Spire Healthcare Limited

Spire Bushey Diagnostic Centre

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This is the first time we have inspected this service. We rated it as good because:

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

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Diagnostic imaging

Good

This was the first time we inspected this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
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- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

We rated this service as good because it was safe, caring, responsive and well led. We currently do not rate effective.

Summary of findings

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Summary of this inspection

Background to Spire Bushey Diagnostic Centre

Spire Bushey Diagnostic Centre is operated by Spire Healthcare Limited. It is located less than two miles from the main Spire Bushey Hospital site. The centre opened in November 2017. It provides diagnostic imaging services and outpatient clinics from a two-storey purpose-built facility which has 10 consulting rooms, four pre-assessment clinics and a diagnostic imaging unit. This was the first time we inspected this location.

Outpatients

Outpatients services at Spire Bushey Diagnostic Centre consists of ten consultation rooms and four treatment rooms across two floors of a purpose-built centre. The service provides a variety of services including outpatient appointments/ consultations for a variety of specialities including orthopaedic, pain clinics, rheumatology and general surgery. In addition, the service completes some low risk clinical procedures.

The centre is open from 8am to 9pm Monday to Friday, 8am to 2pm on Saturdays and 9am to 1.30pm on Sundays. The outpatient service sees around 2500 new referrals and 3000 follow up patients each month.

Staff are provided by Spire Bushey hospital, and work across both sites when necessary. The leadership team is largely based at Spire Bushey, but there is daily presence by at least one member of the senior team.

During inspection we spoke with eight members of staff, and four patients and relatives.

Diagnostic Imaging

At Spire Bushey Diagnostic Centre, patients have access to the diagnostic imaging services and investigations. The service provides magnetic resonance imaging (MRI), ultrasound and x-ray imaging services.

The diagnostic imaging service is open from 8am to 9pm Monday to Friday and 8am to 6pm at weekends.

Staff work across Spire Bushey Hospital and the diagnostic centre site. The imaging department management team are based at the Spire Bushey Hospital site but there is a daily presence by members of the senior leadership team.

During this inspection, we spoke with 10 members of staff which included radiographers, mangers, healthcare assistant and administrative staff. We reviewed 10 patient records, and reviewed policies and audits. We also spoke with four patients and observed their MRI and x-ray imaging being completed.

How we carried out this inspection

We carried out an unannounced fully comprehensive inspection of the diagnostic imaging and outpatient services on the 28 September 2021. We spoke with 18 members of staff, four patients and reviewed 10 patient records.

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

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

This was the service's first inspection. We rated it as good.

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. The service completed training via online or in person depending on the topic. Staff completed eleven mandatory training topics during induction and at intervals of up to three years. This included fire safety, health and safety, information governance and manual handling.

Training compliance was reported as 100% for all staff for all topics, with the exception of compassion in practice (96%) and incident reporting (96%). This was above the hospital target of 95%.

Medical staff received and kept up-to-date with their mandatory training. Mandatory training was largely provided by the consultant's host NHS acute trust. The service ensured compliance with mandatory training through regular reviews of consultant's records which were shared by the acute trusts. Any site specific training was completed as part of staff's induction and as processes were updated.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Locally managers kept details of training and promoted staff to complete training as per guidance. However, there was also a record held centrally by the Spire group which enabled targeted training per site. Staff generally attended the host hospital site for training although could access training on site.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. Staff compliance with safeguarding training was 100%. Staff completed safeguarding adults and children's training in line with local guidance. The level of training varied according to the staff role, for example, administration staff completed safeguarding level 2 training, and clinical staff level 3. All staff had access to an organisational safeguarding lead who could advise on actions to be taken if necessary.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service did not regularly see children or young adults as patients; however, they could use the service. Staff confirmed that they also had contact with children when attending appointments with their parent/ guardian.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff in outpatients reported that they would escalate any concerns if necessary and were able to give examples of how to report concerns internally and externally.

Staff followed safe procedures for children visiting the service /department. There was no designated waiting area for children, however, as waiting areas were small and located adjacent to consultation rooms, there was rarely more than one patient waiting to be seen in each waiting area, reducing risks. Children were always accompanied for appointments.

Cleanliness, infection control and hygiene

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

Following the COVID-19 outbreak, the service had changed visiting rules, with patients discouraged from bringing family or friends to appointments, although they could attend following discussion with the team. Staff discussed guidance for COVID-19 testing for patients and any visiting relatives at preadmission appointments or at pre appointment booking calls.

Staff explained that patients attending the pre-operative assessment service were required to complete COVID-19 testing and remain isolated prior to any procedures at the main Spire Bushey hospital site. This process ensured that if they were admitted for a procedure, they were COVID-19 free.

On arrival to the centre, patients were encouraged to sanitise their hands and use a clean face mask. These were provided at the main entrance and reception staff prompted if these were not seen to be utilised. All staff and patients were seen to be wearing face masks whilst in the centre.

Clinical areas were clean and had suitable furnishings which appeared clean and well-maintained. All areas were visibly clean and tidy. There was a dedicated cleaning team who ensured that environmental cleaning was completed. We were told that they were particularly dedicated and took great pride in their role.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning was completed regularly and recorded on checklists in multiple occupancy areas. We also saw that clinic treatment rooms were cleaned at the end of each clinic by staff.

Good

Outpatients

The service generally performed well for cleanliness. Cleaning audits were completed at regular intervals and we saw that that all infection control and prevention audits showed compliance over 94% and in line with target. Other environmental audits such as the personal protective equipment assurance audit and sharps audits showed compliance over 95% for quarter one and quarter two in 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that staff wore PPE in line with guidance. Face masks were worn throughout appointments and all visitors were requested to wear face masks unless they were medically exempt. There were face masks and PPE available on entry to clinical areas, and hand sanitiser located regularly throughout the site. Staff prompted visitors to sanitise their hands.

All specialist equipment was cleaned by appropriate clinical staff. Staff cleaned equipment after patient contact and labelled with 'I am clean' stickers to show when it was last cleaned. We saw that all equipment was cleaned using appropriate sanitiser or products in line with guidance.

Environment and equipment

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

The design of the environment followed national guidance. The environment had been designed specifically to meet the needs of the service. The centre was easily accessible with adequate car parking for a large number of visitors. Upon arrival there was a reception area which was manned from 8am to 9pm, with staff who were able to direct visitors to the area of their appointment. The centre had two floors (ground level and first floor), with lift access. There was a second reception desk on the first level to assist with directing patients to the correct waiting area.

There were ten consultation rooms and four treatment rooms which were used for specific procedures. For example, one treatment room was set up for gynaecology procedures. Where possible consultants used the same rooms for their appointments and specialist equipment was distributed to the correct rooms prior to the clinic commencing.

Staff carried out daily safety checks of specialist equipment. We saw checklists for equipment in all treatment rooms. These were checked and signed by the days staff. Staff told us they were able to access replacement equipment as necessary.

Resuscitation equipment was easily accessible across all treatment rooms and we saw that this was checked daily and compliance audited. Hospital data showed that resuscitation equipment had been checked 100% in quarter one and quarter two 2021.

The service had suitable facilities to meet the needs of patients' families. We were told that patients were able to be accompanied, however, where possible this was discouraged due to COVID-19 and social distancing. There were adequate waiting areas which could be used by accompanying persons whilst the patient was seen in a treatment room. All areas were wheelchair accessible.

Staff disposed of clinical waste safely. Waste was removed from clinical areas at regular intervals.

Assessing and responding to patient risk

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

Good

Outpatients

Staff responded promptly to any sudden deterioration in a patient's health. Patients attending the department were generally fit, attending for an outpatient's appointment or consultation. This meant that patients did not routinely have clinical observations performed. This depended on the type of clinic appointment being undertaken and clinical preferences.

When clinical observations or risks assessments were required, staff completed them using a recognised tool, and reviewed them regularly, including after any incident. Staff used the National Early Warning Score (NEWS2) tool to monitor clinical observations. On arrival to the department, those patients requiring assessment, were reviewed by a nurse or support worker, who took baseline clinical observations including blood pressure, pulse rate and temperature. These were used to inform decisions made about the patient's clinical condition and plan their treatment.

Staff knew about and dealt with any specific risk issues. At assessment, patients were monitored for risks that may affect their treatment or recovery. For example, those patients with past medical histories of blood clots, were assessed for anticoagulant therapy to prevent reoccurrence post treatment. Venous thromboembolic (VTE) assessments were completed on all patients as part of the preparation for surgery.

All patients planned to undergo surgery, or a procedure at the main Spire Bushey hospital site were seen by the preadmission clinic based at the Diagnostic Centre, to obtain baseline observations and blood results prior to attending for their surgical procedure. Patients were categorised according to risk. Those deemed high risk, were not usually treated at the hospital with arrangements being made with the local acute hospital for their treatment. Lower risk patients were seen by the preadmission nursing team, the consultant and the anaesthetist. Appointments were designed to provide ample time for discussion about treatments, potential risks and side effects.

Patients undergoing simple procedures within outpatients were assessed by the consultant, supported by the nurse and healthcare assistant and prepared for the treatment. This could include clinical observations, blood testing or swabbing. All results were reviewed prior to treatments commencing.

The service had access to mental health liaison and specialist mental health support. The service did not routinely provide treatment to patients with known mental health conditions, although staff knew how to access support if there were any concerns. We were given an example of a patient with a mental health condition who was referred to the service for a clinical procedure. Staff reported that the patient would normally have been treated in the acute hospital, but with support from the mental health team, they managed to provide care at the service, preventing an acute admission to hospital.

All patients undergoing cosmetic surgery were given necessary information and adequate time for changing their minds. A cooling off period was built into the service with transparency about cost at each stage, which enabled patients to make informed decisions. This was also audited to monitor compliance.

Staff shared key information to keep patients safe when handing over their care to others. Once patients had been seen in clinics, information was shared with the rest of the hospital teams who would be responsible for completing the patients care pathway. For example, if an admission was planned, notes were shared with the preadmission team, who completed assessments and following agreement of the procedure, the booking team arranged admission.

Notes were seen to be clear, gave instructions and detailed discussions and clinical findings from the appointments. Notes were held centrally at the diagnostic centre and transported between services securely.

Good

Outpatients

Staffing

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

The service had enough nursing and support staff to keep patients safe. We saw that staff were allocated to clinics to ensure that patients and doctors had access to support as necessary. When more complex appointments were scheduled, additional staff were provided.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Clinics were planned in advance so staffing could be arranged. Any last minute changes were discussed to ensure the correct level of staffing was available.

The manager could adjust staffing levels daily according to the needs of patients. We were told that staff worked across the Spire Bushey sites so any unplanned last minute changes could be managed across the service.

The number of nurses and healthcare assistants matched the planned numbers. We saw that the numbers of staff on duty were as planned.

The service had low vacancy rates. Data for July to September 2021, showed that there were no vacancies within the service and no turnover of clinical and administration staff.

The service had no sickness reported for clinical staff from July to September 2021 with a reported 1.4% COVID-19 reported sick leave in July 2021.

The service had low rates of bank and agency nurses and where possible, limited their use of bank and agency staff and requested staff familiar with the service to ensure consistency. Managers made sure all bank and agency staff had a full induction and understood the service. We were told that agency staff followed the same induction process as new members of permanent staff.

Medical staffing

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

The service had enough medical staff to keep patients safe. Consultations and appointments were arranged according to the doctor's availability. Consultants would inform the hospital of when they were available for clinics and then appointments were scheduled accordingly. Some consultants maintained regular clinics which meant that the booking team were able to plan appointments well in advance. Others provided smaller, less frequent clinics, which would be slotted into the calendar as able. We saw that medical staffing matched the planned number. Staff reported that there were no occasions where clinics could not be accommodated.

Following acceptance into the service, consultants worked under practicing privileges. The majority of doctors also worked at nearby NHS acute or specialist hospitals and completed training and revalidation through their host organisation. The service ensured compliance with these as part of annual reviews.

Good

Outpatients

Records

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

Patient notes were comprehensive, and all staff could access them easily. Paper notes were held for patients, however, we were told that most consultants dictated consultation notes which were later added to the patient's records. In the interim, a note was added to the paper record stating that patients had been seen, noting the date and time in case the notes were needed before the record had been updated.

Records were held on site and collected prior to any appointments to ensure they were available for the consultation. Staff reported that notes were usually available for appointments although occasionally they were not. On these occasions, the incident was reported.

Records were stored securely. We saw that notes were not left in any public areas, and not left unattended. Patient notes were transported between departments securely and not left unattended. Nursing staff told us that they would place patients notes in consultation rooms prior to their appointment. Doctors clarified patients details prior to commencing the appointment.

Clinic lists were held at the reception desk and names crossed off when arriving and when entering consultation rooms to keep track of which patients had been seen. All lists were held in files at the reception desk to prevent unauthorised access.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Minimal medicines were used within the service. The majority of medicines used were local anaesthetics which were used for some clinical procedures. These were stored securely and checked in line with best practice when used.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients medicines were discussed at most clinic appointments. Any changes to medicines were explained and there was a pharmacy on site which enabled patients to access any new medicines in a timely manner.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in the treatment room which was secure at all times. We saw that the temperature of the treatment room had been escalated on two occasions for being higher than recommended. On both occasions, there was evidence to confirm that staff had reported this to the pharmacy and took advise on whether temperature sensitive medicines remained safe to use.

Staff followed current national practice to check patients had the correct medicines. All medicines were checked by two practitioners prior to any administration.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The pharmacist on site was responsible for ensuring safety alerts were shared and stocks checked. Safety alerts were also escalated through safety briefing and huddles.

Good

Outpatients

Incidents

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

Staff knew what incidents to report and how to report them. The service used an electronic reporting tool which was accessible to all staff, without a password for a computer. This meant that agency staff could report incidents as well as permanent staff. Hospital data showed that incidents were reviewed and investigated in a timely manner.

Staff raised concerns and reported incidents and near misses in line with provider policy. We saw that there were a variety of incidents reports which included actual and near misses. The hospital provided us with an update from August 2021, which showed that there had been 22 incidents at the Diagnostic Centre in August 2021, which included 11 cancellations, nine documentation related incidents and two clinics reported as running late.

For the period June to September 2021, there were seven reported incidents relating to outpatient at the centre. All incidents detailed actions taken in response and resolution.

There was one reported serious incident for January to June 2021, which occurred within outpatient services. This related to a patient attending the hospital who had a seizure and was consequently transferred to an acute hospital. The incident was fully investigated and learning shared. We saw that learning included the sharing of key information and risks between reception staff

The service had no never events from January to June 2021. Managers shared learning with their staff about never events that happened elsewhere. We were given examples of how incidents and their findings had been shared across the site, hospital and wider organisation. There were flash reports at daily huddles which outlined any actions that needed completion within 48 hours in response to incidents that had occurred at any Spire site. We also saw that the governance update from August 2021, detailed learning from incidents across the hospital sites.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Although staff reported that there had been no serious incidents within the department, they were familiar with duty of candour and knew how to apply it.

Staff met to discuss the feedback and look at improvements to patient care. Staff attended team meetings and discussed how services could be improved. When attendance at team meetings was not possible, key information was shared through emails or newsletters. We saw a variety of newsletters used across the hospital which all referred to learning from incidents and improvements needed for patient care.

Are Outpatients effective?

Inspected but not rated

This was the service's first inspection. We do not currently rate effective for Outpatient services.

Good

Outpatients

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a number of policies and saw that these reflected best practice and were in date. Clear review dates were set and there was a robust process for ensuring policies were reviewed.

In addition to policies, the service had a number of standard operating procedures (SoPs) which were all based on current guidelines and reviewed regularly. Policies and SoPs were accessible in paper copies (for key items) or via the intranet. Staff told us they were encouraged to use electronic versions as reference as these were the most up to date and prevented old information being used. Heads of department would replace any policies or SoPs in paper format when they were updated.

Staff audited practice and monitored outcomes to ensure staff followed guidance.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain was discussed at most appointments, and actions taken appropriately. Staff did not routinely administer pain relief in outpatients, unless patients were undergoing a procedure, when some pain relief medicines may be given. Patients received pain relief soon after requesting it.

Patients with ongoing pain needs could be referred to pain teams if necessary, for ongoing advice or treatment.

Patient outcomes

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

The service participated in relevant national clinical audits including Patient Reported Outcome Measures (PROMS) and venous thromboembolism audits. Data collected was compared to the wider Spire group and national figures. Outcomes for patients were variable. For example, hospital data showed that PROMS performance was below the target of 80% for hip and knee procedures for baseline completion and questionnaires being completed. The majority of PROMS data is collected in inpatient areas, however, some outpatient services, such as physiotherapy and follow up appointments also contributed data.

Managers and staff used the results to improve patients' outcomes. Actions were clearly attributed to audit results and trends were monitored to ensure an improvement in performance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We reviewed audit results for January to June 2021 which showed, 98 to 100% compliance in the World Health Organisation (WHO) five steps to safer surgery checklist audit, 94 to 98% compliance in the bare below elbows audit, 96 to 100% compliance in the personal protective equipment audit and 100% compliance in the hand hygiene audit.

There were three speciality specific audits which included the surgical safety checklist, physiotherapy notes and the cosmetic surgery cooling off period audit. Hospital data showed that there were 32 submissions across the three audits for quarter one with 100% compliance for two audits and 99% compliance for the surgical safety checklist- outpatients observational audit.

Managers shared and made sure staff understood information from the audits. We saw that audit results were discussed across all areas of the service. This included at team meetings, performance meetings and as part of the organisational performance monitoring. A dashboard was displayed detailing performance.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had a number of staff who worked across the diagnostic centre and the Spire Bushey hospital. Staff were skilled to manage the workload and used competencies to confirm skills.

Managers gave all staff a full induction tailored to their role before they started work. There was a robust induction process which included orientation and escalation processes to ensure staff were familiar with the environment and processes used by the service. Agency staff completed the same induction process to promote safety and consistency.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff told us that they had completed an appraisal within the last year. The appraisal rate for the service was reported as 100% with a midpoint objective setting appraisal rate of 95%.

Medical revalidation was completed at the consultant's host organisation. Consultants were responsible for ensuring that revalidation information was shared with the service, and this was tracked to ensure compliance. Any staff member with out of date revalidation was not permitted to work until it had been completed. This was monitored through regular medical advisory and governance meetings.

Consultants capabilities and performance was monitored through the medical advisory committee (MAC) and any concerns were flagged and addressed accordingly. Consultants were not permitted to complete any procedures which they had not been deemed competent to complete. The MAC approved all procedures prior to them being completed within the service.

The clinical educators supported the learning and development needs of staff. Staff had access to inhouse educators and an organisational team. This enabled training to be standardised across the wider Spire group.

Managers made sure staff attended team meetings or had access to full meeting notes when they could not attend. We saw that meetings were largely well attended by staff and minutes were sent electronically to all staff to enable access.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff reported that they were given time and were supported to develop. Managers made sure staff received any specialist training for their role. We were given examples of how staff had attended additional training to develop.

Good

Outpatients

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. We were given examples of patient pathways and how they included MDT meetings and discussions. Following the outpatient appointment, if necessary, patients were referred to the preadmission team who assessed the patient's suitability to be treated at the main Spire Bushey hospital site. We were told that MDT meetings were inclusive, and all opinions were taken into consideration when planning care.

Patients could see all the health professionals involved in their care at one-stop clinics. For example, patients attending an appointment could also attend the diagnostic imaging department for further tests, and staff completed blood testing and swabbing at the same time to prevent repeated attendances.

Staff worked across health care disciplines and with other agencies when required to care for patients. We were given examples of where patients had not been suitable for their planned procedure at the hospital and how these patients were discussed with peers from the local acute hospital trusts. Staff also told us how other agencies/ speciality staff could be accessed to gain support for more complex patients.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including diagnostic tests. The service was available from 8am to 9pm Monday to Fridays, 8am to 2pm on Saturdays and 9am to 1.30 pm on Sundays. However, staff did report that they occasionally started at 7.30am to meet the needs of the patient and consultant's availability.

Clinics had been extended to offer weekend slots due to the recent increase in activity. Staff told us they were as flexible as possible to meet the demands on a service and to meet patients' needs and availability.

Outside these hours, patients could access support or advice through the hospital site who had a doctor available 24 hours per day. If necessary, patients could attend the hospital for treatment or diagnostic testing.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw that patients were regularly offered support to live healthier lives. This included signposting to smoking cessation and prompts for reducing alcohol consumption.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service audited consent forms to ensure that they were completed fully, detailing potential risks, the procedure planned and that they were signed and dated. Consent was discussed within outpatient appointment for treatments or procedures completed within the department. Hospital data shows that 96.7% of consent forms were completed in line with best practice.

Good

Outpatients

Staff clearly recorded consent in the patients' records. Consent forms for all procedures completed in outpatients were completed at the time and reflected discussions of risk. Staff were able to describe conversations and processes for ensuring consent was gained prior to treatments.

Staff ensured that there was the required cooling off period for patents who wished to undergo cosmetic surgery.

Are Outpatients caring?

Good

This was the service's first inspection. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We were told that appointments were designed to enable sufficient time for discussion and questioning.

Patients said staff treated them well and with kindness. We spoke with four patients or relatives who told us that they had excellent experiences in the service.

Staff followed policy to keep patient care and treatment confidential. All information was kept securely, with medical notes in rooms with doctors and any expected patient lists, covered in files. All discussion were held in rooms which prevented unauthorised persons overhearing key personal information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We were given examples where patients with a past medical history of a mental health condition were discussed sympathetically, resulting in consideration for a procedure at the hospital. Staff told us that the patient would have been transferred to an acute hospital for their procedure if staff had not identified coping mechanisms to enable the patient to be safely treated on site. The reported outcome was positive for the staff and patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service provided care and treatment for a diverse population and employed staff from a number of different cultures or religions. Staff expressed that they were able to meet the demands of patients through understanding of their needs from discussions.

Emotional support

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

Good

Outpatients

Staff gave patients and those close to them help, emotional support and advice when they needed it. Following the COVID-19 outbreak, the service had reduced the number of people attending the department, and discouraged patients from bringing companions with them. However, we were told that staff understood that this caused anxiety with patients, and where necessary this could be wavered to enable a relative or friend to join the patient for their appointment.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Difficult conversations were generally completed by the consultants; however, nursing staff were asked to accompany doctors when holding difficult conversations. We were told that staff took their time to explain news to ensure that it was fully understood.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us time was taken to ensure that patients fully understood their options and next steps.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff told us that they explained treatment and plans clearly with patients and / or their relatives. Staff extended appointments where necessary to ensure patients fully understood what was happening.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used plain language to ensure patients understood what was happening. Patient we spoke with reported clear communication, and we observed staff being friendly and considerate when speaking to patients and their relatives.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information was collected following appointments about patients' experiences. This was used to make any changes to the service.

Patients gave positive feedback about the service. We saw that feedback was largely positive detailing that the service had been 'excellent'.

Are Outpatients responsive?

Good

This was the service's first inspection. We rated it as good.

Service delivery to meet the needs of local people

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

Good

Outpatients

Managers planned and organised services, so they met the changing needs of the local population. Following COVID-19 the service had seen an increase in activity. The service had increased opening hours to enable patients to access clinics later in the day and at weekends to meet demands.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Patients attending the clinic were able to see other services while attending the centre. Blood testing, swabbing and diagnostic imaging were available on site along with a pharmacy which provided prescription and non-prescription medicines.

Facilities and premises were appropriate for the services being delivered. Consultation rooms were large enough to enable patients and clinicians to attend. Each room had an examining couch which meant that any physical examinations could be completed in the same room, these were screened by curtains from any escorts. Chaperones were also offered for any patient attending appointments on their own, who may require a physical examination.

Managers monitored and took action to minimise missed appointments. We saw that patients were sent reminders of appointments and were able to make appointment to suit their homelife. Missed appointments were minimal.

Managers ensured that patients who did not attend appointments were contacted. Following a missed appointment, the team would contact patients to identify why they had missed their appointment and offer an alternative slot.

The service relieved pressure on other departments when they could treat patients in a day. The service provided some clinical procedures, which were planned in advance to prevent repeated attendances. Staff told us that patients usually attended a consultation appointment and were then offered a date/ time for their procedure to be completed within one week. This enabled patients to prepare for their tests.

Meeting people's individual needs

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

Patients requiring additional support were not generally treated at the hospital although those requiring some additional support were offered longer appointments for additional explanations, or familiarisation with the service. This was arranged following initial discussions at the booking phase of the appointment.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Where necessary additional support was used to facilitate an attendance at the department or an admission to hospital. Patients that had a diagnosis of dementia, or a severe learning disability were not routinely treated at the service, due to the complexity of their care requirements. However, each patient would be assessed prior to decisions being made.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff did not permit relatives to act as translators, and telephone interpreters were used when an in person interpreter could not be identified for appointments.

Good

Outpatients

All clinic and treatment rooms were suitable for use by patients attending who required walking aids. There were low level reception desks, and a lift for use. Public toilet facilities were available for those requiring walking aids or wheelchairs, and there was ample disabled parking close to the entrance.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, were minimal.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. We were told that once a patient had attended their outpatient appointment, and preoperative assessment, admission to hospital was usually planned within a week. Procedures could be flexed according to the doctor's availability and in line with the patients plans. There were no waiting lists for outpatient appointments, as patients were allocated an appointment as soon as they were referred to the service. This was usually to suit their needs and availability and therefore not an official 'waiting list'.

Data provided showed that there were between 2109 and 2562 new outpatient appointments each month from April to September 2021. There were also 2492 to 3118 follow up appointments each month for the same period.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. Nursing staff told us that there were hardly ever any cancellations. We saw that there was one occasion in the three months preceding the inspection where a clinic had been cancelled due to changes to the consultant's availability.

The service monitored clinic running times and cancellations. For April to September 2021, there were 19 clinics where appointments were delayed by up to 30 minutes. This affected 58 patients which was an improvement on the previous six months. Patient satisfaction data showed that 74% of patients thought their appointments ran to time, 12% felt they were late by up to 15 minutes, 11% felt that appointment ran up to 30 minutes late and 3% felt their appointment were delayed more than 30 minutes. These percentages were similar to other hospitals within the Spire group. Any delays to appointments (over 30 minutes) were also recorded as incidents and investigated. Data showed that there were ten reported delays as incidents for the same period. Staff told us that any consultant who regularly had delays in clinics, were escalated to the management team for, if necessary, a review.

The service monitored the did not attend (DNA) rates for the service and had a process in place to follow up on all non-attendances. Data showed that there had been minimal DNAs for the service with 80 reported for April to September 2021. The DNAs were largely low numbers each month, however we saw a peak of DNAs in August 2021 with 26. All but one DNAs received a follow up call to identify reasons and to arrange an alternative appointment where necessary. The total DNAs was below 6% of all appointments each month.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge plans would be discussed as part of the preparation for theatre, with staff informing patients of the expected number of nights in hospital, recovery period and any impact on their wellbeing. For example, patients attending for knee surgery, were informed of the follow up appointments and need for physiotherapy following discharge from hospital, prior to attending for the procedure.

Learning from complaints and concerns

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

Good

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. Hospital data showed that there had been 14 complaints for the hospital in August 2021, three related to outpatient services. Two of these referred to the conduct of a nurse or consultant during an appointment, and one referred to a cancelled appointment. Investigations were conducted where necessary to identify what had occurred and actions taken to prevent reoccurrence.

The service clearly displayed information about how to raise a concern in patient areas. Posters were displayed asking for feedback about services.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would escalate any concerns to the nurse in charge or manager if available. We saw how staff discussed any concerns flagged at team huddles and briefing sessions to ensure all staff were aware of events and any lessons learnt.

Managers investigated complaints and identified themes. We were told there were not any themes around outpatient appointments. Any concerns regarding treatment plans were discussed with the consultant directly.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw that complaints were discussed at team meetings and across the organisation if appropriate.

Managers shared feedback from complaints with staff and learning was used to improve the service. Any concerns were flagged at daily local and hospital wide safety huddle meetings. We saw how staff shared positive and negative feedback and recognised where staff had acted to address concerns raised. We observed staff being informed of a complaint the night prior to the inspection and how this had been witnessed by another patient. The witness reported how positively staff had interacted with the complainant.

Are Outpatients well-led?

Good

This was the service's first inspection. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The service was managed by the leadership team at Spire Bushey hospital. Leadership consisted of the hospital director, supported by the director of clinical services, operations manager, head of business development, finance and commercial manager and the head of people. They were further supported by the deputy director of clinical services, theatre manager, a governance team and heads of departments. Clinical leadership was provided by an interim Medical Advisory chair (MAC). This structure had been reviewed in the last six months and extended to include the deputy director of clinical services.

We saw that the head of business development was based at the diagnostic centre to offer senior leadership and support. We were told that the hospital director attended on a rolling rota at least one day per week and that all the leadership team were regular visitors to site. The deputy director of clinical services was temporarily based on site due to project work being completed. Staff confirmed that the deputy and director of clinical services were frequently available on site and met with staff regularly.

Good

Outpatients

Local heads of departments (HoDs) managed their teams across both sites. Some of the team members also worked across both sites depending on activity. Staff told us that they did not feel isolated from the hospital team and that they felt included in all activities and events held at the hospital site. Staff said that the leadership team were accessible.

HoDs were visible and accessible, and staff reported that they felt comfortable in escalating concerns to any senior member of staff. They also reported that they felt confident that action would be taken when they escalated concerns.

Although senior leadership had undergone changes, heads of departments remained the same and staff felt that there was some stability within the team. Staff told us that the changes to the leadership team had refreshed the team, and there was a new focus. Staff told us the leadership team were focused on ensuring patient safety, and as a result was reviewing pathways and services.

Staff spoke positively of the service and senior leads. We saw positive interactions between staff which demonstrated that there was regular contact between staff groups and levels. Leads and senior leads knew staff by name and engaged in conversations which demonstrated that they knew their team well. For example, we saw staff asking how family members were and thanking them for work that had been completed.

Service leads and senior leads had open door rules and encouraged staff to 'drop in' if they wanted to talk about anything.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood them and monitor progress.

The service followed the Spire Bushey clinical strategy which had been reviewed in 2021 and was focused on 'making a difference to patients' lives through outstanding personalised care'. There were three key areas of focus which included clinical quality, patient safety and medical and clinical governance. All staff we spoke with could refer to the strategy and spoke about the drive to improve patient safety and experience.

Culture

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

Staff we spoke with were positively about their roles and enjoyed working for the organisation.

Staff were positive about their jobs and worked collaboratively with their peers. We saw that staff adopted practices to support each other when activity increased ensuring tasks were completed in a timely manner. There was a full team focus, with nurses and healthcare assistants working collaboratively with reception staff, housekeeping and other non-clinical staff to communicate about patients and caseloads.

We were told that there had been an improvement in the transparency of services since leadership had changed. Staff felt more comfortable raising any concerns and staff generally felt that something would happen if they escalated concerns.

Staff also felt encouraged to develop and told us they were given opportunities within the organisation or externally if possible, to develop new skills or gain knowledge.

Good

Outpatients

The service participated in the annual staff and touch point surveys. Data showed that outpatient's staff were largely positive and had improved since the 2020 survey. The survey result showed that staff were proud to work for Spire and felt positive about succeeding together.

Governance

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

There was a robust governance structure. There was a variety of meetings which fed into one of three committees. For example, clinical audit and effectiveness and infection prevention and control fed into the health and safety and clinical governance committees. This enabled the escalation of any issues or concerns to the senior leadership team and from the 'floor to board'. Each of the three committees reported into the senior management team meetings. We saw that each meeting was clearly minuted and actions recorded. There was a clear pathway of escalation to the senior leadership team and the wider Spire organisation. Spire followed the same reporting structure which enabled oversight of all services and a standardisation of information.

Medicines advisory committee meetings were held quarterly and attended by the senior leadership team and a selection of consultants from each speciality. The meetings would review performance and discuss any safety issues, any requests for new membership or new procedures.

There was clear evidence that policies and forms/ templates used by the service were reviewed, updated and replaced at regular intervals. The governance team had oversight of all templates used and when they were due for review. All policies and templates were reviewed and approved prior to use.

The governance lead had oversight of all risks, incidents, complaints, as well as operational governance such as policy reviews. The team produced a quarterly performance report which covered all areas of governance including, compliance with targets and audits, details of serious incidents and actions taken, incidents and near misses reported, infection control rates, and patient satisfaction scores. The reports were discussed at the governance and performance meetings, and staff were held to account by the senior leadership team.

The governance team also produced governance messages weekly. We saw that these covered any relevant topic and were used to either promote something, such as a new policy or training, or to share information, such as accessing emails, and accessing policies. Staff within the service were familiar with the reporting framework and attended meetings when necessary to keep informed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was an extensive audit programme which monitored compliance against standards. We saw that there were three outpatient specific audits which included physiotherapy documentation, surgical safety checklist- observational audit and the cosmetic surgery cooling off period audit. There was a set criteria for each audit and staff were expected to complete a specified number of reviews each month. In addition to the outpatient specific audits, staff completed the infection control and prevention audits, such as cleanliness, asepsis, hand hygiene and sharps audits. We were told that audit results were reviewed by heads of department and the deputy/director of clinical services at regular intervals.

Good

Outpatients

There was a risk register for the diagnostic centre, and a high level risk register maintained by the hospital leadership team. Once identified, risks were graded according to their potential harm/ risk. Any risks graded equal to or over eight (significant risk) were escalated to the high level hospital risk register for additional scrutiny and oversight, with risk scores lower than eight being managed by the departmental teams. The local register included all risks, including those which had been escalated. We saw one risk added to the hospital risk register (score of 12) which related to the age of equipment in the department and the potential risk to information storage. Local risks included the impact of supply disruption for blood sample bottles, and manual handling risks for staff. Staff we spoke with were familiar with the risks and added concerns regarding staffing.

A dashboard was used to compare performance indicators locally and across the Spire group. We saw that performance for outpatients was generally within target. For example, risk assessments in outpatients was reported as completed 100%, against a target of 95%.

Heads of department (HoDs) were held responsible and accountable for their department. We were told that HoDs had regular performance meetings with the senior leadership team to review performance, compliance, staffing, and any concerns.

Information Management

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

Information systems enabled staff to complete appropriate analysis of data and compare results with peers and identify trends. Staff reported that data was of a good quality and enabled them to complete the tasks in hand.

Staff knew how to escalate information internally and externally and felt that systems were in place to facilitate that.

Staff completed general data protection regulation (GDPR) and information governance training and were familiar with how to maintain information security.

Engagement

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

The service completed monthly satisfaction surveys. Data from August 2021showed that 87% of patients attending the outpatient services had a good or very good experience, which was in line with the organisations average. The same survey showed that 86% of patients would choose the hospital again and 74% said they were seen on time or within 15 minutes of their planned appointment.

The service had a closed social media group which was used to share information. Staff reported that this was a good way of catching up with any changes or with seeking support or cover. The service also used newsletters to keep staff informed.

Where possible, the service worked with nearby organisations to ensure patient care and treatment. On occasion, staff had referred to local services to gain support for patients or refer to them due to being inappropriate for the service.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

This was the first time we have rated this service. We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory and statutory training was provided by a combination of e-learning and face-to-face training sessions, including adult and paediatric basic life support, infection prevention and control, fire safety, manual handling, health and safety, equality and diversity, safeguarding children and vulnerable adults, information governance, compassion in practice and conflict resolution.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a training matrix with a 'traffic light' system which would alert the manager and the staff when training was due to be completed.

At the time of our inspection, 96% of staff had completed their mandatory training against a target of 95%. Staff who were non-compliant had recently started working for the service.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training. Records showed that 96% of staff had completed adult safeguarding training and 94% of staff were also compliant with children safeguarding training at level two and three. All clinical staff completed level 3 training for both children and adults safeguarding. This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) and the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

Good

Diagnostic imaging

The service had a safeguarding lead with level 4 adult and children safeguarding training. All staff we spoke with knew who the safeguarding lead was and how to contact them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. Staff were aware of their responsibilities to protect vulnerable adults and children.

The service had a safeguarding children and vulnerable adult's policy including guidance on female genital mutilation (FGM). The safeguarding policy contained definitions of abuse, signs of potential abuse and the definition of FGM. The policy contained up to date contact details for the local authority and clear guidance on the process staff should follow if they suspect abuse or harm. Staff had access to the safeguarding policy on the electronic shared drive

The service had a named safeguarding lead who was trained to level three safeguarding adults and children.

The service had an up to date chaperone policy. Staff were available for any patient requiring or requesting chaperoning.

Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Examination couches, chairs and pillows had wipeable covers and we saw disinfectant cleaning wipes being used to clean after every patient.

The service generally performed well for cleanliness. The service undertook a monthly infection control environmental audit to check compliance with the infection control and prevention policy. The audit results from October 2020 to September 2021 demonstrated compliance above the 95% target for all months except October 2020 which was below target at 86%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All areas were visibly clean and well maintained. Each area of the imaging department had a daily checklist for cleaning, and all were completed fully.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE such as disposable gloves and aprons were readily available for staff to use.

Hand washing posters were in appropriate areas, demonstrating best practice hand washing techniques. We observed staff were bare below the elbows even when not working clinically. Bare below the elbow national guidelines are for all staff working in healthcare environments to follow to reduce the risk of cross contamination between patients.

We reviewed hand hygiene audit results from October 2020 to September 2021. The results for October and December 2020 were non-compliant at 94% and 79% respectively, against the providers' target of 95%. We saw actions were added

to the electronic audit system and reminder emailed to team leads with any overdue actions on a weekly basis. The audit results and the actions put in place to improve staff compliance were shared at the team meetings. Actions taken in response to these audits resulted in improved compliance between January 2021 and September 2021, and 100% compliance was achieved in April, June, July and September 2021.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. In line with the government guidelines for Covid-19 the service performed enhanced and more frequent cleaning of surfaces to prevent transmission of the virus. This included increasing the frequency of cleaning of both the environment and equipment in patient areas, including frequently touched sites/points and shared communal facilities.

Environment and equipment

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

The design of the environment followed national guidance. The layout of the unit was compatible with health and building notification (HBN06) guidance.

The imaging department was located on the ground floor of the two-storey purpose-built facility.

The service had suitable facilities to meet the needs of patients' families. The reception area provided ample waiting area and toilet facilities for patients and their relatives

The service had enough suitable equipment to help them to safely care for patients. The fringe fields around the magnetic resonance imaging (MRI) scanner were not clearly displayed as per Medicines and Healthcare products Regulatory Agency (MHRA) Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use (February 2021). We were told by the deputy manager of imaging that onsite engineers had the plots and as the MRI room was large the, fringe field was noted to be inside the room. All staff we spoke with were aware of the fringe field. The fringe field is the outer magnetic field outside of the magnet core. This reduces the risk of magnetic interference with nearby electronic devices, such as pacemakers. Although the strength of the magnetic field decreases with distance from the core of the magnet, the effect of the “fringe” of the magnetic field can still be relevant and have influence on external devices.

This was feedback to managers and following the inspection the we were told that the MRI fringe field was marked and displayed as per guidelines.

There was sufficient space for staff to move around the scanner and for scans to be carried out safely. During scanning, all patients had access to an emergency call / panic alarm, ear plugs and ear defenders. Patients could have music played whilst being scanned. There was a microphone which allowed contact between the radiographer and the patient at all times.

In accordance with MHRA guidance, the MRI room was equipped with oxygen monitors to ensure that any gas leaking, for example liquid nitrogen or liquid helium would be identified. This ensured that oxygen levels remained safe not compromising patient safety.

An MRI safe wheelchair and trolley were available for patients in the event that they would need to be transferred from the scanner in an emergency. Unauthorised access was restricted. We saw warning signs and lights in use on the day of our inspection, all areas were monitored and had oversight from the reception staff.

Good

Diagnostic imaging

All relevant equipment in the MRI unit was labelled in accordance with MHRA recommendations. For example, 'MR Safe' or 'MR Unsafe' to indicate that these pieces of equipment were safe or unsafe to use in an MR environment as per the MHRA safety guidelines for magnetic resonance imaging equipment.

The x- ray room was accessed off the main reception. The room where radiation exposure took place was clearly marked with warning signs and lights.

Lead screens were in place to protect staff from radiation. These were checked on an annual basis by the service's medical physics expert.

Lead aprons were available for use if required and were subject to regular integrity checks by the service's medical physics expert.

Staff working within areas exposed to radiation wore dosimeters. A dosimeter is a device that measures exposure to ionising radiation.

All equipment conformed to relevant safety standards and was regularly serviced. All non-medical electrical equipment was electrical safety tested.

There were systems in place to ensure repairs to machines or equipment were completed and that repairs were timely. This ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use.

Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme.

During our inspection we checked the service dates for equipment, including scanners. All the equipment we checked was within the service date. The generators were also tested monthly on a planned schedule to ensure patient scanning was not affected.

Scales for weighing patients in the MRI unit did not have a calibration sticker or service. We escalated this to the managers and following the inspection we were told the weighing scales were calibrated on 30 September 2021.

Resuscitation equipment was available in the imaging department located by the reception area near the x-ray and ultrasound rooms. The resuscitation equipment was visibly clean, serviced and tagged to indicate whether equipment had been tampered with.

Staff carried out daily resuscitation equipment checks. We reviewed the records for resuscitation equipment checks from July to September 2021, and these were completed accordingly.

Staff disposed of clinical waste safely. Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.

Sharps management complied with Health and Safety and the Sharp Instruments in Healthcare Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.

Good

Diagnostic imaging

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on arrival, using a recognised tool. For example, the service used a magnetic resonance imaging (MRI) patient safety questionnaire. Risks were managed and updated in line with any change in the patient's condition. Patients referrals were checked at the point of referral for any potential safety alerts that required further investigation.

Processes were in place to ensure the correct patient received the correct radiological scan at the right time. The service did have a Society of Radiographers (SoR) 'pause and check' poster within the unit. The posters were used as a reminder for staff to carry out checks on patients.

We saw staff checking three-points of demographic checks to correctly identify the patient. Completing the 'pause and check' provides assurance that the radiographer used the correct imaging modality, the correct patient and correct part of the body was scanned. Using the 'pause and check' also decreases the number of wrong site scans.

In the event of an emergency, there were procedures in place for removal of a collapsed patient from the MRI scanner. Staff told us of a practice evacuation of a patient from the MRI in the last 12 months. Staff were confident in their explanation of what they would do in the event of having to remove a patient from the scanner in an emergency.

Staff responded promptly to any sudden deterioration in a patient's health. There were clear pathways and processes for staff with regards to people using the service who became unexpectedly unwell or if an unexpected result was found during the scan. If a patient required urgent treatment staff told us they would call 999 for an emergency transfer to the local hospital.

All staff completed adult and paediatric basic life support (BLS) training. At the time of our inspection 91% of staff were compliant with adult BLS training and 84% were compliant with paediatric basic life support training, against a compliance target of 95%. Managers told us that staff who were non-compliant with their BLS training, of which there were five, had already been booked to the next available training slot.

Staff we spoke with explained the processes to escalate unexpected or significant findings both at the examination and upon reporting. In accordance with Spire policy, the service has a pathway for unexpected urgent clinical findings. Once the report was received, an email was sent to the referrer to highlight an urgent report. In addition, the team also contacted the referrer by phone to inform them an urgent report had been sent. All images would be sent to the referrer urgently via the image exchange portal to assist in patient management.

The service had a radiation protection advisor (RPA) and medical physics expert (MPE) supplied through a service level agreement (SLA). We reviewed the SLA and noted it was in date. All staff described the RPA and MPE as responsive and contactable.

The service had a nominated radiation protection supervisor (RPS) in post. The RPS ensured compliance with the Ionising Radiations Regulations 2017 (IRR17) in respect of work carried out in an area which is subject to Local Rules.

Local rules were in place to ensure the health and safety of patients and staff in areas where ionising radiation was in use. Details of the RPS and RPA were included in the local rules, which was in line with the Ionising Radiations Regulations 2017 (IRR 17).

Good

Diagnostic imaging

Clear signage was in place to warn patients of areas where radiation exposure took place, therefore, preventing unrestricted access.

Each imaging area contained an emergency alarm cord in the event of emergency or patient collapse.

Staff had access to a medical physics expert in the event of advice being required regarding diagnostic reference levels (DRLs). DRLs are a tool to optimise levels of radiation.

Pregnancy status was routinely checked prior to any imaging taking place. Staff confirmed the patients name, date of birth and address, confirmation of pregnancy status, and ensured the patient had read information on the procedure to be carried out. We saw these checks being carried out on the day of our inspection.

Staffing

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

The service had enough staff to keep patients safe. Staffing levels were planned and reviewed in advance to ensure that an adequate number of suitably trained staff were available for each clinic.

The manager could adjust staffing levels daily according to the needs of patients.

The number of radiographers, health care assistants, and reception staff matched the planned numbers. We reviewed the planned versus actual rota for September 2021 the number of staff on duty were as planned.

Managers made sure all bank and agency staff had a full induction and understood the service. The service utilised a pool of bank and agency radiographers. Bank staff were offered the same training as regular staff and competencies were monitored.

In the three months prior to September 2021, a total of 14.2% shifts had been carried out by bank and agency staff. This included 9.7% of shifts for x-ray radiographers and 4.4% shifts for MRI radiographers' assistants.

The service had low vacancy rate. Managers told us that they had recruited one radiographer who would be starting in October, which meant there was only one whole time equivalent vacancy for the department.

The service had reported a low sickness rate for clinical staff. This was between 0.9% and 3.5% from July to September 2021.

The service had set minimum staffing requirements for all sessions. This included one receptionist, two radiographers and a clinical assistant. Which meant there were always suitably skilled and qualified staff available .

Medical staffing

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

The service had enough medical staff to keep patients safe. All reporting radiologists worked for Spire through practising privileges. The ultrasound service was led by consultant radiologists that also worked under practising privileges.

Good

Diagnostic imaging

Records

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

Patient notes were comprehensive, and all staff could access them easily. Patients completed a safety consent checklist form consisting of the patients' answers to safety screening questions and recorded the patients' consent to care and treatment. This was later scanned onto the electronic system and kept with the patients' electronic records.

Records were stored securely. Patients' personal data and information were kept secure. Only authorised staff had access to patients' personal information. Staff training on information governance was part of the mandatory training.

Prior to completing a scan, staff confirmed that the patient had consented. Once the scan was completed, staff submitted the images to a radiologist for reporting.

We reviewed 10 patient records during our inspection and saw records were accurate, complete, legible and up to date.

The service provided electronic access to diagnostic results and could share information electronically if referring a patient to a hospital.

The service used radiology information system (RIS), picture archiving and a communication system (PACS) to load the images for the scans and for radiologists to report and transfer to the referring clinician. Both these systems were secure, and password protected. Each member of staff had their own password to access the information system.

The service had an up-to-date policy for records management and information lifecycle. The policy provided staff clear guidance on the storage, retention period and destruction of records according to current information and data protection guidance.

Medicines

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

Staff followed systems and processes when safely administering, recording and storing medicines. The service only used medicine for ultrasound guided joint injections. These included steroid and local anaesthetic injections which were stored in a locked cupboard in the ultrasound scanning room.

Medicines were not used in other parts of the diagnostic imaging department due to the centre having a remit to provide scanning for low risk patients. The service did not use contrast media (MRI contrast media, agents or 'dyes'). These are chemical substances used in some MRI scans. A patient that required the use of contrast would be referred to the main Spire Bushey Hospital.

Incidents

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

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents, and investigate and record near misses. Staff reported incidents using an electronic reporting system.

Good

Diagnostic imaging

Staff reported serious incidents clearly and in line with provider policy. An up-to-date incident reporting policy and procedure was in place to guide staff in the process of reporting incidents.

There were no never events reported for the service from August 2020 to September 2021.Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

In last 12 months, there were no serious incidents reported for the service. Serious incidents are events in health care where there is potential for learning, or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.

The service reported five incidents from June 2021 to September 2021. These incidents were subcategorised as cancellation, delayed waiting time and documentation error.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with could tell us their understanding of the requirements of the duty of candour regulation.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents was shared with staff at daily safety huddle, team meetings, by email and through the weekly 'Feedback Friday' newsletter.

Staff used a specific form to record and report radiation doses greater than the intended dose. The service had a named radiation protection advisor (RPA) who would review any incidents relating to radiation. There had been no radiation incidents in the 12 months prior to our inspection.

National patient safety alerts (NPSA) that were relevant to the unit would be communicated by email to all staff and through the feedback Friday bulletin.

Are Diagnostic imaging effective?

Inspected but not rated

This was the first inspection for this service. We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed policies, procedures and guidelines information, which referenced guidance from professional organisations such as the National Institute for Health and Care Excellence (NICE), Medicines, the Healthcare Products Regulatory Agency (MHRA) and the Department of Health (DoH).

Good

Diagnostic imaging

Patients care and treatment was delivered, and clinical outcomes monitored in accordance with guidance from the National Institute for Health and Care Excellence (NICE). NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions.

The service had local rules based on national guidelines. We found the local rules provided clear guidance on areas relating to hazards and safety and the responsibilities of staff to ensure work was carried out in accordance with the local rules. The MRI and X-ray unit had its own local rules with a suitable review date. All local rules were all in date.

The provider had an audit plan in place. Local audits were completed monthly, quarterly and annually to assess clinical practice in accordance with local and national guidance. Topics audited included infection and prevention control, patient experience, waiting times, report turnaround times, image quality assurance and quality of referral form.

Nutrition and hydration

Due to the nature of service provided, food was not routinely offered to patients. Patients had access to water and hot drinks whilst waiting for their scan. During our inspection, we observed staff offering patients drinks before and after they were scanned.

Pain relief

Staff assessed and monitored patients regularly to see if they were in any pain during the procedures. We saw staff frequently asking patients if they were comfortable during their procedure.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. An annual local audit plan was in place and used to drive service improvements. Some of the areas audited included radiation protection supervisor (RPS)/ Ionising Radiation (Medical Exposure) Regulations (IRMER) report, pause and check, rejected images, quality assurance and radiation badge. The results of these audits and any issues thatwere identified were fed back to the radiologists and radiographers and the service used it for quality assurance purposes and learning and improvement.

Audit data for quarter two 2021 showed 100% compliance for the WHO observational checklist, pause & check, imaging quality assurance and quality of post examination documentation. For the same reporting quarter quality of referral form was 99% compliant and reporting of turnaround times was 98% complaint.

The service had an infection prevention and control (IPC) audit programme which included, hand hygiene & environment, sharps audit and PPE assurance. Data for quarter one and two 2021 showed that the service was 100% compliant with the IPC audit programme.

Patient feedback was captured through the friends and family test (FFT) survey. Details on how to give feedback was displayed on notice boards throughout the clinic. Managers told us that patient feedback was reviewed monthly and shared at staff meetings and through the feedback Friday bulletin. Any dissatisfied patients, if they left their contact details, would be contacted and they would resolve the issues raised. We noted the majority of feedback was positive.

Managers shared and made sure staff understood information from the audits. The results from the audits were discussed at governance meetings and shared with the wider team for learning and action.

Good

Diagnostic imaging

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff skills were assessed as part of the recruitment process, at induction, through the probation period and then ongoing as part of the continuous professional development (CPD) process.

Managers gave all new staff a full induction tailored to their role before they started work. All staff received a local and corporate induction and completed an initial competency assessment. Staff we spoke with told us the local induction provided assurance that staff were competent to perform their required role. For clinical staff, this was supported by a comprehensive competency assessment toolkit. This covered key areas applicable across different staff roles including equipment and clinical competency skills relevant to their role and experience.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the service showed that 100% of staff had completed an appraisal in the last 12 months prior to the inspection.

Performance of radiographers was monitored through peer review and quality audit. Any issues were discussed in a supportive environment. Radiologists fed back any performance issues with scanning to enhance learning or highlight areas of improvement in individual radiographers' performance.

All radiographers employed by the service were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients.

Multidisciplinary working

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

Staff told us that they worked closely with other providers who referred patients to their service to provide a seamless treatment pathway for patients.

Staff told us there was good communication between services and there were opportunities for them to contact other providers for advice, support and clarification.

The service had systems and processes in place to communicate and refer to the local hospitals or the referring clinician in the event of further examination and or treatment being required. We saw evidence that reports to other healthcare professional took place in a timely manner.

Seven-day services

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

Appointments were flexible to meet the needs of patients, and appointments were available at short notice.

The Spire Bushey Diagnostic Centre operated six days a week and the service operated from 8am to 9pm Monday to Friday and 8am to 6pm on Saturdays. If patients required a Sunday appointment, then they were given appointment at the Spire Bushey Hospital site.

We were told that a senior manager was available in an on-call capacity out of usual office working hours.

Good

Diagnostic imaging

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. In line with COVID-19 guidelines all patient leaflet had been removed from display and signs to ask the reception staff for any patient leaflet was clearly displayed.

Information leaflets were provided for patients on what the scan would entail and what was expected of them prior to a scan. The service also provided information to patients on self-care following a scan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff we spoke with understood the requirements of the Mental Capacity Act 2005. Staff complete an e-learning course on the Mental Capacity Act as part of the safeguarding training module.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed 10 patient records which demonstrated that written documented consent was obtained prior to the patient's procedure.

Staff made sure patients consented to treatment based on all the information available. All staff we spoke with were clear in their responsibilities with obtaining and documenting consent.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. Gillick competency is often used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Staff were aware of children's consent procedures. The service had a paediatric consent form for under 18-year olds.

Are Diagnostic imaging caring?

Good

This was the first inspection for this service. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff treating patients with dignity, courtesy and respect. We observed that staff introduced themselves prior to the start of a patient's imaging scan, interacted well with patients and included them during general conversation.

Patients said staff treated them well and with kindness. Patients we spoke with described staff as caring and kind.

Good

Diagnostic imaging

Staff ensured that patients' privacy and dignity was maintained during their time in the diagnostic centre and during scanning. Patients had designated changing rooms and were provided with a gown if required in the changing room. Staff ensured patients were covered as much as possible during procedures to preserve their modesty and dignity.

Patient feedback was consistently positive. We reviewed the patient experience survey friends and family test (FFT) for quarter one and two, where 97% and 95% of patients respectively responded that they had a very good or good experience of the service. Staff told us negative comments were scrutinised for opportunities to drive improvement in the service which included changes to premises, staff training or patient information.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported people through their scans, ensuring they were well informed and knew what to expect.

Staff provided reassurance and support for nervous, anxious, and claustrophobic patients. They demonstrated a calm and reassuring attitude so as not to increase patients' anxiety.

We observed staff provide ongoing reassurance throughout the MRI scan, they updated the patient on how long they had been in the scanner and how long was left. Patients also had a panic button they could press any time during the scan to summon help. Staff could stop the scanning immediately if the patient requested this.

Patients had a choice of music to listen to during the MRI scan which was played through headphones. This helped to disguise the noise the scanners made which could cause anxiety for some patients. Earplugs were also available which protected their ears and helped to reduce the noise.

We reviewed patient feedback from quarter one and two of 2021, and comments included, 'put me at ease and explained everything they were going to do', 'I felt very welcome which made me more at ease', 'staff were professional and efficient, whilst still being friendly and helpful'. 'kind and reassuring', 'staff were fantastic, made you feel at ease'

The MRI room had a special backlit picture ceiling, which features images of a blue sky, clouds and trees to help patients relax and provide a visual distraction.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and procedures. Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included for example, access to interpreting and translation services

We observed that staff answered patients' questions appropriately, and in a way they could understand. Staff explained to patients how and when the results would be sent to the referring clinician.

A range of diagnostic and imaging related leaflets were available to patients. Patients could also access information on MRI scanning and the different types of diagnostic imaging modalities from the Spire Bushey Diagnostic Centre website.

Good

Diagnostic imaging

The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.

Patients and their families could give feedback on the service and their treatment. Throughout the service posters were displayed on how to give feedback and there was also a barcode patients and their families could scan on their phone to give feedback electronically.

Patients gave positive feedback about the service. Friends and family test (FFT) for quarter 1, 2021 showed 97% of patients responded that they had a very good or good experience of the service and for quarter 2 this figure was 95%.

Are Diagnostic imaging responsive?

Good

This was the first inspection for this service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the changing needs of the local population. The service provided evening and weekend appointments to accommodate the needs of patients who were unable to attend during the day on weekdays.

Facilities and premises were appropriate for the services being delivered. Patients were greeted when they entered the service and accessed a comfortable waiting area, there were toilet facilities available for people to use.

There were adequate seating areas within the service, it was well lit, and patients and visitors had access to refreshments. Waiting areas were designed to provide a calm environment to make the patient visit as relaxing as possible.

The service and all areas within the service were accessible to wheelchairs users. This included level access from the car park set down area and automatic entry doors at the main entry as well as entrances to the diagnostic imaging department.

There were ample free car parking facilities for patients to use, with designated disabled parking.

The service's website gave people useful information about the service it provided, its other clinic sites and the referral processes.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Good

Diagnostic imaging

We saw staff making patients as comfortable as possible. For example, for patients having MRI scans they used padding aids, ear plugs and ear defenders to reduce the noise of the procedure. They ensured the patient was in control throughout the scan and gave them an emergency call buzzer to allow them to communicate with staff if they needed to. The MRI scanner had built in microphones to enable a two-way conversation.

We saw patients being advised should they wish to stop their examination, staff then assisted them and discussed choices for further imaging or different techniques and coping mechanisms to complete the procedures.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Where necessary additional support was used to facilitate an attendance at the department.

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

An interpreting service was available for patients whose first language was not English. The staff we spoke to showed good knowledge and awareness of the service and knew who to contact if required.

The service had arrangements to meet the needs of those with sensory impairment. Hearing loops were available in the service, which helped those who used hearing aids to access services.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed. The service did not have any patients waiting for diagnostic imaging appointment for more than 6 weeks. People could access the service when they needed it. Patients were offered a choice of appointment and staff told us that there was no issue with providing appointments in timely way.

The average wait time for imaging across all modalities over the last 12 months was 4.6 days. X-ray's was a walk-in service done on same day with no wait time. Ultrasound requests would be booked in with the preferred radiologists and could at times be done on the same day or within a week. Non urgent magnetic resonance imaging (MRI) scans were booked within a week and if urgent on the same day.

Managers worked to keep the number of cancelled appointments to a minimum. In the last six months the service had six cancelled appointments. Reason for cancellation was varied including equipment break down and wrong referral form.

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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with knew how to make a complaint or raise concerns.

Good

Diagnostic imaging

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

The service reported they had received one complaint between September 2020 and August 2021. The complaints were investigated and responded to in line with the policy. We saw evidence of the changes implemented as a result of the complaint where the imaging referral form was updated to make it clear to patients the type of diagnostic tests being requested and the potential charges.

Staff understood the policy on complaints and knew how to handle them. The service had an up to date concerns and complaints management policy. Staff we spoke with explained how complaints were managed, the responses included an apology to the patient, any lessons learnt from the complaint shared and actions implemented.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was communicated to staff through staff meetings and through 'feedback Friday' staff bulletins.

Are Diagnostic imaging well-led?

Good

This was the first inspection for this service. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.

The diagnostic imaging service was managed by the imaging manager who reported to the director of clinical services. The imaging manager was supported by the deputy manager who was lead MRI radiographer.

At the time of our inspection the imaging manager had resigned, and the deputy manager had stepped up to have oversight of the department's daily operations. Spire's national clinical specialist for imaging supported the team during the transition.

The head of business development for the service was based at the centre, which meant there was always oversight from the senior management team.

Locally the day to day running was led by the deputy imaging manager and the designated leads for each modality.

Staff we spoke with told us that the leaders were visible, accessible, approachable and supportive.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Spire Bushey Diagnostic Centre had a hospital wide purpose which was 'making a positive difference to patient's lives through outstanding personalised care'. To achieve the purpose a strategy was in place which had a focus on clinical quality, patient safety and governance.

Good

Diagnostic imaging

Aligned to the overall hospital strategy, diagnostic imaging had a departmental strategy with three objectives; serve the local community by providing a patient centred service which is safe, responsive and accessible, staff empowerment to challenge consultants and strive to retain and attract the best imaging staff and the latest technology.

The service had a strategy and engagement plan to achieve the objectives and this was shared with staff in various forums. Staff understood the part they played in achieving the objectives of the service and how their actions reflected the organisation's vision.

Culture

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

Staff were consistently positive when describing the culture within the service. They felt supported by all leaders and colleagues within the service. Staff felt respected and valued. All staff we spoke with were very happy in their role and stated the service was a good place to work.

During our inspection we saw that staff interacted and engaged with each other in a polite, positive and supportive manner.

The service promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices.

A whistle blowing policy, duty of candour policy and appointment of freedom to speak up guardians supported staff to be open and honest

There was good communication in the service from both local managers and at corporate level. Staff stated they were kept informed by various means, such as newsletters, team meetings and emails.

The service awarded recognition to staff who had gone above and beyond within their departments. We saw a number of staff from the diagnostic imaging department that had received the award in the last 12 months.

Governance

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

There was an effective governance framework to support the delivery of the strategy and good quality care. The service undertook a number of quality audits, information from these assisted in driving improvement and giving all staff ownership of things which had gone well, and action plans identified how to address things which needed to be improved.

We viewed a number of policies that the service had in place including; consent policy, incident reporting policy, infection prevention and control policy, concerns and complaints management policy, adult and children's safeguarding policy and chaperone policy. All the policies had implementation and review dates, they contained references from national bodies such as the National Institute for Health and Care Excellence (NICE).

Good

Diagnostic imaging

Spire Bushey Hospitals operated a clinical governance and assurance framework which aimed to assure the quality of services provided. At board level quality monitoring was through the clinical governance and safety committee.

Monthly safety, quality and risk committee meetings were held which included clinical assurance directors, medical directors and head of risk across the Spire Imaging sites structure of the service. Senior managers told us that this helps to bring consistency across the Spire imaging sites and support the local imaging steering groups .

The service also had a diagnostic imaging group meeting which consisted of the diagnostic manager, radiation protection supervisor (RPS), national clinical specialist for imaging.

The senior management team had a quarterly meeting. We reviewed the minutes from the May 2021, Operational issues, human resources update, governance, finance and information management and governance were standing agenda items.

All these meetings had a standard agenda and were minuted with an actions log. This ensured the actions to improve services were recorded and monitored to completion.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Performance was monitored on a local and corporate level. Progress in delivering services was monitored through performance dashboard scorecards and reports were produced which enabled comparisons and benchmarking against other Spire services.

The performance dashboard scorecard was updated and reviewed quarterly by managers. The dashboard recorded report turn around, pause and check audit, WHO observational checklist, quality of referral form and post examination documentation and Patient experience.

There was a risk assessment system with a process of escalation onto the corporate risk register. The local Diagnostic imaging risk register was reviewed, updated and new risks added regularly. Each risk had an identified risk handler and actions to reduce the risk. There were review dates for all the risks. We saw examples of risk assessments, all had been completed with adequate information, and updated with any additional measures taken to reduce the risk.

Medical physics and radiation protection advice (RPA) was provided by service level agreement (SLA) with a radiation protection advisor (RPA) from an external NHS trust. The RPA report dated March 2021 found no concerns.

There was a comprehensive business continuity plan detailing mitigation plans in the event of unexpected staff shortages or equipment breakdown.

Information Management

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

All staff had access to the Spire intranet where they could access policies and procedures.

Good

Diagnostic imaging

Staff told us there were sufficient numbers of computers in the centre. This enabled staff to access the computer system when they needed to.

All staff we spoke with demonstrated they could locate and access relevant information and records easily, this enabled them to carry out their day to day roles.

Electronic patient records could be accessed easily and were kept secure to prevent unauthorised access to data.

Information from examinations could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.

Engagement

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

The service completed patient satisfaction survey. We reviewed data from quarter one and two of 2021 which showed 97% and 96% of patients respectively reported a good or very good experience at the service. For the same reporting period 87% and 84% of patients said they were seen on time.

Staff met on a regular basis to discuss service delivery and planning. Meetings were attended by the imaging manager and deputy. The service also used newsletters and email correspondence to keep staff informed of any changes. Staff told us that they used a closed social media group used to share information. Staff said that there was a range of ways to be informed of changes or to seek support senior managers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Spire Bushey Diagnostic centre was part of the corporate wide work to bring consistency of imaging quality standards. This was supported by an imaging steering group which was aligned to the clinical governance structure.