admission and discharge policy aimed to discharge patients before 11am. Clinical score card data for all of 2015 showed that only 37% of all discharges were before 11am. However, each quarter the number did vary. For example in quarter three, the total was 47%. The ward manager we spoke with was aware of this and informed us of actions that had been taken to ensure timely discharge. A checklist had been introduced to ensure that all actions for discharge were completed, for example that medication had been ordered and transport arrangements had been made. Outstanding actions to enable discharge were also discussed at ward handover. In addition the clinical scorecard was scrutinised by Spire's senior clinical managers.
- From January 2015 to December 2015, between 79% and 89% of NHS funded patients were being treated within 18 weeks of being referred. Senior managers told us that this was as a result of the lateness of patients being referred to the hospital.

Meeting people's individual needs

- All areas were accessible to patients and relatives who had problems with mobility.
- An interpretation service was available to patients who did not speak English and staff were aware of how to access it.
- Patients discharge plans took account of their individual needs, circumstances and on-going care arrangements. For example, during our inspection staff arranged for a patient to remain in the hospital until late afternoon, as their partner was unable to collect and care for them until then.
- Hospital staff we spoke with had attended dementia training and had an awareness of the needs and challenges patients living with dementia faced. During nurse handover, a patient living with dementia was discussed in detail to ensure that nursing staff met their needs.
- A medical consultant, who had practising privileges at the hospital, was willing to accept referrals from the surgeons for specialist medical care.
- The hospital had links to a local hospice and access to a palliative care consultant, which meant that advice and assistance could be given to ensure that patients who were at or near the end of their lives had their needs met.

- Nursing staff carried pagers linked to the patient room call bells. This meant that call bells were not sounding in the main ward, which disturbed patients, but that all nursing staff could still be alerted to patients needing assistance.
- When a young person (16 to 18 years old) was admitted to the hospital, a registered nurse who was also trained in caring for children and young people assessed the patient to ensure that they were suitable to receive care under adult services. Part of the assessment considered whether the young person needed the emotional support of a parent or carer overnight.
- There was an opening visiting policy at the hospital and family and friends could visit between 9am and 9pm. This meant that patients could be supported by their loved ones during consultations and loved ones could ask questions about their treatment and care.
- Patients felt they were given appropriate written information on what to expect from their care and treatment.
- The hospital employed a concierge to improve the patients' experience. The concierge was able to greet patients and keep them informed about what was going to happen. For example, the concierge liaised with clinical staff in theatre each morning and was then able to inform patients where they were on the theatre list and when they could expect to be going to theatre.

Learning from complaints and concerns

- Complaints were handled effectively and confidentially.
- Staff we spoke to were aware of the complaints policy and their responsibilities if a patient or relative raised a concern and generally reported that they would try to resolve the issue if they could. If they could not resolve the complaint, they told us that they would report the patient's concerns to a senior member of staff.
- There was information provided in patient rooms which included how to make a complaint if there was dissatisfaction with an aspect of care.
- The number of complaints, both written and verbal, received by the hospital had decreased from 133 in 2014 to 124 in 2015. The Care Quality Commission had not received any complaints about the service during 2015/16.
- We considered complaints made in March 2016. There were three concerning care on the wards. No complaints had been received about the operating theatre.
- Spire Healthcare had a corporate complaints policy that directed the management of complaints and associated timescales. All complaints were reviewed by the hospital director, the matron, MAC and clinical governance committees. We saw evidence of actions taken as a result of complaints. These were shared with individual departments via team meetings.
- Complaints information was also reviewed at senior management and clinical effectiveness and audit meeting ensuring all learning was shared with head of departments. This was then cascaded to ward and theatre staff through department and ward meetings. Staff we spoke with confirmed that they received feedback from complaints at ward meetings.

Are surgery services well-led?

Good

We rated surgical services good for well-led because:

- The hospital had a clear governance structure.
- Clinical effectiveness and audit committees met monthly and monitored and discussed a range of hospital issues. This committee fed into the clinical governance committee.
- Information was cascaded from the clinical governance committee to all hospital staff.
- Hospital senior management members were visible, approachable and supportive.
- Staff could raise concerns or share ideas and feel that they were listened to.
- There was a relatively stable workforce who felt valued by the senior managers.
- The hospital sought feedback from all patients (NHS, insured and self-funded). This feedback was consolidated and reported on monthly. Feedback was reviewed and acted upon.
- It was clear that the senior staff strived for improvements.

Leadership/culture of service related to this core service

- The hospital was led by a senior leadership team which consisted of the hospital director, the matron/head of clinical services, finance and operations manager and head of sales and marketing. Both the ward and the operating theatre had a clinical head of department.

- Leadership within the surgical services reflected the visions and values of the hospital and promoted good quality care.
- Staff told us that the hospital director and matron were highly visible and very approachable, providing assistance when required. Staff felt they were working within a supportive environment.
- Staff felt that they could raise concerns or share ideas with senior staff and be listened to.

Vision and strategy for this this core service

- There was a clear vision and a set of values. Quality and safety were the top priority.
- There was a robust, realistic strategy for achieving the priorities and delivering good quality care.
- Staff were aware of the overall corporate vision, which was: 'To be recognised as a world class healthcare provider and to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'

Governance, risk management and quality measurement for this core service

- There was an effective governance structure within the hospital, which consisted of various appropriate subcommittees, which ultimately reported to the Spire board. All these committees had terms of reference which accurately reflected their role in the hospital, their structure and purpose.
- Clinical effectiveness and audit meetings were attended by departmental leads, head of clinical services and the governance facilitator. These committees monitored and discussed a range of hospital issues such as safety alerts, shared learning from incidents, policy updates and reported to the clinical governance committee (CG).
- The clinical governance (CG) committee met every month. The hospital subcommittees reported into the CG committee and therefore this committee had an overview of governance, risk and quality issues for all departments. Senior department leads attended these meetings and were responsible for cascading information back to their department.
- The hospital had a schedule of annual audits with associated timescales. Audit reports were reviewed locally at clinical governance meetings and MAC and results shared with staff through the heads of department. We saw evidence of this in the meeting minutes and staff we spoke with were able to confirm this

Public and staff engagement

- The hospital sought feedback from patients, both those who were funded privately or by the NHS. Monthly friends and family test results were collected. The friends and family test is a survey designed for NHS patients to gauge feedback from patients about the quality of service and whether patients would recommend the service to their friends and family. The hospital also conducted its own survey for private patients. Both sets of results were consolidated into a monthly report and were discussed at clinical governance and effectiveness meetings.
- The hospital conducted an annual staff satisfaction survey. In 2015, there was a 69% response rate to the survey. Staff identified priority action areas, for example, 41% felt that senior managers provided rationales for decisions that impacted on them and 59% felt that other departments understood the impact their actions have on other teams. This meant that senior managers were aware of staff's level of satisfaction with all aspects of their work and working environment.
- We saw examples of the senior staff taking a personal interest in staff welfare.

Innovation, improvement and sustainability

- The hospital had planned to introduce an electronic GP discharge summary system. The system was due to commence in May 2016 and in preparation for its introduction, all staff had completed training. An electronic system such as this will ensure that important information relating to patient admission to the hospital would be immediately communicated to their GP surgery.
- The hospital had introduced a concierge to improve patient experience. The concierge greeted patients and kept them informed about what was going to happen. For example, the concierge liaised with clinical staff and was able to inform patients where they were on the theatre list and when they could expect to be going to theatre.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Spire Harpenden Hospital provides an outpatient service for various specialties to both private and NHS patients. These include general surgery, general medicine, gynaecology, orthopaedic, ophthalmology, dermatology and urology. There were 74,216 outpatient attendances between January and December 2015, 9% of the attendances were for NHS patients. The hospital offers outpatient services to children aged over three years old and adults. There were 2,258 children attended outpatients between January 2015 and December 2015.

There are 22 consultation rooms and two treatment rooms, where dressings and minor dermatological procedures are carried out and a phlebotomy room, where blood samples are taken. There is a dedicated reception area for outpatients and three waiting areas located close to the consultation rooms.

The imaging department offers plain film radiography, computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound and fluoroscopy. There is a separate waiting area and dedicated changing facilities within the department.

The physiotherapy department is adjacent to outpatients and has a dedicated reception, waiting area, individual examination rooms, as well as a gymnasium and hydrotherapy pool.

We spoke with 40 staff members, including consultants, nursing staff, care assistants, allied health professionals, senior management and support staff. We spoke with seven patients and reviewed 10 sets of notes.

Summary of findings

Overall, we rated the outpatients and diagnostics service as good for safe, caring, responsive and well-led. Effective was inspected but not rated. We found that:

- Safety concerns were identified and addressed. Staff were clear with regards to the process to report incidents. Staff were fully aware of the Duty of Candor regulation.
- There were good infection control procedures in place and the areas were generally visibly clean and well organised. However, we found some areas did not comply with the Health Building Notes for flooring and sinks in a clinical area.
- Records were accessible and completed accurately.
- Staffing levels were appropriate for the service provision with minimal vacancies. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
- Consent was obtained before care and treatment was given.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. However, staff employed by the hospital, who were responsible for assessing children's care in outpatients, did not all have the correct level of safeguarding training.
- Staff had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Good

Outpatients and diagnostic imaging

- There were systems to ensure that services were able to meet individual patient needs, for example, for patients living with dementia. Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. Patients could access the right care at the right time.
- The imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice. Staff had the right qualifications, skills, knowledge and experience to do their job.
- The learning needs of staff were understood. Staff were supported to participate in training and development.
- Multi-disciplinary teams worked well together to provide effective care.
- Referral to treatment times were in line with the national average and appointments could be made easily and quickly if required.
- Patients were positive about the way staff treated them in all outpatients and diagnostic areas. They were involved in decisions around their care and treatment and there were information leaflets regarding any potential surgery. Self-pay patients were informed about relevant fees for their consultation before they attended their appointment.
- Although, there were no toys or books in the waiting areas specifically for children when they attended outpatients, physiotherapy or diagnostics appointments. There were no information leaflets available specifically for children or young people using the services. Complaint information or how to raise a concern was available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner.
- Staff had knowledge regarding the vision for the hospital. There was good staff satisfaction. Staff felt supported and valued. There was a strong culture of team working across the areas we visited.

Are outpatients and diagnostic imaging services safe?

Good

Overall, we rated the service as good for safe because:

- Performance data showed a good track record in safety.
- Staff knew how to report an incident via an electronic system.
- Medical records were maintained accurately and securely; there was an effective record tracking system.
- Staff were observed as being bare below elbow and using personal protective equipment when necessary. Gloves and aprons were available in all clinical areas.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns.
- Staffing levels were adequate for the service provision.
- There were effective systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to diagnostic imaging.
- There were systems in place to ensure the right patient received the correct diagnostic procedure.
- All equipment was maintained annually by either the manufacturers or hospital estates department.
- Staff maintained high levels of mandatory training. All areas had a local induction programmes in place to support new staff.
- There was evidence that patients were told when things went wrong and offered an apology.

However we found;

- Staff employed by the hospital, who were responsible for assessing children's care in outpatients, did not all have the correct level of safeguarding training.
- New laminate floor in some consultant rooms did not comply with Health Building Note (HBN) 00-10 Part A. As well as non-compliance with sinks and taps in some consultant rooms.
- We found high and low level dust in some clinical areas, but this had been rectified and an action plan was in place by the time of our unannounced inspection.

Incidents

- Staff were aware of how to report an incident and explained the process that they would follow. The incident reporting form was accessible via an electronic online system.
- There had been no never events reported between April 2015 and April 2016. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between April 2015 and April 2016 there were no serious incidents reported within outpatient and diagnostic imaging services.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or magnet related events between April 2015 and April 2016.
- The imaging manager confirmed that the Radiation Protection Adviser (RPA) carried out a review every three months in relation to radiation doses and any anomalies would be reported. No anomalies were found between April 2015 and April 2016.
- From November 2014, all providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person. Staff understood their responsibilities with regard to the duty of candour legislation. The managers described a working environment in which any mistakes in patients' care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not. We saw evidence of this.

Cleanliness, infection control and hygiene

- We saw that some consultant rooms in outpatients had been refurbished, but did not comply with Health Building Note (HBN) 00-10 Part A: Flooring, where the floor joined to the wall. The HBN states that: 'In clinical areas and associated corridors, there should be a continuous return between the floor and the wall. For example, coved skirtings with a minimum height of 100 mm for easy cleaning.' This was not the case in the rooms with new flooring. This meant effective cleaning could have been difficult and there was a possibility that bacteria could be harboured posing a risk of cross infection. The hand wash sinks in the consultation rooms did not comply with HBN 00-10 Part C: Sanitary Assemblies. The HBN states that: 'Basin taps used in clinical areas and food-preparation and laboratory areas are required to be operated without the use of hands,' and HBN 95 standard states separate hot and cold taps are required.
- The infection control lead and matron confirmed they would be involved in future developments and ensure these were signed off to ensure they were safe. We saw an action plan to address this, including that this had been raised at the infection control committee and with Spire Healthcare Limited head office to review. The action plan also stated that future refurbishments would be brought to the infection control committee for final agreement. In addition, this was on the hospital's risk register.
- There was planned refurbishment in nine consultant rooms and both treatment rooms to ensure compliance with HBN recommendation for sinks and taps.
- We saw defined cleaning schedules for all areas within outpatients, diagnostics and physiotherapy departments. There were checklists for staff to complete daily. Monthly audits were carried out by the housekeeping manager and specific feedback provided for staff.
- Staff informed us that nurses were responsible for cleaning the examination couches and work surfaces between each patient, using wipes. If a patient with an infection, for example, with infectious diarrhoea, flu or MRSA, was seen, staff confirmed that the whole room would be cleaned after use.
- We found the outpatient department waiting areas to be visibly clean and consultation rooms were tidy. Each room had an individual cleaning checklist. However, we found visible dust, predominately at high levels, in five of the consultation rooms and in the treatment rooms. This was raised with senior managers at the time of our inspection. During the unannounced inspection on 25 April 2016, we found all areas to be visibly clean and tidy. An action plan had been implemented to ensure vents, trolleys and couches were added to the daily cleaning checklist.

- Personal protective equipment, for instance gloves and aprons, were available in all of the consultation rooms. A staff member confirmed that goggles were also available as required.
- Staff were observed and noted to be 'bare below the elbow' in line with the hospital's infection control policy.
- A biohazard spill kit (containing relevant equipment to manage blood and other bodily fluid spillages) was located in a separate dirty utility room and easily accessible.
- We saw all rooms had appropriate facilities for disposal of clinical waste and sharps.
- Waste was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps, clearly marked with foot pedal operated lids. Bins were not overfilled.
- Infection control audits were completed, including environmental cleaning audits and measuring the usage of hand hygiene gel in each area. Observational hand hygiene audits were not undertaken. We saw evidence of these audits and actions in place to address any shortfalls. Compared to other hospitals in the Spire group, Harpenden reached or exceeded the targets set.
- The hospital's 2016 Patient Led Assessments of the Care Environment indicators were better than the England average. Cleanliness scored 100% across all areas.
- The hospital was not using the safer sharps needles that were recommended by the Department of Health to prevent needle stick injuries. Hospital staff were aware of these and were using up old stock and awaiting delivery. We raised this with senior hospital managers and during the unannounced inspection on 25 April, we saw the safer needles were in use and staff were receiving specific training.

Environment and equipment

- The main outpatient's department reception area was open plan and well lit. Patients who arrived at reception were sign posted to the specific waiting area, which was nearest to the consultation rooms.
- During our inspection, we observed that there was adequate seating and no patients or relatives were standing.
- There were clear signs in areas where ionising radiation was used, this included lights and warning notices.
- The diagnostic department had clear guidelines on which specialised personal protective equipment (PPE) should be used for specific procedures, such as lead aprons. Staff told us that they were always able to access appropriate PPE to carry out procedures. The department carried out regular audits of specialised PPE to ensure that they were still suitable for use.
- Resuscitation equipment, for use in an emergency was located in the corridor of the outpatient department and diagnostics department. The trolleys were secured with tags, which were removed daily to check the trolley and contents were in date.
- There was sufficient equipment to maintain safe and effective care, such as, electrocardiogram machine, to monitor the heart, blood pressure and temperature monitors, and specific ophthalmology equipment such as visual field machine, which is used to measure the vision.
- We saw evidence that the equipment in the diagnostic department was maintained and external engineers were used for specialist equipment, such as the mammography machine.
- There were systems to maintain and service equipment as required. Equipment had portable appliance testing (PAT) stickers with appropriate dates. PAT is an examination of electrical appliances and equipment to ensure they are safe to use.
- The pathology laboratory which stored specimens was situated next to the hospital kitchen and staff from both departments would use the same corridor for access. There was a possibility that specimens, such as urine, could be dropped near to the kitchen. This was raised with the senior hospital managers at the time of our inspection. During the unannounced inspection on 25 April, we noted that a risk assessment had been completed and additional storage and carrying boxes for specimen had been purchased to reduce the risk of specimens being dropped near to the kitchen area. Posters were in place to inform staff that storage and carrying boxes where required when transporting specimens. We saw evidence that this had been added to the hospitals risk register.
- The hydrotherapy pool was well maintained. The physiotherapy manager was the 'national pool plant operator' and had attended a specific course on health and safety and maintenance. The hospital engineer inspected the pool three times a week and weekly water testing was carried out. Single sex changing rooms were available.

Medicines

Good

Outpatients and diagnostic imaging

- The hospital had a pharmacy on site that provided daily cover between 8am and 5pm. Nursing staff reported that the pharmacy team were available to offer support and advice to both staff and patients and dispensed outpatient prescriptions.
- Medicines were stored in locked cupboards or refrigerators. Nursing staff held the keys to the cupboards to prevent unauthorised personnel from accessing the medication supply. There were no controlled drugs or intravenous fluids held in the outpatient areas.
- Staff told us that they could access medication if necessary to meet any needs of the patients attending the department. Staff reported that this was rare, due to the appointment system in place and patients often brought their own medication with them, or were not in the department long enough to require additional medication.
- Temperature checks were completed on a daily basis where medication was stored, including the fridge. Records were also seen in the x-ray room of temperature checks of the medication cupboard and room. This was to ensure the correct temperature was maintained and medication was stored appropriately.
- Medications to assist with diagnostic imaging, for example contrast for computerised tomography (CT) were stored in locked cupboards in the department. Medication was administered under a Patient Group Directive (PGD) which radiographers had signed after being assessed as competent to administer them. A PGD allows some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a doctor. Questionnaires and blood tests were carried out to identify any medical problems, for example degrees of kidney failure, prior to administration of the medication.
- Private prescription pads were stored in a locked cupboard within the outpatient department. This meant prescription pads were stored securely to prevent theft and abuse. Consultants generally used headed paper to prescribe medication, if the pharmacy was closed, which could then be taken to the local pharmacy.

Records

- There were separate outpatient notes and in-patient notes stored within the hospital. Outpatient notes were stored within the consultant secretary's office in locked filing cabinets and in-patient notes were stored within a dedicated secured medical records room.
- Staff told us it was unusual for patients' records not to be available for appointments and they could access the medical secretary's office and medical records room if required. However, this was not audited.
- We reviewed a random sample of ten records of patients attending outpatient appointments and found that referral letters, information about procedures undertaken and results of investigations were available.
- We found patient information was stored securely. Records we saw were complete and legible.
- We observed that patient identifiable data was kept behind the receptionist's desk, which was manned whilst clinics were underway to prevent this from being accessed by other patients or visitors.
- We visited the medical records department where patients' records were kept; access was restricted with a key code used for entry. We noted that all records were stored securely.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including how to manage suspected abuse and out of hours contact details for hospital staff.
- Staff received training and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- The staff were able to explain safeguarding arrangements and when they were required to report issues to protect the safety of vulnerable patients. All outpatients staff were trained to safeguarding Level 1 and 2 for both adult as and children via e-learning mandatory training. The outpatient manager and physiotherapy manager were both trained to safeguarding level 3 for both adults and children. Outpatients and imaging were between 90% to 100% compliant with safeguarding training. Although we saw no evidence of a failure to safeguard children, we were not assured that all OPD staff who had contact with children or young people had received the appropriate level of safeguarding training.The provider should ensure that a process is in place to ensure clinical staff working with children, young people and/or their

parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns has received training to the appropriate level of competency as outlined in the Intercollegiate guidance Safeguarding Children.

- Any consultant that had practising privileges were not permitted by the hospital to see children as patients unless they had provided the hospital with evidence that safeguarding level 3 training had been completed and was in date.
- There was a poster displayed in the staff area to inform staff of action to be taken and who to inform of any safeguarding concerns.
- Staff were aware of female genital mutilation (FGM), which involved genital cutting and female circumcision and removal of some or all of the external female genitalia. Any patients under the age of 18 years would have been immediately referred to the police as outlined in the national document: 'Working Together' (March 2015.) Staff told us they would report this to the outpatient's manager and matron.
- In 2015, the hospital reported 93% of staff had up to date training in adult safeguarding and children safeguarding both at levels 1 and 2. Staff had commenced the same training for 2016.

Mandatory training

- Staff informed us they had completed all mandatory training and e-learning. Some of the topics covered by mandatory training included fire, infection control and health and safety. Training records confirmed that mandatory training modules had a completion rate of between 90% and 97% for all mandatory topics. The organisational target was 95%.
- There was an induction programme for all new staff. We spoke with one new staff member who was supernumerary and undergoing competency training and felt it met their needs.

Assessing and responding to patient risk

- Staff were knowledgeable about the actions they would take if a patient deteriorated in the outpatient department. This included using the emergency call bells that sounded in the main reception area and some staff held bleeps that alerted them when there was an emergency. During the unannounced inspection, we noted staff attending to an emergency promptly and accessing the emergency equipment required.
- If a patient became unwell whilst in either the outpatient or imaging department, they were reviewed by the RMO and could be admitted to the inpatient unit. If the patient collapsed or needed a higher level of care, there was a written agreement in place with the local NHS trust, to transfer patients who were unwell.
- Staff told us that they had undergone training, which included scenarios or 'mock arrests'.
- The imaging manager informed us that all patients were asked if they had undergone a recent x-ray. If the x-ray was applicable to the appointment, the image would be obtained to prevent the risk of over exposure to radiation.
- The radiology department had a radiation protection supervisor (RPS) whose main role was to ensure that staff complied with requirements of IRR99 and the local rules. The RPS assisted with risk assessments and audits. IRR99 are the main legal requirements for the use and control of ionising radiation in the United Kingdom.
- The department had clear guidelines on who was entitled to make a request or referral for diagnostic imaging in accordance with IR(ME)R. For example, all medical and dental practitioners were entitled to act as referrers; other healthcare professionals, such as physiotherapists could act as referrers after undergoing a specific training programme and appropriate checks by the hospital.
- There were clear signs and information in the radiology department informing people about areas and rooms where radiation exposure was taking place.
- All women within childbearing age were asked whether there was a possibility they could be pregnant. This was to ensure appropriate actions were taken to reduce any potential risk to the unborn foetus from radiation.
- The radiology department had clear processes in place to ensure that the right patient received the correct radiological scan. Staff used a PAUSED guidance that encourages staff to pause and follow a checklist prior to proceeding. The PAUSED checklist includes for example: Patient - checking with the patient verbally their details, Autonomy - checking the correct site to be x-rayed/ scanned, User checks – confirm the examination is on the right date and the right time, Systems and settings -

select the correct imaging protocol, Exposure - recording dose, Draw to a close - ensure images are stored correctly and inform patient on how they can get the results. A safer surgery checklist was used in the department when interventional procedures were carried out.

Nursing staffing

- There was no baseline acuity tool for nursing staffing in outpatients. Staff and consultants that we spoke with said that staffing levels were adequate for the clinics and services that were delivered. During our inspection, we observed that staffing levels were adequate to meet the needs of patients and there was an appropriate skill mix including healthcare assistants (HCAs), registered nurses, administration staff and support staff.
- The outpatient manager was responsible for ensuring that staffing levels were appropriate for all clinics, using professional judgement and historical data. We saw staffing levels was pre-planned four weeks ahead of clinics in line with demand. Regular bank staff were used to cover increased activity, sickness or annual leave. No agency staff were used.
- There was one registered nurse vacancy that had been appointed to and the nurse was due to start in the next few weeks.
- We saw evidence that all registered nurses working in outpatients had a valid nursing and midwifery registration. This is to confirm nurses that are eligible to practise within the UK.
- Radiology staff had specific competencies and skills to carry out specific diagnostic investigations with the department for example CT scans. Staffing levels were determined against booked activity and to support outpatients clinics.

Medical staffing

- Consultants and radiologist, all of whom who worked under practising privileges, attended the outpatient department and diagnostic department on set days at set times. This meant that the managers knew in advance of which consultant was attending and were able to allocate staff appropriately to the clinics.
- Medical staff were contacted by telephone, email or via their secretaries to offer advice to staff if they were not present at the hospital.
- There was a resident medical officer (RMO) at the hospital 24 hours a day. They could be easily contacted by staff for advice or to review a patient for example, for a wound review.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the hospital.
- Staff were aware of actions to take in the event of a major incident, such as a fire.

Are outpatients and diagnostic imaging services effective?

We inspected, but did not rate the service for effectiveness. We found:

- Care and treatment was delivered in line with evidence-based guidance.
- There was a programme of audits to improve care.
- Staff were proactively encouraged to develop new skills.
- Staff had received an up to date appraisal and identified individual training needs. Staff had the right qualifications, skills, knowledge and experience to do their job.
- Multi-disciplinary teams worked well together to provide effective care.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) by the consultants.

Evidence-based care and treatment

- Assessments for patients were comprehensive; patients' care and treatment was planned and delivered in line with evidence based guidelines. For example, consent for surgery commenced in the outpatients department.
- Patients undergoing cosmetic surgery were given a mandatory two week cooling-off period between the initial consultation and committing to the procedure, to allow them time to reflect on the information prior to making a final decision.
- Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE). For example, infection control and cosmetic surgery.
- The hospital complied with the NICE quality standard for breast care recommendation that a clinical nurse specialist is present during appointments.

- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross-referenced to national audit levels and if they were found to be high, a report to the radiation protection advisor would be made.

Nutrition and hydration

- Staff informed us that patients could be offered snacks and beverages if required. The hospital cafe offered a range of hot and cold food and drinks that could be purchased for patients and visitors.

Pain relief

- The hospital had a pain relief link nurse to provide support to the clinical team ensuring best practice.
- Pain was assessed using the pain scale within the national early warning score (NEWS) charts and appropriate medication given as prescribed.
- Staff were able to give patients simple analgesia and recorded instances of this on patients' records; staff told us that this did not happen very often.
- Patients that we spoke to during our inspection had not required pain relief during their appointments.

Patient outcomes

- Staff participated in local audits, such as laser safety audit and managing abnormal blood results. In addition the physiotherapy department carried out quarterly audits of a sample of patients, measuring their outcomes after hips and knee surgery. Results were shown to be in line with national average.
- An audit took place on every breast care patient. We saw the audits which confirmed 100% of patients had a clinical examination, imaging and needle biopsy, confirmed the results and had been referred to the multidisciplinary team if required.
- The imaging manager confirmed that annual imaging audits and radiation protection audits were carried out. We reviewed the results from the most recent audits and noted that action plans had been put in place to correct the light beams and output rates of the equipment to ensure compliance with national output rates.
- The service did not participate in the imaging services accreditation scheme (ISAS) or improving quality in physiological services (IQIPS).

Competent staff

- All staff working in outpatients, diagnostic imaging and physiotherapy services had an up to date appraisal.
- The imaging manager confirmed that radiographers' registration was renewed every two years with the Health and Care Professions Council (HCPC).
- Physiotherapy staff confirmed that all professional updates and best practice was checked by the hospital, including training records to ensure competent staff treated patients.
- The outpatient manager told us that competencies were maintained by completing e-learning training. All new staff members were inducted corporately and were supernumerary until they had completed their induction. A new nurse confirmed this during our inspection; they were supernumerary and completing all e-learning and competencies.
- There was an induction programme for all new staff. We spoke with one new staff member who was supernumerary and undergoing competency training and felt it met their needs.
- Nursing staff in outpatients were given bespoke training in specific specialities to develop competencies in different areas. For example, the visual field machine, used to measure peripheral vision, and the flow machine, used to measure urine flow. Staff told us this allowed them to gain new skills and meant that they were able to work confidently in additional areas.
- Each staff member had a small pocket book, which included specific information as a quick reference, such as dementia care, duty of candour and infection control. Stall told us they used the booklet for quick references for care and treatments.
- Staff confirmed they had protected time to complete competency training. This included IR(ME)R training for radiographers.
- All doctors who had practising privileges were at consultant level and were registered with the General Medical Council (GMC). This meant patients could be assured that registered practitioners treated them.
- Patients who attended outpatient clinics and the diagnostic imaging department told us that they thought the staff had the right skills to treat, care and support them.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- The one-stop breast clinic was consultant led and available Mondays, Tuesdays, Wednesdays, Fridays and Saturdays. If patients required mammography, ultrasound, fine needle aspiration and/or core biopsy during the clinic, this could be arranged with the consultant radiologists on site. The breast care nurse was present for all breast care clinics.
- Patients requiring referral to the local NHS services MDT for cancer services were referred directly by the consultant or breast care nurse.
- There were specialist nurses at the hospital for breast care, a plastics specialist nurse, chemotherapy nurse and infection control nurse. Staff and patient could access them for support and information.

Seven-day services

- The outpatient department was open Monday to Friday, 8am to 8pm and Saturdays, 8am to 1pm. Staff confirmed that additional clinics were held on request from the consultant.
- The imaging department was open Monday to Friday 8am to 8pm and Saturdays 8am to 1pm. The imaging manager confirmed that they provided a 24 hour on call service, seven days a week and radiographers took it in turns to do out of hours on call shifts.
- When the outpatient department was closed, patients could phone the ward staff for advice.

Access to information

- Staff were aware of how to access policies and procedures on the hospital's intranet, which was demonstrated to us.
- All inpatients records were kept on site for three months and then archived in a secure off site store; these could be accessed for outpatient appointments.
- Each consultant had a folder with appointment schedules, referral letters, investigation results and general correspondence prepared for each clinic.
- Each clinic room had a computer were staff could access results of examinations such as blood tests and view x-ray images.
- Diagnostic imaging departments used the picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily.
- All diagnostic images were reported on within three working days and sometimes sooner.
- Discharge summaries of the care and treatment received were sent to the patients GP by the consultants' secretary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were able to describe the relevant consent and decision-making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty safeguards (DoLS) in place to protect patients. Patients' consent was obtained as per hospital procedures.
- Consent for care and treatment was managed by individual consultants. The hospital had three nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure and one for those aged 16-18 years.
- Staff followed the hospital policy on consent to investigate or treatment by using the Gillick competency when assessing a young person's ability to consent to treatment. Gillick competency is used to decide if a child or young person is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. This means that the child had sufficient maturity and understanding to make the decision in question. Where a child is not Gillick competent, consent can be given by someone on his or her behalf who has parental responsibility. The hospital did tell us that no child under the age of 18 years had been seen without a parent or guardian present.
- We saw one patient arrived for outpatient appointment with their relative that had power of attorney, but had not brought the relevant paperwork with them. Power of attorney is giving someone the legal authority to make decisions on a person's behalf if mental capacity is lacking. The outpatient staff immediately sought advice from a senior manager. The patient's appointment went ahead and the relative returned the following day with the relevant paperwork to complete the consent forms

which complied with the hospitals consent to investigate or treatment policy. This meant that staff were aware of the policies to follow, but did not delay the patients appointment.
- Verbal consent was gained as a minimum prior to any diagnostic procedures.
- Staff told us that MCA was covered as part of the mandatory training in safeguarding. We saw evidence that 89% of all staff in outpatients and radiology and physiotherapy staff had completed their mandatory training.

Are outpatients and diagnostic imaging services caring?

Good

Overall, we rated the service as good for caring because:

- Patients told us they were treated with dignity and respect and were involved in their treatment and care.
- Patients were informed of any associated costs.
- Feedback from patients and those close to them was positive about the way staff cared for them and the treatment they had received.
- The friends and family test were consistently high with good response rates.

Compassionate care

- We observed staff to be polite and friendly towards patients.
- All patients we spoke with were complimentary of the staff and the hospital.
- We saw staff taking the time to interact with patients in a respectful and considerate manner.
- Patients told us staff were kind, respectful and always introduced themselves.
- Patients' dignity and privacy was respected at all times. For example, we observed all consultations took place in closed rooms and staff knocked on clinic room doors before entering. Patients we spoke with in radiology and outpatients praised the staff for the level of compassionate care they provided.
- Patients told us that confidentiality and privacy was good. One patient said: "I was anxious when they (staff) told me I was required to get undressed, but they (staff) showed me to a bathroom next to the x-ray room, provided me with a gown and didn't rush me".
- The Friends and Family survey results which included both NHS and private patients were displayed in the main outpatients department and the physiotherapy waiting area.
- The results between July and December 2015 showed that 97% to 100% of patients would recommend the hospital to family and friends. The response rates were similar to the England average of 36%. During our inspection, patients told us they had often recommended the hospital to their families and friends.

Understanding and involvement of patients and those close to them

- Patients told us they were involved in making decisions about their treatment.
- All patients we spoke with knew the name of their doctor.
- Patients that we spoke to after their appointment said that they had received information about when they would receive their test results and if they required further diagnostics or treatment what that would consist of.
- Patients said that doctors and nurses explained treatment options in a way that they could understand. One patient told us that the risks and benefits of their treatment options were thoroughly explained to help them make an informed decision. Another patient said: "I understood everything, from outpatients, on the ward and on discharge".
- Patients were given the opportunity to be accompanied by a friend or relative during consultations.
- Two patients we spoke with said their partners were involved in discussions about treatment and were made to feel welcome at appointments.

Emotional support

- Specialist nurses were available at the hospital. There was a specialist breast care nurse, cosmetic nurse and chemotherapy nurse that patients could book an appointment with for advice, support or felt they needed to discuss their care.
- The hospital had a list of multi-faith contact details should patients require these.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

Overall, we rated the service as good for responsive because:

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- Care and treatment was coordinated with other services.
- Patients could access the service at times to suit them.
- One-stop clinics were available for some specialities such as breast care to minimise the amount of attendances for patients.
- The services had protocols and procedures in place to manage patients with complex needs, including those living with dementia and learning disabilities.
- Information on complaints or how to raise a concern was available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner.
- Child friendly feedback sheets are available for children to give us their own feedback.

Service planning and delivery to meet the needs of local people

- Clinics were held at weekends and evenings in specific specialties to provide flexibility and manage waiting lists.
- Some consultation rooms were used for specific specialties, with dedicated equipment, for example; ear, nose and throat; and ophthalmology. This meant consultants would be able to work in an appropriate room according to their specialty and staff could be arranged to support and deliver the service.
- Some outpatients clinics had been designed as 'one-stop' so patients could undergo tests and a consultation within the same appointment; these included specialities, such as breast care.

Access and flow

- Referral to treatment time (RTT) is the term used to describe the period between when an appropriate referral for treatment is made and the date of the initial consultation or treatment. The Department of Health stated for NHS patients, 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral; this was withdrawn in June 2015.
- RTT times were met in all months between January and December 2015, except for December 2015 when this dropped to 92%.
- Patients felt that the booking system for appointments was excellent. One patient told us they were referred by their GP, seen within days at the hospital and did not have to wait for their appointment on arrival to the hospital.
- Some NHS patients were able to book their appointment via an NHS 'Choose and Book' system, which allowed them to choose a time that was more convenient for them, or they could contact the outpatients booking teams directly. Staff in the booking teams also contacted patients if a referral was received from a GP or other referrer that was urgent.
- The percentage of patients who did not attend (DNA) their appointments in the previous three months was on average 4%, which was better than the England average of 7%.
- Patients would be contacted if they DNA for their appointment. If the patient no longer needed an appointment, this was recorded. The same process was followed for NHS patients. If the patient still needed an appointment, a further one would be made. However, if the patient DNA for a second time the hospital discharged the patient back to their GP and recorded this.
- The imaging department saw an average of 2,200 patients per month. The imaging manager confirmed that there was a short waiting list and the longest a patient would need to wait for an appointment, if a radiologist was needed, would be up to a week.
- Results from the imaging department were sent to the referrer via hard copy and images available to view on the hospital computer system. Any urgent requests or images of concerns where phoned to the referrer for immediate attention.
- No excessive waiting times were observed during our visits. Posters were displayed in each waiting area advising patient to inform reception if they were not seen within 20 minutes of their appointment time. Staff told us they would investigate and inform the patients of delays and estimated waiting times.

Good

Outpatients and diagnostic imaging

- During our visit, one clinic was cancelled, as the consultant had not informed the hospital that they would not be attending. Patients were offered an apology and another appointment was made, patients were also offered an appointment with another consultant if they wished. In addition, this was reported as an incident. Staff told us this was an unusual occurrence as consultants and their medical secretaries told the hospital of any cancelled clinics well in advance.
- There was clear signage to outpatient areas and reception was staffed during clinic times to assist with directions.

Meeting people's individual needs

- Appointments in the radiology department were booked by the estimated time the imaging would take; this meant that appointment lengths were tailored to patient needs.
- Specialist nurses, for example breast care nurse and plastics nurse, completed outpatient lists to provide care and treatment for patients known to their service. This enabled easy access to support and advice for patients with specialist conditions.
- Chairs for larger patients were available in the waiting rooms and physiotherapy department; staff were aware of weight limits on certain couches in the department, but some could accommodate heavy patients.
- The hospital was able to accommodate patients in wheelchairs. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe manner.
- Patients who were living with dementia were given extra time for appointments and staff told us they encouraged a carer or relative to stay with them.
- Patients with a learning disability were also given extra time for appointments.
- Patients with working dogs were also accommodated and seen quickly to prevent anxiety from the animal and other patients.
- A hearing loop was in place in the outpatient department for patients with hearing difficulties. This meant some adjustments had been made to remove barriers and meet individual needs.
- There were posters displaying interpreter services in outpatient waiting areas. The interpreter service was that a translator could be contacted by telephone at the time of appointment.
- We saw a list of staff members that were able to communicate with patients in a different language.
- Information leaflets were available in main reception and outpatients waiting areas. Patients told us information leaflets with relevant information about treatment options were provided and they had received written information in the post.
- There were no toys or books in the waiting areas specifically for children when they attended outpatients, physiotherapy or diagnostics appointments. However there was colouring books available at reception.
- There were no information leaflets specifically for children.
- Patients told us they were informed about the fees for their consultation before their appointment. This meant patients received appropriate information in relation to costs to enable them to make an informed decision about their appointment.
- Staff were caring and compassionate and patients told us staff were flexible to meet their needs.

Learning from complaints and concerns

- Spire Healthcare Limited's corporate complaints policy directed the management of complaints and time scales for responses. This was in line with industry standards. All complaints were reviewed by the clinical governance committees and medical advisory committee (MAC) and actions as a result of the complaint shared with individual departments via team meetings.
- There had been 11 complaints in outpatients and diagnostics between April 2015 and April 2016. The complaints mainly related to delays in treatment or communication with the patients, charges for treatments and lack of wheelchair availability. The action taken included the purchase of two wheelchairs for outpatients and improving communication amongst staff.
- Staff were knowledgeable about the complaints process and explained how they would try to resolve a patient's concern or complaint at the time.
- Patients were aware of the complaints process. Patients told us they were satisfied with the service, however, knew how to raise a concern or complaint if they had one.
- We saw posters in the main waiting areas responding to comments from patients using "You said" and "We did".

For example, "You said:" "Disabled parking spaces near the outpatient department are not big enough" and the hospitals "we did" response was: "Rearranged spaces making them bigger".

Are outpatients and diagnostic imaging services well-led?

Good

Overall, we rated the service as good for well-led because:

- Staff that we spoke to were aware of the hospital vision and the individual department values.
- The hospital had a clear governance structure.
- Clinical governance committee met monthly to monitor and discuss a range of hospital issues.
- Information was cascaded from the clinical governance committee to all hospital staff via team meetings.
- The hospital had an effective risk register.
- Patients' care was consultant led.
- Hospital senior management members were visible, approachable and supportive.
- There were high levels of staff satisfaction and staff were proud to work for the hospital; they felt supported and valued.

Leadership/culture of service

- The service was led by an outpatient manager, who reported to the matron. We saw strong leadership, commitment and support from the senior management team within the hospital. Staff told us the senior managers were supportive and approachable.
- Each department had a manager who was responsible for the day-to-day management and staffing levels. Departmental leads told us they had autonomy to make decisions and were proud of their staff.
- The nursing team, diagnostic team, physiotherapy team and administration team communicated well together and supported each other.
- Staff were enthusiastic and proud about working at the hospital. They enjoyed working at the hospital and felt respected and valued.

Vision and strategy for this this core service

- Staff were aware of the overall corporate vision, which was: 'To be recognised as a world class healthcare provider,' and: 'To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'. Senior managers told us that the hospital aspired to become world class providers within the sector.
- The outpatient department had values displayed which included being open and honest and offering a wide range of outpatient services. Staff were aware of both the corporate and outpatient values.

Governance, risk management and quality measurement for this core service

- There was a governance structure within the hospital. All individual Spire Healthcare Limited hospitals clinical governance committee reported to the Spire Healthcare Limited board.
- The clinical governance committee met monthly. This committee had an overview of governance risk and quality issues for all departments. Senior department leads attended. Information discussed included safety alerts, learning from incidents, policy updates and audits.
- Heads of departments attended managers meetings where information was shared across the hospital such as new starters, training needs, building works and workloads.
- Heads of departments were responsible for cascading information back to their departments. We saw minutes of meeting were these items were discussed at team meetings.
- Administration staff received a monthly newsletter with departmental and hospital updates.
- The hospital maintained a MAC whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice.
- The hospital had a schedule of annual audits. Audit reports were reviewed locally at clinical governance meetings and MAC and results cascaded to staff through heads of department.
- Meeting minutes we reviewed confirmed audits, for example, hand hygiene and the environment, were completed monthly and the results were discussed at relevant meetings, including the hospital governance committee.
- We reviewed the hospital risk register and noted there were risks identified for each department. Each risk had control measures and an identified owner. Risks

included for example, hydrotherapy pool drowning, control measures taken include training of staff and practice scenarios, and over exposure of radiation, control measure include safety check and check the body parts, correct examination is requested and follow IR(ME)R regulations regarding radiation dose.

Public and staff engagement

- Patient satisfaction survey was collated monthly for the whole hospital and not for individual departments. Questions asked included, how likely are you to recommend our hospital to friends and family if they need similar care or treatment, satisfaction with care and attention from nurses and were you involved as much as you wanted to be in decisions about your care. Overall, patient satisfaction was above 95%.
- The staff satisfaction survey for the whole hospital in 2015 showed a response rate of 69% with an overall satisfaction rate of 77%. Areas of positive satisfaction included; 'I believe what I do at work makes a positive difference to my hospital' and 'I am proud to work for my hospital'. The lowest staff satisfaction included, 'other departments understand the impact their actions have on my team' and 'senior managers provide rationale for decisions that impact on me'. We saw an action plan which included senior manager attending departments meetings, regular staff forums, promoting an open culture and open constructive dialogue between teams.
- Administration staff received a monthly newsletter with departmental and hospital updates. Staff told us they liked receiving these as this enabled them to keep up to date with the hospital developments.

Innovation, improvement and sustainability

- The hospital supported a breast care support group run by the breast care nurses and oncology lead and offers support to patients requiring breast care treatments. The group meet informally and offer support to patients and their carers, gain feedback on their experience and share information about local support groups. This group supports national guidelines to provide patients with a support system from diagnosis into the survivorship programme

Outstanding practice and areas for improvement

Outstanding practice

- Oncology services offered a high standard of personalised care for a variety of patients. This included bespoke appointments, support out of hours and access to specialists. Treatment options were inclusive of new medications and not limited by clinical commissioning. Patients experience was individualised and supportive of their decision-making.

Areas for improvement

Action the provider MUST take to improve

- Staff who have responsibility for assessing, planning, intervening and evaluating children's care, in the ward area, must be trained to level three in safeguarding.

Action the provider SHOULD take to improve

- Ensure compliance with Health Building Note (HBN) 00-10 Part A: Flooring and HBN 00-10 Part C: Sanitary Assemblies, in all clinical areas.
- Consider the effective management processes required for out of hours endoscopy emergencies.
- Consider formally collecting patient outcomes and participate in national audit programmes to enable benchmarking against national standards.
- Although there were clinical hand basins in utility areas, there were no clinical hand basins in patients' rooms. Therefore staff were using these patient sinks at the point of care when it was necessary to wash their hands. Therefore the hospital should ensure clinical sinks are available at point of care.
- The hospital should consider reviewing coving in patient bedrooms and bathrooms as they are not compliant with current infection control guidelines.
- The hospital should ensure that medical representatives visiting theatre have their identification routinely checked.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing** **18.**—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. How the regulation was not being met: Not all staff who were trained to the right level in safeguarding. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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