

Spire Parkway Hospital

Quality Report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Outstanding



Are services responsive?

Good



Are services well-led?

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Parkway Hospital opened in 1982 and is operated by Spire Healthcare. The hospital was previously run by an independent hospital group until Spire Healthcare acquired the hospital group in 2007. Spire Parkway Hospital provides medical and surgical care to the residents of Solihull, Birmingham, Warwickshire and further afield, with over 600 GP surgeries referring patients to the hospital in a range of specialities including: orthopaedics, general surgery, ear, nose and throat (ENT), plastics, ophthalmology, urology, gynaecology and cosmetics.

The hospital has 43 beds and facilities include five operating theatres, one specifically for endoscopy cases, an extended recovery unit, two in-patient wards, a day care unit, a specialist cancer centre, and an endoscopy suite. We inspected all services provided including surgery, endoscopy, oncology services, services for children and young people, outpatients and diagnostic imaging facilities.

Services were provided to patients who were self-funding, those covered by private medical insurance and to NHS patients who had been referred by their GP or who had booked via the NHS “choose and book” service. Chemotherapy and children and young people services was not provided to NHS patients.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17 and 18 September 2019, along with an announced visit to the hospital on 26 September 2019.

To get to the heart of patients’ experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people’s needs, and well-led? Where we have a legal duty to do so we rate services’ performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Services we rate

Our rating of this hospital improved. We rated it as Good overall.

We found good practice within the services:

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

Summary of findings

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

We found areas of outstanding practice

- The hospital had a multi faith resource box. This included a prayer mat, various religious texts and scriptures. There was a specific room that could be used as a 'quiet room' for patients and relatives to use when needed.
- Radiology staff had completed home visits for patients with additional needs alongside the Occupational Therapist to describe the process to the patients and their families so they were fully informed, prepared and aware of the procedure to be undertaken.
- A broad range of age appropriate information had been developed for CYP and their families. This included a range of activities, the use of pictorial cards to enhance understanding, information about bullying, safeguarding and supporting CYP with learning disabilities.
- Pharmacy staff had developed personalised leaflets for patients regarding their medicines following joint surgery and for oncology patients.
- Pharmacy staff had robust systems in place to safely manage and comply with medicines in the oncology service which was in line with national best practice.
- A broad range of age appropriate information had been developed for CYP and their families. This included a range of activities, the use of pictorial cards to enhance understanding, information about bullying, safeguarding and supporting CYP with learning disabilities.
- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets those needs, which was accessible and promoted equality.
- The hospital had a comprehensive audit and risk management structure which ensured the service had a transparent approach to the management of risk and the assurance of safety.
- The hospital had gained and held national accreditations such as: ISO accreditation for pathology (ISO certification is a seal of approval from an external body whereby a company complies to one of the internationally recognised ISO management systems), British United Provident Association (BUPA) accreditation for breast care, bowel care, prostate care, and the cancer survivorship programme. The specialist care centre (oncology unit) had been awarded a Macmillan Mark of Quality Environment (MQEM) for achievements in quality for cancer care environment.
- The oncology service was awarded an Exemplar award by the provider's group clinical director and had been recognised for excellent care and service for cancer patients in 2018.

However, we also found the following issues that the service provider needs to improve:

- The service was not carrying out face to face pre-operative assessment appointments for all children and young people, this was not on the hospital risk register.
- Not all records in oncology had a recording of the time they were signed.
- There had been instability in the chemotherapy leadership team during 2019 and an interim manager was in post at the time of our inspection. The culture within the oncology service was variable due to leadership changes and some staff felt unsettled and unsupported.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good 	As surgery was the main inpatient service within the hospital, where arrangements were the same, we have reported findings in the surgery service section. We rated this service as good because it was safe, effective, responsive and well led. We rated caring as outstanding.
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, responsive and well led. We rated caring as outstanding.
Services for children & young people	Good 	As surgery was the main inpatient service within the hospital, where arrangements were the same, we have reported findings in the surgery service section. We rated this service as good because it was safe, effective, caring, responsive and well led.
Outpatients	Good 	As surgery was the main inpatient service within the hospital, where arrangements were the same, we have reported findings in the surgery service section. We rated this service as good because it was safe, effective, caring, and well-led. We rated responsive as outstanding.
Diagnostic imaging	Good 	As surgery was the main inpatient service within the hospital, where arrangements were the same, we have reported findings in the surgery service section. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

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Good



Spire Parkway Hospital

Services we looked at

Medical care (including older people's care); Surgery; Services for children & young people; Outpatients and Diagnostic imaging.

Summary of this inspection

Background to Spire Parkway Hospital

Spire Parkway Hospital is operated by Spire Healthcare Limited. The hospital/service opened in 1982. It is a private hospital in Solihull, West Midlands. The hospital primarily serves the communities of the Solihull, Birmingham, Warwickshire and surrounding areas. It also accepts patient referrals from outside this area.

The hospital has had a registered manager who was approved in post in March 2019.

The hospital has been inspected previously, the last inspection was in November 2018 when we only inspected surgery service. We carried out a full comprehensive inspection in December 2015 and March 2014.

We inspected this service using our comprehensive inspection methodology. We carried out a short announced inspection on 17,18 and 26 September 2019.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manager, five CQC inspectors, an assistant inspector, a CQC pharmacy

inspector and seven specialist advisors with expertise in surgery, paediatrics, outpatients, diagnostic imaging and governance. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Spire Parkway Hospital

Spire Parkway Hospital provides inpatient and day case elective (planned) surgery, endoscopy, oncology services, services for children and young people, outpatients and diagnostic imaging facilities for various specialties both to private and NHS patients. This includes, but is not limited to, orthopaedics, ear, nose and throat (ENT), general surgery, gynaecology, pain management, cosmetic surgery, spinal surgery and urology. It has 43 inpatient beds all with ensuite facilities and a further seven day case beds. The hospital has five operating theatres, three of which have laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). The hospital has 13 consulting rooms and diagnostic imaging facilities, which include magnetic resonance imaging (MRI), X-ray, computerised tomography (CT), mammography and ultrasound scanning. Physiotherapy facilities include seven treatment rooms, a two-bedded bay and gym area.

During the inspection, we visited all departments. We spoke with 65 members of staff including nurses, consultants, healthcare assistants, operating department practitioners, pharmacy staff, pathology staff and senior managers. We observed the environment and care provided to patients and spoke with 30 patients and

relatives. We reviewed 39 patient records and 19 prescription charts. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the hospital's third inspection since registration with CQC, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2018 to June 2019)

- In the reporting period July 2018 to June 2019, there were 2437 inpatient, 5,555 day case episodes of care recorded at the hospital; the majority of these patients were privately funded.
- 12% of all NHS-funded patients and 19% of all other funded patients stayed overnight at the hospital during the same reporting period.
- Two young people aged between 16-17 years were admitted as overnight patients and 17 admitted as day cases. 63 children aged between three and 15 years were admitted as day cases.

Summary of this inspection

- There were 74,181 outpatient total attendances in the reporting period. The majority of these were privately funded.
- 2,415 children attended as outpatients, of these 193 were aged two and under, 1766 were aged between three and 15 years and 456 were aged between 16-17 years.

As of June 2019, 310 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Regular resident medical officers (RMO) operated a 24 hour, seven day a week rota to ensure cover was maintained at all times. The hospital employed 45 full time equivalent (FTE) registered nurses, 27.9 FTE operating department assistants and care assistants and 158.9 FTE other hospital support staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (July 2018 to June 2019)

- Zero Never events
- There was 1010 clinical incidents reported of which 661 no harm, 254 low harm, 89 moderate harm, 3 severe harm, 3 death
- 4 serious injuries were reported, two pulmonary embolism reported, one surgical site infection and one emergency transfer
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- 108 complaints, none of which were referred to the Parliamentary and Health Service Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

Services accredited by a national body:

- SGS accreditation for sterile services
- Macmillan Environment Quality Mark for the Specialist Cancer Centre
- ISO 15189 accreditation for Pathology
- BUPA Accreditation for Breast Care Centre
- Bowel Care Centre, Cancer Survivorship Programme
- Prostate Care Centre
- Paediatrics and Cataract Provider.

Services provided at the hospital under service level agreement:

- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of safe improved. We rated it as Good because:

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. There were processes in place to monitor training compliance.
- 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.
- The hospital controlled infection risk well and used control measures to prevent the spread of infection. Staff kept themselves, equipment and the premises clean.
- The premises, facilities and equipment were suitable and kept people safe. Staff were trained to use equipment and they staff managed clinical waste well.
- Equipment was maintained and well looked after.
- Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Assessments were in place to alert staff when a patient's condition deteriorated.
- The service had enough staff with the right qualifications, skills and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave new and bank staff a full induction.
- The provider managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

However,

- Not all records in oncology were up to date.

Good



Summary of this inspection

- The service was not carrying out face to face pre-operative assessment appointments for all children and young people, this was not on the hospital risk register.

Are services effective?

Our rating of effective stayed the same. We rated it as Good because:

- The hospital provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- The hospital managed patients' pain effectively and provided or offered pain relief when required.
- The provider made sure staff were competent for their roles. Managers appraised staff's work performance
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- The hospital monitored the effectiveness of care and treatment and consistently used the findings to improve them.
- Staff supported patients to manage their own health, care and well-being and to maximise their independence during and following treatment and as appropriate for individuals.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Good



Are services caring?

Our rating of caring improved. We rated it as Outstanding because:

- Staff cared for patients with compassion. Patients were treated with dignity, respect and kindness during all interactions with staff. Feedback from patients was positive about their care and treatment. We saw staff were friendly, kind and caring and responded quickly and compassionately when patients called for assistance.
- Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- Patients were communicated with and received information in a way that they could understand.

Outstanding



Summary of this inspection

- Children and young people's services ensured a family centred approach. Staff spoke with patients, including children and young people, and families in a way they could understand.

Are services responsive?

Our rating of responsive stayed the same. We rated it as Good because:

- The hospital planned and provided services in a way that met the needs of local people. The hospital provided ensured flexibility, choice and continuity of care.
- The hospital took account of patients' individual needs and preferences, including patients with dementia and children and young people. Staff made reasonable adjustments to help patients access services and adapted them when needed.
- Patients could access the hospital when they needed and there was minimal waiting time for patients to receive the right care promptly .
- It was easy for people to give feedback and raise concerns about care received. Concerns and complaints were treated seriously, investigated and lessons learned were shared with all staff and used to improve services.

Good



Are services well-led?

Our rating of well-led improved. We rated it as Good because:

- Leaders had the integrity, skills and abilities to run services. They understood and managed the priorities and issues faced. They were visible and approachable for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The vision was to be the go to private healthcare brand famous for clinical quality and customer service.
- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The hospital used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of their service.

Good



Summary of this inspection

- The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The hospital engaged with patients, staff, the public and local organisations to plan and manage appropriate services.





However,

- There had been instability in the chemotherapy leadership team during 2019 and an interim service manager was in post at the time of our inspection. The culture within the oncology service was variable due to leadership changes and some staff felt unsettled and unsupported

Detailed findings from this inspection

Overview of ratings






Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	 Outstanding	Good	Good	Good
Surgery	Good	Good	 Outstanding	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	 Outstanding	Good	Good
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	 Outstanding	Good	Good	Good

Notes

We do not rate effective for outpatients and diagnostic imaging.

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Good 

We have not previously inspected chemotherapy and endoscopy services under medical care and cannot therefore compare ratings with the last 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. There were processes in place to monitor training compliance.

Staff received and kept up-to-date with their mandatory training. Overall, training compliance for staff working in the oncology service was 97.4% as at July 2019. Eight out of eleven mandatory topics were completed by 100% of staff, and information governance was completed by 77% of staff. This module was reset in June 2019, and the deadline for completion was December 2019. Training compliance for staff working within endoscopy was included within theatre staff completion data.

The mandatory training was comprehensive and met the needs of patients and staff. Training modules were a mixture of practical sessions and e-learning. Staff reported they were allocated time during quieter periods during their working day to complete training. Mandatory training sessions covered modules such as fire safety, health and

safety, infection control, hand hygiene, basic life support, safeguarding, and sepsis. Training courses were either completed online or at face-to-face learning sessions as appropriate.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All staff we spoke with confirmed they had received training on mental health and dementia. They demonstrated a good understanding of patients with complex needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to an electronic training record, which detailed staff training status. Managers used this to monitor and improve performance with training compliance.

For our detailed findings on mandatory training, please see the corresponding sub-heading in the surgery report.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. The hospital established the level of safeguarding training needed for staff based on their job role and type of contact they had with patients. At the time of our inspection, 100% of staff in oncology had completed level 2 safeguarding adults and level 2 safeguarding children training. The oncology service did not see patients under the age of 18 years and all staff had the appropriate level of safeguarding training for their

Medical care (including older people's care)

roles. Training compliance for staff working within endoscopy was incorporated within theatre staff completion data. Records of safeguarding training for medical staff were held on site.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The hospital had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. We saw these had been reviewed and were up to date. Staff we spoke with showed us how they would locate them on the hospital's electronic system.

Prevent is one of the arms of the government's anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being radicalised into supporting terrorism or being terrorists themselves. During the inspection nursing staff explained how they protected patients and the processes to follow should they have any concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The hospital had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. Nursing staff demonstrated how they located policies on the hospital's intranet system. We saw safeguarding information on a display board. It provided information for staff about what to do if they had a safeguarding concern.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The director of clinical services was the safeguarding lead for children and adults was known to staff and visible around the hospital. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. One staff member described a vulnerable adult concern and how they sought advice from the safeguarding lead and requested police assistance.

Staff followed safe procedures for children visiting the service /department. During our visit we did not observe any children visiting the departments. Staff informed us that all children were to be supervised by the accompanying adult which was in line with the hospital's policy. Staff confirmed they had not had any issues or concerns regarding children visiting.

For our detailed findings on safeguarding, please see the corresponding sub-heading in the surgery report.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All clinical areas, including the specialist care centre (oncology unit), endoscopy, inpatient ward, and physiotherapy department were visibly clean and tidy. Consultation and treatment rooms were clean and uncluttered. All furniture was wipe clean and there were hard, washable floors throughout all clinical departments.

All clinical areas we inspected were visibly clean and had cleaning wipes, alcohol gel or foam, and hand washing facilities available.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff used checklists to ensure that tasks were completed in line with recommendations. We saw that these were updated and signed when tasks had been performed. Deep cleans were arranged following the discharge of patients with an infection and rooms used for patients attending for chemotherapy were cleaned before use.

Patients attending endoscopy with known communicable infections were seen at the end of the day to reduce the risk of infection spreading. Deep cleans were completed after discharge. Disposable curtains in the endoscopy recovery area were changed in accordance to the hospital's policy, and 'I am clean' stickers were found on equipment and provided the date it had been cleaned.

For the period of April 2018 to March 2019 the hospital reported zero cases of MRSA, Methicillin-sensitive *Staphylococcus aureus* (MSSA), *C.difficile* and *E.coli*.

Staff followed infection control principles including the use of personal protective equipment (PPE). Infection control training was mandatory for all staff and oncology staff were 100% compliant. The endoscopy and oncology service leads attended quarterly infection, prevention and control (IPC) committee meetings where new protocols, audit outcomes, and hospital-wide actions were shared. For example, in the March 2019 IPC committee meeting it was

Medical care (including older people's care)

discussed that any patient with a temperature above 38.5 degrees should not be admitted to Spire Parkway but referred to the local NHS emergency department for treatment.

Hand gel was available throughout the hospital including the endoscopy and chemotherapy unit. We saw signs to encourage staff, patients and visitors to wash their hands and use hand gel. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were observed washing their hands and using hand sanitisers and PPE was available and used as necessary. Staff were arms bare below the elbow when completing tasks within the clinical area. We saw the oncology unit hand hygiene audit results for January to March 2019 that demonstrated 100% compliance to policy. Infection control audit results were shared consistently with staff, for example, we saw evidence in the March 2019 cancer committee minutes that outcomes were discussed, and that staff were informed of the plan to start the next audit for cannulation.

There were systems and arrangements in place to manage waste which included processes for managing cytotoxic (cytotoxic drugs are used for cancer treatments to help prevent growth of cancer cells) spillages. Spill kits were readily available in endoscopy and oncology which allowed staff to safely collect and dispose of bodily fluids including blood and urine. Specific spill kits were accessible to oncology staff to clean and dispose of cytotoxic waste. Staff were aware of the precautions when handling cytotoxic medications and waste.

Legionella water testing was completed every three months and pseudomonas testing monthly. Minutes of the September infection prevention and control committee confirmed that neither legionella or pseudomonas was detected in the August water test.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Systems and processes were in place for the decontamination of reusable medical devices. The Department of Health (DH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. Endoscopes are lighted, flexible instruments used for the examination of inside the body. The processes adapted were in line with DH recommendations, which meant there was a clear system in place regarding the tagging and numbering of endoscopes and their traceability. The used

endoscopes were manually cleaned in a sink within the dirty area of the decontamination room, before being transferred to an automated washer disinfectant unit for cleansing. When processed the endoscope was removed from the cleaning unit ready to be transferred to the drying cabinet allocated in the clean area of the decontamination room.

Equipment was tested weekly to ensure endoscopes were cleaned adequately this included water testing within the reverse osmosis (RO) unit. The RO equipment cleans water to ensure it is free from any bacteria. The water was tested weekly to establish that the standard of water was reliable to disinfect the endoscopes. Test reports were validated by the endoscopy team lead and escalated if there were any problems to the head of clinical services.

Dirty and clean areas within the decontamination room were not separated by a door or sealed hatch system. This meant that the areas within the clean area of decontamination room could become cross contaminated. Cross contamination is where infection can be transferred from one area to another. Staff explained the clean and dirty process and how they ensured there was no cross contamination which included use of a double hatch between the procedure room and the cleaning room. There was a mechanism in place to stop both doors being able to be opened at the same time. During our inspection we were assured that all necessary steps were taken to prevent this.

For our detailed findings on cleanliness, infection control and hygiene, please see the corresponding sub-heading in the surgery report.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Patients attending for chemotherapy treatment in the oncology unit were observed at all times and staff were able to quickly see and respond if a patient required support. Within the oncology department, staff observed patients before, during and after treatment and were on-hand to respond to any request for support.

Medical care (including older people's care)

The design of the environment followed national guidance. Clinical areas throughout the department were carpet free which meant they complied with national guidance. Only oncology patients were cared for in the specialist care centre (oncology unit) to prevent the risk of immuno-compromised patients getting an infection. There was restricted entrance to the endoscopy unit to reduce the risk of potential contamination of equipment.

Staff carried out daily safety checks of specialist equipment. Equipment had been checked and electronically tested. There were processes and procedures in place for tracking equipment used for each patient's endoscopic investigation. This included sterile equipment used for biopsies and details of staff members who operated and decontaminated the equipment. Following its use, the equipment was decontaminated and stored appropriately. The endoscopy staff monitored the decontamination system daily, ensuring that there was sufficient clean equipment to meet the demands of the service.

Copies of the Control of Substances Hazardous to Health (COSHH) risk assessments for the endoscopy unit, which included guidance on the handling and storage of items such as disinfectant, were available for all staff to access. The risk assessments outlined the precautions required for the safe handling of cleaning chemicals, use of personal protective equipment, and necessary ventilation requirements.

The service had suitable facilities to meet the needs of patients' families. The specialist care centre was a purpose-built oncology centre that had suitable space and facilities to meet the needs of patient's families. There were six individual pods to provide a degree of privacy, and bedside comfortable, wipe clean chairs were available for visitors. Consulting rooms were spacious and there was a quiet room for families and patients to spend time if required. Relatives were not allowed in the endoscopy unit to reduce the risk of contamination. However, waiting areas were comfortable and inpatient rooms were individual and had suitable facilities for families.

The service had enough suitable equipment to help them to safely care for patients. Resuscitation trolleys, which contained medicines and equipment required in an emergency, were accessible and records demonstrated safety checks were completed in line with policy and that all equipment and medicines were in date. Equipment on

the trolleys, such as the defibrillator, were portable appliance tested and the oxygen cylinders were full. Equipment used for emergency resuscitation in the endoscopy unit was available in the ward area and was easily accessible to staff. There was an emergency box in the endoscopy procedure room which consisted of breathing adjuncts that may be required in an emergency.

Staff disposed of clinical waste safely. Waste was managed appropriately with items segregated according to their type for example, domestic and waste and arrangements for chemotherapy waste disposal. Purple lidded sharps bins were in use to identify specialist waste containers this meant there was segregation of chemotherapy wastes. A waste sealing system was used for infusion giving sets and empty infusion bags to ensure safe and effective handling of hazardous waste. The hospital porters collected all the clinical waste from the unit and placed the waste in specifically labelled waste containers ready for disposal.

For our detailed findings on environment and equipment, please see the corresponding sub-heading in the surgery report.

Assessing and responding to patient risk

Staff assessed risks to patients and monitored their safety, so they were supported to stay safe.

Assessments were in place to alert staff when a patient's condition deteriorated.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Processes were in place to identify, monitor and manage a deteriorating patient and all staff had received sepsis training. The hospital used the National Early Warning Score (NEWS 2) for all patients in line with the National Institute for Health and Care Excellence (NICE) guidelines relating to recognising and responding to the deteriorating patient. We reviewed six endoscopy and two oncology patient records. All had evidence of NEWS 2 being completed and observations being completed prior to, during and after treatment or procedures.

Staff completed anaphylaxis (allergic reaction) training and immediate life support training which meant that all staff were aware of the correct processes involved when caring for medical emergencies. Staff we spoke with were able to describe the signs and symptoms of allergic reactions relating to specific chemotherapy medication.

Medical care (including older people's care)

The hospital had an up-to-date extravasation policy in place. Extravasation is a term used when medicines that are being administered intravenously (such as chemotherapy) unintentionally leak into the surrounding tissue and cause damage. Staff had a good knowledge of the process, treatment, and the importance of recognising the early symptoms of extravasation.

Venous thrombosis embolism (VTE) assessments were completed and recorded within the patient's individual care pathway. From July 2017 and June 2018, between 99% to 100% of patients admitted as inpatients were assessed for risk of developing a VTE.

There was a deteriorating patient policy in place which included guidance and treatment pathways for sepsis such as sepsis six guidance. There was a separate neutropenia policy that set out clear guidance for monitoring and managing the risk of neutropenic sepsis. Neutropenic sepsis is a potentially fatal complication of anticancer treatment (particularly chemotherapy). Chemotherapy staff understood the risks and could describe how they would manage a patient with signs of neutropenic sepsis. Staff accessed an algorithm based on the national institute for clinical excellence (NICE) guidelines regarding treatment of neutropenic sepsis, this included frequency of observations and antibiotic administration.

There was a process in place to support patients, should there be any concerns out of normal opening times. A 24-hour telephone advice service operated for chemotherapy patients and processes were in place to triage patients that called. Chemotherapy nurses used the United Kingdom Oncology Nursing Society (UKONS) triage tool when answering calls. Advice would be sought from the resident medical officer (RMO) if necessary. A feedback form was completed by staff and placed in a folder, so the chemotherapy nurses could see what action was taken the following day. Patients were provided with a 'chemo patient diary' that contained information about how to make contact between treatments. One patient told us they had used the 24-hour telephone advice service and were directed to attend the local NHS trust emergency department where they were admitted as an inpatient.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The hospital had processes in place to assess the risk to patients using the

service and developed risk management plans in line with national guidance. Risk assessments were carried out at pre-assessment, upon admission to hospital and throughout the patient pathway.

An admission policy was in place that set out guidelines for the safe admission of patients. A nurse-led pre-admission risk assessment was completed for all patients in both chemotherapy and endoscopy and ward medical admissions

Processes were in place to ensure safe admissions for treatment. Admissions were not accepted unless the patient was under the care of an appropriate consultant who had practising privileges at the hospital. Practising privileges ensured that all health and social care professionals involved with patient or client care are qualified, competent and authorised to practice. The endoscopy and chemotherapy units did not accept emergency or unplanned admissions. Staff knew about and dealt with any specific risk issues. The service used a modified version of the World Health Organisation (WHO) five steps to safer surgery checklist. Staff conducting procedures were required to confirm the patient's name, age, procedure site and consent before starting treatment and record that this had been done on the checklist. A WHO 'safer endoscopy checklist' was used in the endoscopy procedure room. Staff said that implementing the WHO checklist had proved challenging. However, they commented they believed it provided a team routine to ensure safe practice.

Endoscopy staff telephoned patients to complete a pre-operative assessment. This enabled patients to discuss any concerns, including the process and required bowel preparation, and aimed to reduce the risk of a patient not being fit to undergo the treatment. Endoscopy staff met prior to each endoscopy list to assess if there were any risks identified for the unit and patients. The 'huddles' included sharing information about health risks of patients attending for procedures and planned activities. Trained staff and health care assistants looked after the patients in bays prior to and following the procedure. Staff were trained and competency assessed to assist in the procedure.

Medical care (including older people's care)

Patients' bloods were taken on site and sent to the on-site pathology lab for analysis. Some blood tests, such as blood cultures which couldn't be performed on site, were sent off site to a referral laboratory. Staff could access these blood results easily using an online portal.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff said they could place an alert on patients if they were identified or thought to be at risk of having the following symptoms: self-harm, suicide, dementia, learning disability, deafness or severe blindness. During the inspection we did not see any records which required the patient to be placed on an alert. The patient's capacity to consent to treatment was routinely checked.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The medical staff completed psychosocial assessments and made the necessary referrals for support as required. A holistic needs assessment was completed and reviewed throughout a patient's treatment and care and a referral to a clinical psychologist or local community mental health team was made when required.

Staff shared key information to keep patients safe when handing over their care to others. Staff handover meetings kept staff informed of the progress of patients across the medical service. Staff huddles were held daily, and we observed information was shared regarding calls made by patients to the out of hours, on-call advice service, patients being admitted for treatment that day, assessed patient risks, and staffing levels in the units. Internal multi-disciplinary meetings enabled all professionals involved in a person's care to be updated and informed of progress to keep patients safe when they received treatment with another specialism.

Shift changes and handovers included all necessary key information to keep patients safe. The hospital had a critically ill patient transfer policy for patients who deteriorated and needed a higher level of care than that provided by the hospital. There was a service level agreement with a local acute NHS trust to transfer patients by ambulance if required. Staff we spoke to in the endoscopy and chemotherapy units described how they would manage a deteriorating patient who required transfer. Staff told us that this was rare and if this happened it would be recorded as an incident.

For our detailed findings on assessing and responding to patient risk, please see the corresponding sub-heading in the surgery report.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, there had been a significant turnover of nursing staff during 2018 which meant some specialist nurses had not been consistently available.

The service had enough staff to keep patients safe. The chemotherapy service was predominantly nurse led in their delivery. However, medical staff carried out consultations regarding the commencement of treatment and changing treatments.

Medical staff were readily available for nursing staff within the service to seek advice and patient reviews. Staff told us medical staff were easy to access and always attended the unit when required. Medical staff were accessible by mobile telephone.

The oncology unit was managed by an oncology service manager however, the previous post holder had left the service in August 2019. Following a period of instability in leadership within the service, a clinical nurse specialist (CNS) was responsible for supporting the service manager with leading the service. The deputy clinical services manager was their line manager and undertook management of operational matters, and the CNS oversaw the clinical aspects of the unit.

During 2019, there had simultaneously been a high ratio of nurse staff turnover and, at the time of our inspection, there was increased dependency on agency staff to fill vacant shifts. We found however, that two chemotherapy nurses always worked in the unit when a patient was receiving chemotherapy treatment in line with national guidelines. Staffing levels were planned two weeks in advance using the patient treatment diary, and consideration was given to the number and length of treatments and outpatient cover requirements when planning the staff rota. Patients' appointment times would be staggered as required to ensure safe staffing and we were therefore assured that safe staffing levels were maintained.

Medical care (including older people's care)

Vacancies included the oncology service manager, a chemotherapy nurse, a health care assistant (HCA), a haematology CNS, and a palliative care CNS. At the time of our inspection, we were told a further chemotherapy nurse had resigned from their position.

Despite the decrease in numbers of substantive staff, all shifts had been filled by agency or bank staff who were sufficiently trained and competent for their roles, and a member of nursing staff was allocated to each consultant-led clinic. One consultant told us however, the service required the expertise of a haematology and palliative care CNS, and they hoped the positions would soon be filled. Managers told us the haematology CNS post had been filled and they awaited a start date to be confirmed. A breast CNS worked alongside the chemotherapy nurses and saw patients whilst they attended the unit for treatment and an HCA co-ordinated the multi-disciplinary meeting feedback alongside their clinical role.

The CNS lead for chemotherapy and oncology nurses participated in an on-call rota that was provided during weekdays out-of-hours and at weekends. Due to the vacancies in the service, staff who were experienced to cover the rota completed one on-call week in every three, and some staff told us this was impacting on their wellbeing. At the time of our inspection, the on-call rota had always been filled however, one nurse told us they feared that cover for the out-of-hours service would be limited if there was further depletion in staff numbers.

Recruitment plans were in place supported by the Spire group recruitment team, and staffing was reviewed during the daily huddle. There were internal incentives for staff to recommend a friend or family member to work at the hospital.

Sickness was managed well by senior staff, there were regular reviews of sickness, and these were documented alongside outcomes of meetings and discussions. Staff were referred to occupational health and phased returns were offered to help them back into work.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and HCAs needed for each shift in accordance with numbers of patients in attendance and clinics running each week. The manager could adjust staffing levels daily according to the needs of patients. The

oncology unit did not use a safety staffing tool however, they took into consideration actual patient numbers and the dependency of the patients attending for treatment when managing the rotas.

Staff were appropriately skilled and had completed training from specialist oncology courses at recognised clinical training centres.

Staffing numbers in the endoscopy unit followed recommendations from the British Society of Gastroenterology. Capacity meetings took place weekly to assess the following week's endoscopy lists. Staffing levels and skill mixes were reviewed to ensure adequate staffing were available. When staffing levels did not meet the required recommendations, senior managers were informed, and actions taken to ensure safer staffing within the unit.

Managers had been unable to limit their use of bank and agency staff due to the number of vacancies in the oncology unit however, they requested staff familiar with the service. Managers followed processes to ensure patients safety in the event of unexpected staff absence. Both endoscopy and oncology had a briefing in the morning to discuss patients lists for the day and, if necessary, capacity issues were communicated with the hospital's clinical services director.

Managers made sure all bank and agency staff had a full induction and understood the service. Processes were in place to induct and train temporary agency staff. An orientation and induction checklist was used for agency staff new to the hospital which we saw in place in oncology.

For our detailed findings on nurse staffing, please see the corresponding sub-heading in the surgery report.

Medical staffing

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

The service had enough medical staff to keep patients safe. Oncology consultants were largely drawn from the local NHS hospital which enabled close working relationships and the sharing of services. Consultants were expected to formally apply for practice privileges and the hospital assessed their training, scope of practice, qualifications and GMC registration.

Medical care (including older people's care)

Consultants with practising privileges were required to be contactable always when they had a patient at the hospital. Oncology nursing staff told us that they could call and speak with the consultants at any time for advice and if required the consultant would come into the hospital to see a patient.

Chemotherapy treatment was consultant led and all patients were discussed at a multidisciplinary team meeting (MDT) to agree a treatment plan. MDTs were held at a meeting in an acute trust where the consultant was based.

For our detailed findings on medical staffing, please see the corresponding sub-heading in the surgery report.

Records

Staff kept appropriate records of patients' care and treatment. Records were clear, and available to all staff providing care. Not all records we reviewed were fully completed.

Oncology patient records were both paper and electronic. Paper records had a yellow sticker on the front to alert staff that there was also an electronic patient record.

Chemotherapy consultant records were in the form of a contemporaneous dictated clinical letter to the general practitioner (GP) that was produced and sent out on the day of the appointment. The letter provided a diagnosis, treatment plan, medication regimes and follow up required. All nursing entries were legible and concise.

Chemotherapy records were audited quarterly, and good practice included the 94% completion of the holistic needs assessment from April to June 2019, against a 73% Spire group average.

The oncology unit had a specific chemotherapy electronic record that included chemotherapy treatment prescriptions and to take home medications. Patient observations and hospital specific information was stored on a separate electronic recording system.

We reviewed two oncology records that had a chemotherapy visit care pathway that included a pre-treatment assessment, admission record, patient contact record and a discharge checklist.

We reviewed six endoscopy records. All records had an endoscopy pathway and safety checklist that included a comorbidity checklist, pre-operative complications

checklist, pre-operative assessment, admission assessment, care provided, traceability log and discharge checklist. Records reviewed were up to date, and mostly clear and legible. In three of the six records reviewed, the time the record was signed was not given. In one patient record we reviewed, the notes were not in order, and one record gave the first name of a scrub nurse, and not the surname. In each record we saw evidence that equipment used for the endoscopy procedure was traceable and recorded on the patient record and centralised log.

For our detailed findings on records, please see the corresponding sub-heading in the surgery report.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Patient diagnosis, staging of cancer, treatment protocols and allergies were clearly documented in the electronic prescribing document.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. For example, a personalised leaflet relating to supportive treatments was provided to patients and carers.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Cancer chemotherapy prescribing was undertaken with the use of a specialist electronic chemotherapy system. The technology provided a prescribing model that included predefined regimens, prescribing, scheduling, dispensing, and chemotherapy administration and reporting. This ensured medicine management was safe and efficient. An audit of the electronic chemotherapy system in April to June 2019 demonstrated 100% compliance with documentation completion.

Cancer treatment regimens were in line with national guidance and evidence-based therapies. Staff followed policies and procedures to ensure bloods were available two days before the dispensing of chemotherapy treatment. When blood samples had been reviewed by pharmacy, the prescription could not be altered by a doctor unless a treatment change was discussed with the

Medical care (including older people's care)

oncology pharmacist. An electronic record was kept of all medicines prescribed and was accessible to all healthcare professionals to ensure information supporting safe patient care was available.

All emergency drugs were stored in a medication cupboard in the endoscopy procedure room.

Staff followed current national practice to check patients had the correct medicines. Prescriptions were held electronically and locked when they had been screened so could not be altered unless the pharmacist had been contacted. This ensured it was safe to produce the chemotherapy in the aseptic (sterile) unit. All chemotherapy prescriptions were checked by a trained cancer pharmacist, as per BOPA (British Oncology Pharmacy Association) standards. All chemotherapy was double bagged before it was brought to the unit. Nursing staff then rechecked it prior to administration. The chemotherapy was checked against the prescription (either electronic or handwritten) with two qualified nurses. The pharmacist and nursing team completed a final screen of patients before the planned chemotherapy treatment was administered to ensure no change to the regimen was required. Chemotherapy nurses ensured the patency of intravenous access prior to starting any intravenous treatment therapy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The pharmacy team managed medication incidents and alerted staff and shared learning following an incident. The quarter one 2019 clinical governance report stated there was one chemotherapy medication incident during the period.

For our detailed findings on medicines, please see the corresponding sub-heading in the surgery report.

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 had processes in place to prevent harm to patients and staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff, including administrators, were trained to use the electronic system by staff already trained in the department. All staff we spoke with were able to describe the process they would take should they need to report an incident. For example, one senior nurse told us they reported an incident when an error had been found in an electronic patient record system. All consultants were alerted by email and reminded to check the recording entry system was accurate.

Staff reported all incidents that they should report. Staff told us that there was a positive incident reporting culture and we did not find any issues or concerns with the reporting of incidents with staff having a good knowledge of what they should report. Endoscopy staff told us that all cancelled clinics were reported as an incident to enable any themes, such as the late arrival of consultants, to be addressed.

The service had no never events. However, managers would share learning with their staff about never events that happened elsewhere if applicable. The Spire June 2019 Safety Update bulletin contained information about a never event that occurred at another Spire hospital. The bulletins outlined key areas of learning that could be transferred and shared across the organisation.

All incidents and near misses were reported onto the hospital's electronic system and were subject to a risk-appropriate level of investigation with serious incidents requiring investigation (SIRI) subject to root cause analysis. There were mechanisms to ensure lessons were learned and improvements made where necessary, including group-wide learning from adverse events. For example, there was one SI reported from December 2018 to March 2019 allocated to the medical oncology service. It was noted in the February 2019 medical advisory committee minutes that a root cause analysis (RCA) was not usually completed for oncology deaths. However, on this occasion an RCA was completed, and we observed, and staff told us that refresher syringe driver training was provided to eligible nursing staff as an action for learning.

Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff told us they were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Staff knew what duty of candour meant and could describe their responsibilities relating to it which included approaching patient when things go wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that changes had been made because of feedback. This included the discussion of incidents and the actions taken through staff meetings, daily huddles and information on staff noticeboards. A daily briefing sent by email to all staff in the hospital outlined all incidents that had been reported. Staff working in the medicine department told us that learning from incidents was fed back and disseminated through daily huddles and staff meetings. Themes from incidents in 2018/19 included delayed reports from pathology and, as a result, a pathology co-ordinator was recruited to support with 'chasing' outcomes. A consultant told us that there was no longer a delay with receiving results in a timely way for clinic appointments. It was reported in the quarter two 2019 clinical governance report however, that there were cytology delays (cell investigations) and transcription errors within the Spire pathology group. Following implementation of new processes across the Spire pathology group, there were no cervical cytology or transcription errors at the time of our inspection. This was under monthly review to ensure improved compliance.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw an example of an investigation into an incident and observed that the family were kept fully involved in its progress and of the findings.

Managers debriefed and supported staff after any serious incident. Managers and staff told us they were supported following a serious incident. Staff could access clinical supervision and counselling support if required. There were quiet rooms that could be used by staff and managers when not occupied by a patient to debrief staff.

For our detailed findings on incidents, please see the corresponding sub-heading in the surgery report.

Safety Thermometer (or equivalent)

The hospital monitored information equivalent to the NHS safety thermometer, including instances of pressure ulcers, falls, venous thromboembolism (VTE) acquired on admission and catheter-related urinary tract infections acquired during admission. Staff used care pathways to prevent avoidable pressure ulcers and falls. This included risk assessments and monitoring based on individual patient need.

For our detailed findings on safety thermometer, please see the corresponding sub-heading in the surgery report.

Are medical care (including older people's care) effective?

Good 

We have not previously inspected chemotherapy and endoscopy services under medical care and cannot therefore compare ratings with the last inspection. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance and internal audits were completed in accordance with the hospital's agreed timetable. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high-quality care according to best practice and national guidance. We saw policies and procedures in place. Staff told us they could access policies on the intranet. There were systems in place for reviewing policies and staff were informed when changes had been made. The corporate Spire national team reviewed all chemotherapy policies and protocols, and updates were cascaded to staff. For example, the cancer services committee minutes had an agenda item for policy updates, and the March 2019 minutes informed attendees of amendments made to the extravasation policy.

Medical care (including older people's care)

Policies and processes relating to cancer care were based on the National Institute for Health and Care excellence (NICE) and UK oncology nursing society (UKONS) guidelines. The endoscopy service policies were evidence based, for example they followed the British society of gastroenterology guidelines.

Staff used defined pathways based on national guidance to ensure treatment and care was delivered based on individual need. For example, patients who received chemotherapy and endoscopy had specific care pathways.

The oncology consultants and nurses were part of the Pan-Birmingham Cancer Network and UK Oncology Nursing Society (UKONS) and had access to evidence-based resources and training which aimed to help improve patient outcomes and introduce best practice into the service.

Clinical endoscopy staff used the World Health Organisation (WHO) surgical safety checklist for each procedure. This meant patients received consistent care and treatment to established standards, including the NHS five steps to safer surgery. We looked at six sets of patient records and found staff had fully completed the WHO checklist in each patient record.

Oncology records we reviewed indicated that the service assessed patients physical, mental health and social needs prior to treatment starting. Patients were reassessed at each visit using the chemotherapy visit care pathway tool. Treatment pathways were in line with NICE guidelines and the UKCON standards.

For our detailed findings on evidence-based care and treatment, please see the corresponding sub-heading in the surgery report.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were provided with water jugs, and we observed staff offering assistance to enable patients who

were unable to take oral nutrition or fluids to be given specialist feeds. Pre-admission information for patients provided clear instructions on fasting times for food and drink before endoscopy procedures.

Records showed checks were made to ensure patients had adhered to fasting times before procedures went ahead. Patients were given written information on suitable foods to eat and nutritional value of different food types whilst undergoing therapy and patients told us the hospital food was of good quality and they had plenty to eat and drink throughout the day. There were water coolers and hot drinks machines around the departments for patients and visitors to help themselves.

Staff used the Malnutrition Universal Scoring Tool (MUST), food intake charts and fluid intake charts to monitor patient nutritional needs and risks. Patient hydration was monitored during care rounds and recorded in patient notes. Food and fluid records we reviewed were complete, accurate and current. An audit of records from April to June 2019 demonstrated 100% compliance with MUST completion. Staff referred patients to the hospital or Macmillan dietitian service for advice and support and nutritional advice and support was given to patients and families to enable them to develop a plan for good nutrition.

Patients attending the oncology and endoscopy department were not generally in the department for long periods of time. Refreshments were offered to patients in endoscopy who had fasted prior to the procedure. Food menus were provided to day patients in oncology. We observed that staff offered drinks to patients and visitors and assisted them if required.

Patients with nausea or vomiting were formally assessed and prescribed antiemetic medicine (a drug effective against vomiting and nausea).

Patients with diabetes who were treated in the endoscopy unit had blood sugar checks before and after each procedure. This meant risks relating to blood sugar levels were managed appropriately.

For our detailed findings on nutrition and hydration, please see the corresponding sub-heading in the surgery report.

Pain relief

The service managed patients' pain effectively and provided or offered pain relief when required.

Medical care (including older people's care)

The service met the Faculty of Pain Medicine (2015) Core Standards for Pain Management Services. Chemotherapy patients with acute pain had an individualised analgesic plan and staff conducted regular pain assessments using appropriate tools. Nursing staff communicated any concerns with pain management to the patients' consultant who would then review the patient.

Pain was regularly risk assessed and recorded using the National Early Warning Score (NEWS 2) scale and we saw these were completed for chemotherapy patients during treatment.

Nurses and consultants monitored patients' pain and discomfort during and after an endoscopic procedure and a mutually agreed score was recorded. Discomfort scores were audited twice yearly and fed back to the consultant. A senior nurse told us the service planned to trial assessing the patient's self-reported discomfort rating in 2020 to enable service improvements to be made accordingly.

If patients required pain relief it was prescribed by the resident medical officer (RMO) and administered by a staff nurse. Staff told us that the need for pain relief in the departments was very rare.

For our detailed findings on pain relief, please see the corresponding sub-heading in the surgery report.

Patient outcomes

Staff monitored the effectiveness of care and treatment in all areas. They used the findings to make improvements and achieved good outcomes for patients. The service had not been accredited under all relevant clinical accreditation schemes.

The hospital had a comprehensive audit and risk management structure which ensured the service had a transparent approach to the management of risk and the assurance of safety. For example, audits included infection control, hand hygiene, medicines management, patient records, endoscopy decontamination and isolation.

A cancer dashboard enabled managers to have an immediate overview of performance in the unit. Compliance targets were met or exceeded in eight out of nine audits in quarter two of 2019. For example, 99% of electronic prescribing records were compliant against an 80% target; and 84% of patients had a venous access assessment against a 65% hospital target. Actions had

been completed that aimed to increase performance with the recording of consent. The hospital also monitored and benchmarked performance against targets and other hospitals/providers. This included: medicines management and administration, record keeping and policy management.

The endoscopy service continued to work towards meeting the required competency standards to deliver against the Joint Advisory Group Gastroenterology Society (JAG) accreditation. This meant the endoscopy unit and its staff would be assessed and monitored for quality performance and clinical safety against established international benchmarks. Senior staff told us a self-assessment had identified that the JAG required standards had been met, for example, the completion rates of endoscopy procedures were collected and audited regarding patient outcomes. The service also audited their decontamination procedures. The nurse lead planned to apply for an independent assessment to achieve accreditation in December 2019.

The hospital had gained and held national accreditations such as: ISO accreditation for pathology 15189 (ISO certification is a seal of approval from an external body whereby a company complies to one of the internationally recognised ISO management systems), British United Provident Association (BUPA) accreditation for breast care, bowel care, prostate care, and the cancer survivorship programme. The specialist care centre (oncology unit) had been awarded a Macmillan Mark of Quality Environment (MQEM) for achievements in quality for cancer care environments. The oncology service was awarded an Exemplar award by the provider's group clinical director and had been recognised for excellent care and service for cancer patients in 2018.

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

Competent staff

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

All staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff who worked in endoscopy and chemotherapy services had an

Medical care (including older people's care)

annual appraisal with a senior member of staff using the Spire enabling excellence framework. Staff we spoke with said the appraisal process enabled them to focus on professional development.

Processes were in place to ensure staff were signed off as competent in oncology and endoscopy. Each oncology nurse had competency folders containing specific oncology competencies to be signed off. Training was provided in extravasation (leakage of intravenous fluids into the surrounding tissues) and chemotherapy spillage. Competency records were completed on paper and not stored electronically however, the manager told us they planned to develop an electronic system to support ease with monitoring. Two oncology staff records we reviewed had not been dated which meant it could be difficult to evidence compliance, and the manager was made aware of this. Bank and agency staff in oncology and endoscopy had received a local induction.

The service provided opportunities for staff to attend external training and skill sessions. For example, some oncology staff had attended Macmillan recovery package training to help people feel supported, and to manage their own care.

A specialist oncology physiotherapist told us they were supported to complete additional training; for example, they were funded to complete pilates training.

Oncology staff were in the process of completing the United Kingdom oncology nursing society (UKONS) passport. The UKONS passport is a competency assessment for oncology nurses for the safe handling and administration of anti-cancer therapy.

Staff within oncology had undertaken additional training relevant to their role. This included, dealing with emotional stress and living well with cancer. They had also completed cold cap training. A cold cap is used to help reduce or prevent hair loss caused by chemotherapy. Some nursing staff had attended study days covering a range of topics such as surgical reconstruction, the management of neutropenic sepsis, care for patients at end of life, and pain and its management.

The pharmacy team had three specialist oncology pharmacists employed in the service. The hospital has an in-house, oncology pharmacist training programme to

ensure staff were competent in their roles. The training was delivered to both pharmacists and technicians and was adapted according to the level of the competence already held.

The pharmacy manager told us the 'enabling excellence' process was used to identify objectives and focus on behaviours, and mid and end of year reviews took place with all staff.

The pharmacy team delivered medicines management 'drop in' sessions for nursing staff. The training sessions were held over four weeks and most staff told us they had attended a session.

For our detailed findings on competent staff, please see the corresponding sub-heading in the surgery report.

Multidisciplinary working

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

Regular and effective multidisciplinary meetings (MDTs) were held to discuss patients and improve their care. Relevant staff, teams and services were involved in assessing, planning and delivering patient's care and treatment. All patients undergoing cancer treatment were subject to a formal MDT prior to commencing treatment, including medical and surgical intervention. Compliance was monitored across the Spire group of hospitals and there was 100% compliance with the requirement during 2019. The hospital had a service level agreement with a local NHS trust where the largest percentage of patients were discussed before and after a cancer diagnosis. MDT outcomes were sent to the unit's administrators and clinical nurse specialists (CNSs) within 48 hours of discussion. The urology CNS also had access to an independent urology MDT.

The oncology service held their own daily MDTs which were attended by CNSs, a physiotherapist, pharmacists, occupational therapists, dietitians and clinical psychologists as required. We observed an MDT in progress. All patients were discussed including new patients and those completing their treatment. An overview was provided of each patient and staff gave updates, including the planned management of care and treatment. All attendees demonstrated good oversight of all patients.

Medical care (including older people's care)

Pharmacists attended MDTs across the hospital and 10 at 10 meetings when leads from each service discussed patient risks and chemotherapy treatment regimens to support effective patient planning.

A daily huddle was held each morning on the oncology unit where the nursing coordinator would discuss the patients attending the clinic for treatment that day, incidents and patient safety requirements. Each chemotherapy nurse was allocated specific patients to care for during their shift.

Staff had good working relationships with teams at other local hospitals to support patients undergoing treatment and investigations off site. A named nurse would take responsibility for communicating with other clinical teams and this information would be shared with all staff at the daily MDT.

There were pathways for referral between specialities both at the hospital and local acute hospitals. For example, there was a formal pathway for transfer of emergency and urgent patients to a local NHS trust. An emergency ambulance would be called for patients who had a condition that required urgent treatment, for example, bleeding. Staff were aware of these pathways.

Staff could refer patients to the local mental health team for assessment if they showed signs of mental ill health or depression. Staff told us they rarely had a need to refer to mental health services.

All patients admitted were under the care of a consultant and had their care and treatment reviewed during their inpatient stay. Whilst consultants were not always on site, there was effective communication between nursing staff and the specialist consultants.

For our detailed findings on MDT working, please see the corresponding sub-heading in the surgery report.

Seven-day services

The oncology and endoscopy units did not provide seven-day services but had systems in place to respond to patients needs outside of service opening times.

The oncology service was open Monday to Friday from 8.30am to 9pm. Specially trained oncology nurses provided a 24-hour telephone number for patients to call out of hours for support.

Consultants were always contactable to respond to any concerns about patients that had attended for chemotherapy. Staff told us consultants were always responsive when required.

The hospital's resident medical officer (RMO) was available 24-hours a day, seven days a week to support patients, hospital staff and care for patients.

The endoscopy department was open Monday to Friday and provided a seven-day on-call service for diagnostic purposes. High risk patients who required endoscopic procedures attended a local NHS hospital.

For our detailed findings on seven-day services, please see the corresponding sub-heading in the surgery report.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. Patients were provided with information to help support them through cancer treatment pathway, manage their symptoms and promote their well-being. The Parkway Living Survivorship Programme provided therapeutic treatments such as aromatherapy massage, Indian head massage, reflexology and Reiki to help improve circulation and overall wellbeing of the body and mind.

Health promotion information including leaflets regarding stopping smoking, living with dementia and advice on managing symptoms were available for patients and visitors to read.

Staff assessed each patients' health when admitted and provided support for any individual needs to live a healthier lifestyle. All patients underwent an assessment on admission, which included an assessment of their wellbeing and special needs. Patients also underwent a detailed assessment at the beginning of their treatment journey, receiving support from community-based nurse specialists, who supported them through their hospital stay.

For our detailed findings on health promotion, please see the corresponding sub-heading in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

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

Consent for chemotherapy was completed by the consultant and then checked by nursing staff prior to any administration of medication. The service had a checklist in place to ensure that consent was checked. Patients receiving chemotherapy had completed consent forms in the records we reviewed. All the consent forms were specific to the treatment required. The standardised systemic anti-cancer therapy (SACT) specific consent forms used included details of the toxicities and possible side effects. The United Kingdom chemotherapy board recommend using the standardised SACT regime specific consent forms. Patients told us that both doctors and nurses went through consent and provided a good level of information.

Patients were provided with written information to help them understand treatment before it started. Patients attending the service for chemotherapy were advised of possible side effects of treatment during the pre-chemotherapy assessments and prior to attending for treatment. This ensured that patients had time to consider the impact of medications prior to agreeing to the treatment.

The service had good oversight of the level of compliance around consent to treatment for patients. The service completed a chemotherapy quarterly documentation audit. The quarter one 2019 audit showed that 98% of files were compliant with consent requirements. This was above the Spire network average of 93%. The quarter two audit however, showed deterioration in that 92% of files were compliant with consent in line with policies and procedures. Action included an email being sent to all consultants to remind them to fully complete patient documentation to evidence conversations and the date and time consent was given.

Two endoscopy patients we spoke to told us they were happy with the level of information they received about the procedure and all were happy with the consent process. Patients told us consultants provided information to the

patient, checked their understanding and clarified they were aware of the risks, and that they agreed to go ahead with the procedure. A patient receiving chemotherapy treatment told us a consultant provided them with two separate dates the week following their diagnosis '...if they wanted to come back and talk it through again before making a decision'.

Staff understood their roles and responsibilities under the Mental Health Act (MHA) 1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Compliance with MCA/consent mandatory training was 100% for oncology staff and 80% (four out of five staff) working in oncology.

The deprivation of liberty safeguards (DoLS) protect people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). None of the patient records seen required an assessment regarding their capacity.

Staff told us that it was rare that they received referrals for treatment for patients with dementia or learning disabilities. Staff told us they would hold a meeting prior to treatment starting and put a detailed support plan in place.

For our detailed findings on consent, please see the corresponding sub-heading in the surgery report.

Are medical care (including older people's care) caring?

Outstanding



We have not previously inspected chemotherapy and endoscopy services under medical care and cannot therefore compare ratings with the last inspection. We rated it as outstanding.

Compassionate care

Medical care (including older people's 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. We observed interactions with patients and found staff had a good rapport with patients. Whilst delivering care and treatment, staff took time to talk to patients about how they were feeling and respond to any queries they had in a respectful and considerate way.

Patients and relatives said staff treated them well and with kindness. Patients spoke highly of the care they were given on the wards/units. Patients told us staff were 'really good' and 'supportive', and 'they take care of all the patients'. One relative informed us they had 'nothing but praise' for all the staff. We saw cards, thanking staff for the care and treatment given during their hospital stay. The hospital website had a section with feedback received from patients and comments included, 'I can't speak highly enough of (the consultant) and the nurse that worked alongside (them). We were put to ease straight away and I would recommend (the consultant) to anyone'.

Staff followed policy to keep patient care and treatment confidential, and people were always treated with dignity by all those involved in their care, treatment and support. We observed staff used quiet rooms when they needed to have sensitive conversations with patients. For example, patients were provided with a private space to discuss their condition with endoscopy staff before their procedure. One nurse told us they could 'have time to give care and attention and talk to patients'.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff demonstrated a good understanding of a patients' individual needs. We observed a nurse-led multi-disciplinary meeting. Staff displayed compassion and empathy when discussing patient care and this included discussions about the personal and social needs of patients.

For our detailed findings on caring, please see the corresponding sub-heading in the surgery report.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Psychological, counselling and emotional support was available to patients and their relatives following diagnosis of a long-term condition. A one-to-one counselling service was offered by a psychologist, and the medical service also signposted patients with long term conditions to other agencies and charities, such as Macmillan, for additional support and counselling.

Patients and their relatives we spoke with told us they felt supported throughout their journey from consultation, pre-assessment through treatment and therapies. One patient told us they were offered emotional support throughout their treatment, and that they rang the out of hours service at times when they were worried. Patient thank you cards thanked staff for the emotional support provided during their treatment and comments included, 'thank you for alleviating all my anxieties and fears'.

Bereavement support was also provided for the oncology patients with referrals to the community services.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The endoscopy unit had four recovery bays, two that were divided by a curtain. Staff told us they 'staggered' patient appointments to ensure patients' privacy and dignity was maintained to ensure male and female patients were moved to the recovery area at separate times. The oncology unit had a quiet room which patients and their relatives could use if they became distressed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All 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. Patients confirmed that staff from all specialisms had an awareness of their treatment on their well-being and they were caring and supportive. At the time of our inspection, the clinical

Medical care (including older people's care)

nurse specialist in palliative care position was vacant however, an appropriately trained nurse attended all consultant clinics to offer additional support to patients when bad news was broken.

The service had a breast care nurse on the oncology unit that also provided on-going emotional and psychological support tailored to each patient diagnosed with breast cancer. All clinics were attended by a consultant and appropriate nurse, and patients were offered an opportunity for a longer discussion with a nurse following an appointment with a consultant.

Most registered nurses on the oncology unit had either completed, or were booked to attend, an advanced communication skills course.

Feedback from people who used the service was continually positive about the way staff treated them. People thought that staff went the extra mile and that their care and support exceeded their expectations. For example, some staff organised evening sessions to support patients' emotional wellbeing such as a health and wellbeing event that was held in January 2019. Topics included managing anxieties and fears; relationships; and complementary therapies. Fifteen patients attended, and all feedback was positive with comments such as 'excellent', 'would recommend' and 'lots of information gained'.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that promoted people's dignity. For example, an event in July 2019 supported oncology patients with the emotional impact of hair loss and a specialist provided advice on the styling of wigs and eyebrow pencilling. Feedback on the company website from one attendee commented, 'The two speakers spoke so eloquently and passionately about how they love to help patients at a time when patients really need help and loving care. I hope that there will be another evening organised soon'.

People's emotional and social needs were seen as being as important as their physical needs. An end of treatment bell was rung to signify the moment when a patient had finished treatment. Staff told us however, all patients were advised that they could continue to ask for advice when required. One nurse told us a patient had contacted them 12 months after their treatment had ended.

For our detailed findings on emotional support, please see the corresponding sub-heading in the surgery report.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed nursing and medical staff talking to patients and their relatives about their care and treatment plan. Staff gave patients an opportunity to ask questions and people who used services were active partners in their care. We observed an oncology pharmacist talking with a patient and concerns about medicines were shared and addressed professionally, and with warmth.

Holistic needs assessments were completed which supported the full involvement of patients and those close to them. The assessments provided oncology patients with an opportunity to think about their concerns which could be physical, emotional, financial, spiritual or practical. Patients were provided with advice according to their needs which enabled them to make decisions about their care and treatment. For example, patients in endoscopy were advised of possible side effects, complications, and what actions to take following discharge.

Patients were given written and verbal information about how to take medicines at home, including anti-cancer treatments and supportive therapies. The pharmacist discussed medications with patients.

Staff talked with patients, families and carers in a way they could understand. A patient told us nursing and medical staff explained everything clearly and kept them informed about the treatment and progress. Staff across the service gave examples of the actions taken to ensure they were assured patients, families and carers understood proposed treatment plans. For example, a breast care nurse told us they telephoned patients following an appointment when they had been given bad news to ensure they understood the next steps, and to provide them with an opportunity to ask further questions.

Staff supported patients to make advanced decisions about their care. The multidisciplinary team discussed options about patients' care and treatment to ensure all

Medical care (including older people's care)

aspects of care were reviewed. Patients had clinical nurse specialists who supported them through their cancer treatment journey to support the patient to make decisions about their care. However, two of the three clinical nurse specialist (CNS) roles were vacant at the time of our inspection, the palliative care and haematology CNS.

For our detailed findings on understanding and involvement of patients, please see the corresponding sub-heading in the surgery report.

Are medical care (including older people's care) responsive?

Good 

We have not previously inspected chemotherapy and endoscopy services under medical care and cannot therefore compare ratings with the last 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.

The service reflected the needs of the local population and was flexible to meet the needs of adults seen. The oncology service only saw adults who were privately funded, and the endoscopy service was provided to both NHS and privately funded patients. Adults accessed services in outpatient clinics, physiotherapy, diagnostics, the endoscopy unit and the Spire Specialist Care Centre. (Oncology unit)

Clinical facilities and treatment areas in endoscopy were appropriate for the purpose they were used for. There was enough space for staff to conduct private calls with patients and ensure patients were assessed and consented in private. The endoscopy recovery area had four individual cubicles where patients were easily observed by nursing staff. Staff segregated male and female patients to prevent mixed sex clinical areas. An admission and discharge lounge was available for patients to use which had drinks facilities, if they needed to wait for transport or relatives.

The endoscopy service had a contract with the local commissioning group to enable additional NHS patients to be seen. As the service did not have JAG (Joint Advisory

Group) accreditation, this was on the departmental risk register as it was a financial concern. During 2018/9, staff had made service improvements and it was planned to apply for a JAG assessment to aim to achieve accreditation in December 2019.

The facilities for chemotherapy patients met the patient's needs. The chemotherapy unit was purpose built in response to the increasing demand for chemotherapy. The unit had six treatment pods offering systemic anti-cancer and therapy (SACT) to haematology and oncology patients. The unit enabled all required clinical equipment to be in one place and responsive to the patient need. Senior manager told us the oncology service provided a range of anti-cancer therapies to treat a wide range of both haematological and oncological disease such as breast, bowel, bladder cancers. Patients were seen by a consultant who specialised in the diagnosis and treatment of their disease. They were supported by a team of clinicians across a range of services, including consultant oncologists, radiologists and pathologists. The chemotherapy unit also had a chemotherapy production aseptic unit where pre-filled syringes and infusion bags, for example, were made in a clean room environment to reduce the risk of contamination. Staff in the unit met individual patient needs as they changed, such as when drugs with a short expiry time were required.

A one-stop breast clinic was available for NHS patients to meet a capacity shortfall. The one-stop clinic enabled patients to undergo required imaging or diagnostic tests following their consultant appointment during the same day.

The hospital had a pathology and diagnostic imaging service, that included CT, MRI, X-ray and ultrasound which meant it was quicker to receive test results and diagnoses.

Patients who required radiotherapy had to go to another hospital for treatment and consultants arranged for this to be carried out for both NHS and privately funded patients.

For our detailed findings on service delivery, please see the corresponding sub-heading in the surgery report.

Meeting people's individual needs

Medical care (including older people's care)

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.

A robust process was in place to ensure patients' needs were being met. Patients individual needs were assessed during an initial assessment and throughout their treatment. This included assessing for physical, mental health and social needs. Staff described how they had adjusted pathways for patients with complex needs such as mental health, learning disabilities, and those with a comorbidity. (The presence of one or more additional conditions). For example, patients who were living with a diabetic condition were offered the first appointment in the morning, to reduce any impact fasting may have on their blood sugar control.

A nurse attended all consultant-led clinics and staff told us this helped to build relations throughout a patient's journey that assisted them with offering appropriate support to meet the individual needs of patients.

Staff knew how to access the translation services for patients who did not speak English. Where required, interpreters were booked for pre-assessments and before treatment. Not all staff knew if leaflets were available or could be obtained in other languages, however.

The hospital had disabled access throughout the site. Nursing staff told us that specific patient communication needs would be assessed before admission and were highlighted in the patient's medical records.

The hospital had a dedicated dementia lead who had developed local pathways of care that had been identified as best practice within the Spire group. Staff told us they very rarely cared for patients with dementia however, staff could describe how they would assess and support someone with dementia or seek advice from the dementia lead. The service had been recognised with an Exemplar award from Spire's group clinical director and staff were encouraged to attend Spire Parkway from other sites to learn from the service and improve services elsewhere.

A breast care clinical nurse specialist based in the hospital supported breast cancer patients throughout the treatment journey. The breast care nurse supported the

oncology clinics with consultants and communicated chemotherapy treatment plans with chemotherapy nurses following clinics. All breast cancer patients were provided with a breast cancer care resource pack.

The service had pathways in place with local charities to support patients undergoing cancer treatment. For example, the chemotherapy service could refer patients to Macmillan services and a local breast care charity. Both charities were set up to support patients and relatives during and after their treatment had finished. There was also a sponsorship programme with a menopause specialist to support patients who experienced early menopause following treatment.

Staff across the service gave examples of how they met individual patient needs. For example, a pharmacist told us they had provided counselling on mouth care when a patient had disclosed discomfort to them but not to any other member of the healthcare team. The pharmacist provided advice on possible treatment options and the patient reported improvement at their next cycle of treatment. A pharmacist had also developed a personalised leaflet for supportive cancer treatments. These were altered based on the treatment regimen the patient was receiving and were given and discussed by the pharmacist when counselling on medicine to take out. A Macmillan physiotherapist offered consultations to all patients and pilates, acupuncture, one to one personal training, clinical psychology, and dietetics could be accessed by patients according to their individual need.

Chemotherapy 'pods' were designed to allow patients control of their environment and to be independent. In response to patients' needs, the service maximised the available time for relatives and friends to stay for the day to support the patient during their treatment cycle.

Patients were offered treatment alongside chemotherapy to reduce the side effects of treatment. For example, patients were offered scalp cooling. Scalp cooling is a treatment that can prevent hair loss caused by some chemotherapy drugs and was offered to patients to reduce or prevent hair loss during chemotherapy treatment.

For our detailed findings on individual needs, please see the corresponding sub-heading in the surgery report.

Access and flow

Medical care (including older people's care)

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

The hospital had a patient journey policy. It set out the process staff should follow when assessing, admitting, treating and discharging patients. All admissions had to be agreed and accepted by a consultant and a booking form completed.

The service monitored all patients who were referred on their internal system to ensure they delivered access to treatment in a timely way. This was reported internally within Spire and monitored. All patients accessing the chemotherapy suite were private patients, and newly referred patients were provided with a prompt service. For example, staff in the rapid access breast clinic aimed to provide appointments within two to three working days, and urgent new referrals were offered same or next day appointments when possible. No patients waited more than six weeks from referral to a diagnostic test in line with national standards.

The chemotherapy day unit was open Monday to Friday from 8.30am to 9pm and if a patient's treatment had been delayed due to their late arrival, for example, the unit remained open and fully staffed. There was a wide choice of consultants in most specialties and pre-treatment assessment clinics were provided in the evenings and on Saturdays, and by telephone where clinically appropriate. An on-call telephone service was provided during the evenings and at weekends to provide a support and advice service for patients who were receiving or had completed their treatment.

An oncology pharmacist prepared individual chemotherapy medicine in advance to reduce patient waiting times when patients arrived. A post discharge telephone service was provided for patients for 48 hours after discharge to support patients with questions about their medicines.

The medicine service had two inpatient rooms to support patients at the end of life and for patients who developed problems that required admission during their treatment. Staff told us the inpatient rooms were used on rare occasions.

Patients who were acutely unwell or at risk of deterioration were not admitted to the hospital and were directed to attend the local NHS emergency department.

The endoscopy service had been restructured to support with increasing capacity within the service. Staff reported a low number of endoscopy procedure cancellations due to consultant unavailability. Managers told us that any patient considered urgent, or where there would be a delay in a diagnosis, would be routinely added to the next available list or added to another consultants list to minimise the delay with an explanation to the patient.

Rebooking compliance for cancelled procedures was monitored by staff. All patients were offered a date at their earliest convenience. From January to June 2019, four patients were cancelled; three due to an issue with decontamination (these patients were rebooked within six days), and one due to the patient no longer wishing to have the procedure.

Endoscopy appointments were offered within six weeks of referral and within two weeks for urgent referrals. Staff told us there was no waiting list. The average wait for an appointment following up referral was between four days and two weeks.

All patients we spoke to in endoscopy were very happy with the time it took to receive an appointment. One patient arranged to go privately and was seen within two working days at Spire Parkway.

For our detailed findings on access and flow, please see the corresponding sub-heading in the surgery report.

Learning from complaints and concerns

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

Patients were advised about the complaints process at the pre-assessment stage. Patients we spoke to said they did not have a reason to make a complaint but knew how to do this if they needed to.

Medical care (including older people's care)

Staff told us that if a patient raised a concern, they would listen to the feedback and try to resolve the issue. If they were unable to do so, it would be escalated to the chemotherapy and endoscopy lead or person in charge.

The oncology and endoscopy department received three complaints from September 2018 to March 2019 with no identified themes. One complaint concerned pathology results being unavailable at a patient's follow-up appointment, and the hospital provided increased administrative support in response to ensure reports were available at appointments.

For our detailed findings on complaints and concerns, please see the corresponding sub-heading in the surgery report.

Are medical care (including older people's care) well-led?

Good



We have not previously inspected chemotherapy and endoscopy services under medical care and cannot therefore compare ratings with the last inspection. We rated it as good.

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, there had been instability with leadership in the oncology unit throughout 2019, and the substantive service manager position was under recruitment at the time of our inspection.

The medical care service was led by the clinical services director and both endoscopy and chemotherapy services had a lead nurse and a senior sister.

There had been inconsistency and change in leadership within oncology during 2019. The previous service manager had recently left the organisation at the time of our inspection and the service was being managed by the deputy matron, supported by a clinical nurse specialist (CNS).

The CNS was responsible for overseeing the clinical management of the unit however, they were not able to

undertake all clinical work themselves at the time of our inspection. Most, but not all staff working in the oncology unit felt the management arrangements were supportive of their roles. The turnover of staff within the oncology unit meant there was a frequent reliance on agency and bank staff. Some staff told us they did not feel that there had been effective leadership to manage workload responsibilities. For example, due to reduced staffing resource the out-of-hours, on-call rota was covered by three members of staff at the time of our inspection. This meant a member of staff covered the on-call rota one week in three during evenings and at weekends, and one nurse told us they did not believe this was sustainable should the cover be reduced further.

In mitigation, the nurse lead substantive vacancy was under recruitment and staff in both the oncology and endoscopy departments said that most leaders were visible and approachable and felt that they could express any concerns to them, and they would be listened to. One nurse told us the senior leadership team were 'very approachable and had 300 years' experience I could tap in to'.

Leadership of the endoscopy team changed from the responsibility of the theatre manager to the radiology and other clinical projects manager in February 2019. This coincided with the resignation of the theatre manager, and the new lead was responsible for making recommendations for service improvements with the aim of securing Joint Advisory Group (JAG) accreditation. It was planned that the role would revert to the responsibility of the recently appointed theatre manager once this was achieved. Staff spoke enthusiastically about the new leadership team and how they felt confident and empowered with their ability to move the service forward.

All staff we spoke with talked about the 'ten at ten' meeting. This was a meeting where senior managers talked about a variety of current issues such as staffing and incidents. Staff told us that the 'ten at ten' meetings made the senior leadership team more visible. Staff were provided with feedback from these meetings.

Staff talked positively about the interim clinical services director. Staff told us that if they had a concern, they felt comfortable talking to the interim clinical services director and felt confident that concerns would be acted on.

Medical care (including older people's care)

Regular team leader forums were held every six weeks and a recently established nurses forum provided development for key staff, where opportunities to progress and improve were discussed.

For our detailed findings on leadership, please see the corresponding sub-heading in the surgery report.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into actions. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Across the medicine oncology and endoscopy services staff were clear on the wider vision and strategy for the hospital. All staff were proud of the job they did and aimed to provide safe and high-quality care and could articulate the hospital's values.

For our detailed findings on vision and strategy, please see the corresponding sub-heading of the surgery report.

Culture

Most, but not all staff felt respected, supported and valued, and that there was an open culture where they could raise concerns without fear. All staff however, were focused on the needs of people receiving care. Patients and their families could raise concerns without fear.

Some staff told us the staffing levels, vacancies and staff changes had impacted on staff morale and, during our inspection, one nurse told us an agency nurse who regularly worked at the hospital had telephoned that day to confirm they would no longer be filling vacant shifts. Some staff reported that the clinical nurse specialist (CNS) lead who was supporting the service manager could not always be helpful as they could not support with 'hands on' clinical work during busy periods. Roles and responsibilities of the service leads did not appear to be fully understood or accepted by all staff working in the unit.

An oncology consultant confirmed they had good working relationships with the chemotherapy nurses and pharmacist in managing safety effectively. They also reported that the change in nurse leadership in the oncology unit had no impact on patient safety.

Most staff in the medicine service spoke positively about working in the hospital and described a culture that was open and friendly with an emphasis on delivering high quality care. The significant change in the staff team in the oncology unit however, had had a negative impact on some staff and we observed conversations that demonstrated there was friction between some staff members. Whilst this did not impact on the provision of patient care, there was a risk that the situation may deteriorate if all staff did not feel respected, supported and valued.

Many staff told us that the culture was positive and that they had worked at the hospital for many years. Staff had development opportunities and told us these were identified during the appraisal process. There were opportunities for staff to develop their knowledge and skills within oncology and endoscopy through the completion of competencies and staff specific training.

Some staff told us that they would not be willing to discuss their concerns to the freedom to speak up guardian as they feared their identity and disclosure would be shared with the senior management team.

For our detailed findings on culture, please see the corresponding sub-heading in the surgery report.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The managers attended heads of department meetings and clinical governance which discussed complaints, incidents, audits, risk and shared information. This information fed into the senior management team meetings and the MAC.

There were daily huddles in each department to plan the workload and share information such as staffing levels, incidents and complaints.

There was a systematic programme of clinical and internal audit to monitor quality and operational processes. There was an oncology dashboard and specific measures for endoscopic decontamination. The departments completed their own quarterly documentation audit.

Medical care (including older people's care)

No gaps were identified in the governance structure and the pharmacy manager participated in the governance and safety structure.

For our detailed findings on governance, please see the corresponding sub-heading in the surgery report.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Staff within the service were aware of local risks and mitigating actions. For example, the endoscopy service was identified as a financial risk as it did not have Joint Advisory Group (JAG) accreditation. Actions had been completed to mitigate the risks to support with the future application for assessment of the service. Staffing was a hospital-wide risk and mitigation included the block booking of agency staff, such as in the oncology service.

The service participated in the hospital's annual audit programme. Audits undertaken included infection control, record keeping, and medicines administration. Any performance issues or concerns were escalated through monthly departmental review meetings held between the heads of department, clinical lead and hospital director.

The senior management team held daily communication meetings which were attended by representatives from all departments to identify issues that could impact on the delivery of patient services. For example, staffing levels, patient dependency, availability of beds and patient safety incidents.

For our detailed findings on managing risks, issues and performance, please see the corresponding sub-heading in the surgery report.

Managing information

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

The service had a wide range of information available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances. Each of the indicators was given an equal rating. The hospital produced a quarterly clinical scorecard which listed performance. We saw action plans in place to manage areas which performed below the hospital target for example, with the full completion of patient records.

Staff received training on information governance as part of their mandatory training. Information technology systems were used effectively to monitor and improve patient care. There were effective arrangements in place, which ensured data was submitted to external providers as required such as serious incidents. The service had invested in a chemotherapy electronic patient management and prescribing platform that provided a safe and effective system.

Performance in the endoscopy unit had been measured against Joint Advisory Group accreditation standards and service improvements made where gaps had been identified.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. There were arrangements in place to ensure confidentiality of patient information and we found staff were aware of how to use and store confidential information. Computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information.

For our detailed findings on managing information, please see the corresponding sub-heading in the surgery report.

Engagement

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

The oncology unit was in the process of developing a new form to ensure patients, families and carers could contribute more effectively to service developments.

Medical care (including older people's care)

'Best practice' was discussed at the daily communications cell meeting where colleague's contribution to achieving 'best practice' was shared. Staff participated in the Spire scheme 'Spire for You' awards to promote the top performing team members.

The nursing leadership used safety huddles as ways of sharing important messages, and regular meetings were held for staff to learn from each other and enable them to cascade the information.

Opportunities for improvement were disseminated to staff and displayed throughout the hospital. Senior staff said they offered equal importance to the things that staff did well to encourage and motivate the team; we share plaudits and compliments widely.

Nursing and medical staff in the oncology unit held regular discussions with GPs to share information about the services provided at the hospital.

From the conversations we had with staff and observations we made during our inspection, it was evident that staff were engaged in the service and empowered to help improve services.

Learning, continuous improvement and innovation

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






The department leaders acted to make improvements in the running of the service. They had regular meetings where learning was discussed in a variety of forums. For example, heads of departments meetings and clinical governance meetings.

The service was committed to training and staff development. Most staff told us they were encouraged and supported to complete additional training.

The endoscopy service had an action plan that had been under continuous review to make required improvements to achieve the joint advisory group (JAG) accreditation. Staff aimed to apply for the assessment in November 2019.

The hospital had provided additional staffing resource within the pathology department to improve the timeliness of reports.

Surgery

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

Are surgery services safe?

Good 

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

In this section, we also cover hospital-wide arrangements such as how they deal with risks that might affect the hospital's ability to provide services (such as staffing problems, power cuts, fire and flood), the management of medicines and incidents, in the relevant sub-headings within the safety section. The information applies to all services unless we mention an exception.

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

Mandatory training

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

The hospital's mandatory training programme was comprehensive and met the needs of patients and staff. Training was primarily provided via e-learning courses, with some face-to-face sessions such as manual handling and infection control. The mandatory training programme was tailored to the skill requirement of staff and was dependent upon their role. Specific training on sepsis recognition was included in the acute illness management training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers could easily see which members of staff in their team had

completed training. Managers told us that training programmes were well embedded due to having a Spire training system in place. The department managers were involved in ensuring staff completed their training by providing opportunities for e-learning to be completed and ensure staff had dates booked for face-to-face modules. Staff were given allocated time to complete their mandatory training, staff we spoke with confirmed this. We saw that staff compliance with mandatory training was discussed at departmental meetings. Compliance was also seen to be discussed when an appraisal was completed.

There were 11 mandatory training modules to be completed annually, in July 2019 the hospital compliance rate for all modules except information governance was 96%. Information governance was at 87% for all hospital staff. This was due to this module being reset in June 2019, so compliance was low at the time of inspection, staff were due to renew this module in December 2019, meaning compliance would be met.

Medical staff received and kept up-to-date with their mandatory training, this was completed via their employing NHS trust, this was checked and updated by Spire Parkway Hospital. Records of mandatory training for visiting consultants were held on site. Resident medical officers (RMOs) completed mandatory and yearly update training with their agency. The hospital received training certificates that verified RMOs training status. This included advanced life support (ALS), European paediatric advanced life support (EPALS), blood transfusion, infection prevention and control, safeguarding children level three. Additional training, such as use of the hospital's electronic incident reporting system, was provided to RMOs and consultants as required.

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Nursing staff received and kept up-to-date with their mandatory training. The hospital set a target of 95% for completion of mandatory training. The hospital training performance for the surgical services showed mandatory training completion results were predominantly above the hospital target of 95%. Staff we spoke with had all completed their yearly mandatory training. However, information governance was at 82% for ward staff and 87% for theatre staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. These subjects were covered in the safeguarding modules. Also, the hospital had a lead for dementia and they carried out regular training updates for all staff.

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.

The hospital had clear systems, processes and practices to safeguard adults, children and young people from avoidable harm, abuse and neglect that reflected legislation and local requirements. Safeguarding adults and children policies were in-date and accessible to all staff. They included contact details for the local authority safeguarding teams and information on female genital mutilation (FGM) as per national guidance (Department of Health and NHS England, FGM mandatory reporting duty, October 2015). Safeguarding information was displayed in all clinical areas.

All employees received some form of safeguarding training. All clinical staff involved in the direct care of children were trained to safeguarding children level three every two years. Surgical ward staff were also trained to this level as children may attend the ward as visitors. Staff also had access to two safeguarding leads who were level 4 children's safeguarding trained. All clinicians were also trained to safeguarding adults' level two every two years and had access to level three trained staff for additional advice and support.

All staff knew the director of clinical services was the safeguarding lead within the hospital and had been trained to safeguarding children level four. 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).

As of July 2019, completion rates for safeguarding training exceeded the hospital target of 95%, for all hospital staff. Both safeguarding adults level 2 and safeguarding children level 2 was at 97%. For safeguarding children level 3, 100% of staff required to attend this training had completed this module. Consultants responsible for the care of children had completed safeguarding level 3 training. The lead CYP nurse and director for clinical services were also leads for children and young people's safeguarding and were trained to safeguarding level 4.

All staff received training specific for their role on how to recognise and report abuse. Staff received training on safeguarding through electronic learning and had a good understanding of their responsibilities in relation to vulnerable adults and children. When we spoke with nursing staff, they demonstrated a good level of knowledge in relation to safeguarding triggers, forms of abuse and the processes followed. They were able to explain how to raise a safeguarding concern.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Information for patients was available in different languages to prevent harassment and discrimination in relation to protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Arrangements were in place to safeguard adults from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures. There was a safeguarding vulnerable adults' policy in place, which explained staff responsibilities, the categories of abuse and how to manage situations of suspected abuse. There was also a separate local safeguarding policy that included information on female genital mutilation. Staff liaised with other professionals and agencies such as GPs, the police and local authority safeguarding leads, when needed.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they had not

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had to make any referrals recently. However, they showed us the process they would follow and who they would inform if they were concerned about the potential abuse of a patient or visitor.

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

There had been no safeguarding concerns reported to the CQC in the reporting period, from April 2018 to March 2019.

The hospital had a chaperoning policy and staff knew how to access it. Nursing staff accompanied patients while they were having procedures or were being examined by consultants.

Cleanliness, infection control and hygiene

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

There were effective systems to prevent and protect people from a health-care associated infection and ensure standards of hygiene and cleanliness were maintained. This was in line with current guidance from the National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 61: Infection Prevention and Control (April 2014). Hard flooring was in clinical areas, handwashing facilities were in place and hand sanitiser gel dispensers were available in corridors, ward areas, bedrooms and clinical areas.

The hospital had up-to-date policies for infection, prevention and control (IPC) and related topics such as decontamination and isolation precautions. Staff could access these for guidance through the hospital's electronic system.

The hospital had a dedicated infection control nurse (ICN) who had recently completed an infection control course. They met with the Spire national ICN and participated in the national IPC group, where policies and procedures

where discussed and updated. The hospital had access to a microbiologist 24 hours a day for advice on patient care and they also attended the hospital infection control committee meeting. Each department had a link nurse.

There was an annual IPC audit programme, which included hand hygiene audits, environmental cleaning audits and surgical site infections.

All staff were required to complete IPC training during their induction and then annually at the level appropriate to their role. As of July 2019, the overall hospital completion rate was 96% for all staff.

The service performed well for cleanliness. We saw the Patient-Led Assessments of the Care Environment (PLACE) audit for 2018 which showed the hospital scored 99% for cleanliness which was in line with the national average.

Legionella water testing was completed every three months and pseudomonas testing monthly. Minutes of the September IPC committee confirmed that neither legionella or pseudomonas was detected in the August water test.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All ward areas and theatres were clean, tidy and free from clutter. Furnishings were suitable, clean and well-maintained. One patient said the ward "exceeded expectations in terms of cleanliness".

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The hospital had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. The daily cleaning checklists were completed in 100% of the records we reviewed. The hospital had policies and procedures in place to manage infection prevention and control. Staff accessed policies via the hospital intranet and were able to demonstrate how these policies were easily available.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw the correct use of personal protective equipment (PPE) such as disposable gloves and aprons. PPE was available in all clinical areas. Staff in theatres wore appropriate theatre clothing (scrubs) and designated theatre shoes were worn. This was in line with best practice (Association for Perioperative Practice (AfPP), Theatre Attire (2011)). Staff followed the hospital's policy on infection control, for

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example, we observed staff complying with 'arms bare below the elbow' and not wearing jewellery. We saw an 'arms bare below the elbow' audit carried out for June 2019 in theatres, where compliance was 100%.

We observed how theatre staff wore disposable gowns over their theatre clothing when leaving their department.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw 'I am clean' stickers were used in all areas, which were all up-to-date. Clean and dirty equipment was managed well within the theatre and there was no cross contamination of equipment. The hospital had its own central sterilisation service to clean and sterilise theatre instruments and equipment. The service had international organisation for standardisation accreditation (ISO) which is a global quality management standard. This meant all the machinery used to decontaminate and sterilise instruments were being maintained correctly and cleaned consistently to an approved standard. In addition, the processes within the department meant that instruments were being decontaminated and sterilised correctly.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital completed monthly hand hygiene audits, where 10 members of staff were observed to check they washed their hands in accordance with the World Health Organisation (WHO) Five Moments for Hand Hygiene. From April 2018 to April 2019, monthly hand hygiene compliance was generally 100% in all departments. Where compliance did not meet the hospital target of 95%, the department was re-audited to ensure there was a return to required standards. For quarter two (July to September 2019) the hospital scored 100% compliance. Three out of the four theatres had laminar air flow ventilation systems. This was compliant with national recommendations (Department of Health, Heating and ventilation systems. Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises (November 2007)). This meant there was an adequate number of air changes in theatres per hour, which reduced the risk to patients of infection. This was serviced on a six-monthly basis and the filters were changed.

The hospital reported surgical site infection (SSI) performance directly to Public Health England (PHE). All patients were followed up at two and 30-days post-discharge, during which staff asked questions in line with PHE SSI monitoring. If a patient raised any wound

infection concerns this was reported through the incident reporting system and investigated. There had been 28 surgical site infections reported for April 2018 to March 2019, 15 of these patients had undergone orthopaedic procedures. This equated to a rate of 0.5% of all surgical procedures carried out. The patients involved had all undergone orthopaedic procedures. We saw they were investigated, and no root cause was identified. However, learning from the incident was shared. The hospital had a consultant dashboard, which recorded incidence of infection. From this, no trends had been identified, for example with particular surgeons, operations, theatres, or scrub teams. On discharge, all patients were given an information leaflet about how to recognise the signs of infection.

The hospital had developed its own IPC post-operative surgical site surveillance alert cards which were provided to patients on discharge. The information on the card includes the hospital IPC lead name and direct contact number. The patient present the card to a medical practitioner assessing the patient in the event of a suspected wound infection following their surgery to ensure correct information was shared.

From July 2018 to June 2019, zero incidences of hospital acquired MRSA, MSSA (a skin infection that may cause pneumonia), E-Coli (a bacterium that can cause severe abdominal cramps, bloody diarrhoea and vomiting) and C. difficile (a bacterium which infects the gut and causes acute diarrhoea) were reported.

All staff were required to complete IPC training during their induction and then annually at the level appropriate to their role. The compliance rate for the ward staff and theatres was 95%. Theatre staff had completed additional training in 'scrub technique' and the handling of surgical instruments. Staff competencies we reviewed confirmed this.

Sharps bins were clearly labelled and tagged to ensure appropriate disposal and prevention of cross infection.

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.

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The design of the environment followed national guidance. The wards were spacious, and patient centred. Inpatient rooms were well-appointed, with ensuite wet rooms and air conditioning. There was free Wi-Fi and a TV in each room. The rooms had a large shower area with hand rails which provided sufficient space for patients with mobility issues. We spoke with five patients who complimented the standard of the inpatient rooms. The wards and theatre were well signposted from the main entrance.

Staff carried out daily safety checks of specialist equipment. We saw that all anaesthetic equipment was checked daily prior to use. Records also indicated that the resuscitation trolleys and their contents were checked daily in line with hospital policy.

Servicing of large items of equipment in the hospital was under service level agreements with the company who provided the equipment. All items had details of service date on them and dated for next service. Staff told us if equipment failed, the processes in place allowed swift response and replacement if necessary whilst being repaired.

The service had enough suitable equipment to help them to safely care for patients. This included anaesthetic equipment, theatre instruments, vital sign monitors and commodes. The hospital had four main operating theatres and one theatre for endoscopy. All had the appropriate anaesthetic equipment in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.

There was appropriate resuscitation equipment available in the case of an emergency. Resuscitation trolleys were situated in the theatre, ward and day care unit. They were all well organised and had tamper evident seals in place. The ward had a sepsis trolley which was easily accessible if a patient developed sepsis. Sepsis is a potentially life-threatening illness, where the body's response to infection injures its own tissues and organs. Theatres also had a difficult airway trolley, transfer bag and malignant hyperthermia kit. Malignant hyperthermia is a type of severe reaction that occurs to particular medications used during general anaesthesia.

We found bariatric surgery was carried out with safe and appropriate equipment for the patient group.

Patients who needed implants, such as hip prosthesis, had this clearly recorded in their notes. This included the device number and size. This meant all implanted devices could

be tracked in case any faults developed. Implants were also stored in a designated store room, which was well organised and reduced the risk of the wrong implant being used. The hospital also recorded implants used on national registers, such as the breast implant register and national joint register (NJR). This showed which patient received which type of implant and when, to allow tracking if needed.

Staff disposed of clinical waste safely. We saw good arrangements implemented for managing waste and clinical specimens to ensure people were kept safe. There were separate colour coded arrangements for general waste, clinical waste and sharps. Theatres had an effective clean and dirty flow for the disposal of clinical waste and used instruments. The hospital had up-to-date policies to support staff with the correct disposal of waste. Sharps containers were labelled with the hospital's details for traceability purposes. This was in line with national guidance (Health and Safety Executive (HSE), Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013)).

Each ward contained a dirty and clean utility room. The clean utility room, which contained medicines, was locked and required a security pass to enter. Within the room the individual cupboards containing medicines all required keypad security access. The dirty utility room contained details about the different coloured clinical waste bags and what should be placed in each. Inside all the dirty utility rooms were locked cupboards, which contained hazardous cleaning chemicals (COSHH) therefore not accessible by the public.

Patients could reach call bells and staff responded quickly when called. Each patient room and bathroom had call bells to alert staff when assistance was required. Call bells and emergency cord pulls in bathrooms were checked regularly to ensure people could promptly summon support when required.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The national early warning score (NEWS2) was used to

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identify deteriorating patients. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored according to pre-determined parameters. There were clear directions for actions to take when a patient's score increased. There were appropriate triggers in place to escalate care, which members of staff were aware of. We reviewed seven sets of patient notes and found that scores were added up correctly and escalation was carried out appropriately. This meant that patients who were deteriorating or at risk of deteriorating were recognised and treated appropriately.

NHS England published national Safety Standards for Invasive Procedures (NatSSIPs) in 2015, to support organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur. The NatSSIPs had enhanced the World Health Organisations (WHO) Surgical Safety Checklist, which included safety-briefing, sign in, time out, sign out and debriefing. This did not replace the existing WHO surgical checklist, but rather enhanced it by looking at additional factors.

We attended two full procedures in theatres which enabled us to observe the complete WHO surgical safety checklist pathway. We observed all staff being fully engaged with team/safety briefings, sign in, time out and de brief. Swabs, needles, instruments and sharps were counted to prevent foreign body retention and subsequent injury to the patient by two members of staff, a registered perioperative practitioner or senior health care assistant appropriately trained/scrub trained. The service audited WHO checklist compliance by observing 10 patients each month through their theatre journey. From May to July 2019, data showed compliance with the WHO checklist was consistently 100%.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. Nursing staff used nationally recognised tools to assess patients' risk of, for example, developing pressure ulcers (Waterlow), malnutrition (MUST), falls, infection control, and risks associated with moving and handling. We reviewed 10 patient records, all risk assessments were completed post-operatively. The completion of post-operative risk assessments was regularly checked as part of the medical records audit. Compliance for April 2019 was 100%.

Elective surgical procedures had a care pathway in place. The pre assessment process was clearly described in each care pathway. We reviewed the care pathway for replacement of a hip joint. Clinical risk assessments included anaesthetic score, vital signs, urinalysis, Waterlow score to assess the risk of pressure sores, thrombosis risk assessment, bleeding risk assessment and falls risk assessment.

Female patients were informed that a pregnancy test may be required on admission to reduce any risk to an unborn foetus in the case of patients who were not aware they were pregnant.

All patients over the age of 75 years completed an abbreviated mental test score for dementia screening. All patients screening positive for dementia then went on to be fully risk assessed to make sure they understood and had mental capacity to make an informed consent decision about their treatment.

Patients had a physiotherapy assessment following their surgery to make sure they were not developing a post-operative chest infection and to check they were able to mobilise.

Staff knew about and dealt with any specific risk issues. National guidance states all surgical patients should be assessed for risk of venous thromboembolism (VTE) (a condition in which a blood clot forms most often in the deep veins of the leg, groin, arm, or lungs) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Reassessment of VTE and bleeding risk should be undertaken at the point of consultant review or if the patients' clinical condition changes (NICE, Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism [NG89] (March 2018)). VTE risk assessments were regularly audited for completion. From January to December 2018, results showed compliance was between 99% and 100%. We reviewed 10 medical records and found VTE risk assessments were completed daily and correctly for all patients.

There was a screening tool and pathway for the management of sepsis. Sepsis is a serious complication of infection. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. The service had implemented the sepsis six pathway in line

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with guidance from the Sepsis Trust. This is the name given to a bundle of medical interventions designed to reduce the death rates in patients with sepsis. The pathway consists of three diagnostic and three therapeutic steps; all should be delivered within the first hour of recognition. The wards had a sepsis box, which contained the equipment and medicines staff needed to promptly initiate the sepsis six bundle.

Patients for elective (planned) surgery underwent a thorough nurse led pre-operative assessment before their operation. Questions included the patient's past medical history, allergies, current medication, and previous anaesthetic and/or infection risk. All required tests were undertaken at the pre-operative assessment, including MRSA screening and routine blood tests such as group and save. This was in line with national guidance (NICE, Routine preoperative tests for elective surgery [NG45] (April 2016)).

Anaesthetists held pre-assessment clinics. They reviewed patients who were classed as high risk for anaesthesia or had medical conditions that deemed them at risk of developing complications after surgery.

The service used the American Society of Anaesthesiologists (ASA) classification system to grade the patients' level of risk before surgery. For example, patients classified as ASA1 were low risk and healthy, while ASA3 patients were higher risk, with severe systemic disease. ASA grades were recorded at pre-assessment nursing team, and on admission for surgery by the anaesthetist in the patient record. Any patients who were identified as high risk by the pre-operative nursing team were referred to an anaesthetist prior to their admission. Patients identified as high risk or had potential complications diagnosed following test results, for example uncontrolled diabetes, were referred to the consultant for further review before surgery was undertaken. The hospital only accepted patients classed as ASA1, ASA2 or stable ASA3.

Patients classed as ASA3 were monitored post-operatively in one of the wards monitored beds if required. These bedrooms were equipped for patients who needed higher levels of care and observation, such as continuous monitoring. These were situated next to the nursing station to enable increased visibility. The service also had a three-bedded extended recovery unit (ERU). The theatre recovery staff would not return a patient to the ward until completely stable.

The service complied with the Association for Perioperative Practice (AfPP) guidance for assessing and responding to patient risk for all surgical areas. This included ward admission, anaesthesia, surgery and recovery.

Staff shared key information to keep patients safe when handing over their care to others. The theatre team held a 'huddle' at the beginning of every day. All members of the theatre team attended to review the cases booked for the day. They discussed the operations, equipment needed, on call and emergency team cover, including advanced life support (ALS) and paediatric immediate life support (PILS) trained staff. These meetings were recorded for staff to refer to if needed. Any changes to the operating list were reprinted on different coloured paper, which we observed during our inspection. This was in line with best practice guidance.

Shift changes and handovers included all necessary key information to keep patients safe. Spire Parkway hospital took a hospital wide approach to assessing and responding to risk on a daily basis. Wards held early morning handovers from the night staff to the day staff. These ensured the safe handover of patients and allocation of work was completed. Any issues from this handover would be picked up at the hospital wide safety huddle.

We attended the morning safety huddle in the theatre, this was attended by all theatre staff on shift for that day and included recovery, critical care and resuscitation staff. This huddle identified who was allocated to which theatre and what level of resuscitation training they had. Each list and theatre team were discussed and any equipment issues, staffing, breaks and who would cover them. Staff were also given a 48-hour Flash Report. This set out learning from other Spire Healthcare hospitals and included never events/ serious incidents which occurred and the learning from them. As in the ward structure any issues identified during this huddle would be taken to the hospital wide safety huddle.

Patients were given the ward telephone number to ring in the event of any issues or to ask questions. All patients were phoned two days and 30 days post-surgery to check on their progress. Telephone enquiries were documented and filed in the patient's notes and further appointments were made if required. Staff told us of a wound check appointment that was brought forward due to concerns picked up from the two-day post-operative call.

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Staff were supported by an RMO (resident medical officer) if a patient's health deteriorated. The RMO was on duty 24 hours a day and was available on site to attend any emergencies. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care. The RMO and staff told us consultants were responsive and supportive. In an emergency, staff would request an ambulance to transfer the patient to the local acute NHS emergency department.

The hospital had a transfer agreement in place with the local acute NHS trust should a patient require a higher level of care. A consultant, anaesthetist and/or nurse would escort the patient during transfer if indicated. Transfer arrangements were determined by the consultant and anaesthetist. From April 2018 to March 2019, the hospital reported 12 unplanned transfers to the local acute NHS trust. We saw detailed root cause analysis investigations were completed for the unplanned transfers, with learning identified and actions taken where indicated, to minimise the risk of recurrence and enhance patient safety.

The hospital's resuscitation team was reviewed at the daily operational meeting. We observed each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and runner. This was in line with best practice guidance (Resuscitation Council (UK), Quality standards for cardiopulmonary resuscitation practice and training (May 2017)). Each member of the team carried a communication device, so they could be contacted immediately in the event of an emergency.

On the wards and in theatres, there was always a member of staff who was trained in ALS (advanced life support) and ILS (immediate life support).

The hospital undertook practice emergency scenarios on both the ward and theatres. These were run by resuscitation officers and received well by the staff.

Nursing and support 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 staff and support staff to keep patients safe. Data we reviewed, and observations made during our inspection confirmed there was sufficient staff to provide the right care and treatment.

Managers accurately calculated and reviewed the number and grade of nurses, operating department practitioners (ODPs) and healthcare assistants (HCAs) needed for each shift in accordance with national guidance. The ward sisters used an adaptation of a national acuity staffing tool. This looked at the acuity of each patients that would be on the ward and allocated the safe number of staff per shift. The hospital's baseline target for inpatients was a ratio of one nurse to five patients (1:5). Better patient outcomes have often been associated with higher staffing levels and ratios of 1:7 and lower (NHS Improvement, Safe staffing for adult inpatients in acute care: evidence review (January 2017)). Flexible staffing rosters were completed a month in advance. Planned activity for the hospital was reviewed by managers on a weekly basis so that substantive and bank staff could be flexed according to activity and patient acuity when needed. The next day's staffing levels and activity was reviewed daily by senior staff. This included the number of theatre cases booked and whether they were major or minor procedures. This helped to assess the correct number of nurses required for each shift.

All staffing tools were used in conjunction with the red flag algorithm following the NICE 2014 Safe Staffing for Nursing in Adult Inpatient Wards. Additionally, variances relating to specific nursing needs were highlighted to the ward following pre-operative assessment (for example, requirement for extended recovery or closer observation).

The number of nurses and healthcare assistants matched the planned numbers. We saw from the staffing rota and the staff on duty at the time of our inspection that actual staffing levels matched planned staffing levels. The number of nurses, HCAs and ODPs in each department matched the planned numbers. From April to June 2019, the hospital reported 100% of shifts were filled.

The operating department used guidance set out by the Association for Perioperative Practice (AfPP) in 2015 related to safe staffing levels; 'Safe Staffing Levels for the Peri-operative Environment as a staffing tool (2015)'. Theatre staffing levels were also based on nationally recognised guidelines such as the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Anaesthetic Recovery Nurses Association (BARNA).

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They used the AfPP safe staffing tool to ensure the department was adequately staffed. Each theatre was staffed with one team leader, two qualified and one unqualified member of staff. There were enough staff on duty during the patient's surgical procedure, which included surgeons, anaesthetists and operating department practitioners. This was in line with AfPP guidance and meant the service had assessed the risk to patient's undergoing surgery.

In the other areas of the hospital we visited we saw there were adequate numbers of support staff on duty including pharmacists, physiotherapists, occupational therapists, pathology laboratory, domestic and catering staff.

From July 2018 to June 2019, the average turnover rate for all staff was 21%.

The service had low vacancy rates. As of June 2019, the service employed 18.8 whole-time equivalent (WTE) registered nurses and 6.1 WTE HCAs for inpatients (the ward), and 22.7 WTE nurses and 14.6 WTE ODPs and/or HCAs for theatres. This equated to a vacancy rate of:

- 3.5% nursing staff – inpatients
- 0% nursing staff – theatres
- 0% HCAs – inpatients
- 6.4% (one WTE) ODPs/HCAs – theatres.

From July 2018 to June 2019, the average sickness rate for all hospital staff was 3.25%.

The service had low sickness rates. From July 2018 to June 2019, the average sickness rate for nursing staff was 2.9% for inpatients and 0% for theatres. For HCAs/ODPs it was 1.8% for inpatients and 4.8% for theatres.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff had completed mandatory training and received an induction before they commenced duties. This was confirmed by bank staff we spoke with. They told us they regularly worked at the hospital and were familiar with local working practices.

Medical staffing

The hospital 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.

Patient care was consultant-led. Consultants were available for advice and/or to review admitted patients. They provided 24-hour on-call cover for patients post-operatively and were required to be within a 30-minute drive of the hospital when off site. It was mandatory for all admitting consultants to visit their patients at least once per day, or more frequently if the patient was receiving a higher level of care, or at the request of the hospital director, the director of clinical services or the resident medical officer (RMO). If the named consultant was unavailable at any time while they had patients admitted to the hospital, they arranged appropriate alternative named cover by another consultant in the same specialty. There was a buddy system in place which was found to be effective.

All consultants who worked at the hospital did so under practising privileges. This is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in a private hospital or clinic.

The hospital had a medical advisory committee (MAC) whose responsibilities included, ensuring new consultants were only granted practising privileges if deemed competent and safe to practice. All consultants carried out procedures within their scope of practice within their substantive post in the NHS. As of July 2019, 310 doctors had been granted practising privileges to work at the hospital.

Three consultants had their practising privileges removed in January 2019 following a review of the dental services provided at the hospital which ended in the contracts being terminated. Two consultants have had their practising privileges removed following clinical concerns, one investigation was ongoing and has been referred for a Royal College of Surgeons review and has been referred to the GMC.

Anaesthetists were expected to be available for 48 hours after surgical procedures in case a patient, whom they had anaesthetised, became unwell.

Immediate medical support was available 24 hours a day, seven days a week. This was provided by registered medical officers (RMOs) who were employed through an external agency. The RMO slept on site and worked a shift pattern of one week on and one week off.

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There was a regular RMO at Spire Parkway. A handover took place between RMOs at the start/end of each week. Handover included a structured discussion of each patient and details of any work outstanding. They also attended daily nurse handovers, the ward round and daily huddles. The RMO said they felt well supported by nursing and medical staff and could contact a patients' named consultant or anaesthetist if they needed further advice or support. They had access to policies and procedures via the hospitals intranet. Should an RMO be unavailable due to, for example, sickness, another RMO could be in place within four hours. Consultants would provide medical cover should a patient become unwell within this time

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. We reviewed 10 sets of patient records and found they were generally legible, up-to-date and contained all relevant information regarding patients' care and treatment.

Clear pathway documents were used throughout the patient pathway. Risk assessments were completed from the start of the patient's pathway in pre-operative assessment through to admission.

There were surgical pathways which included preoperative assessments. The assessments were carried out in line with NICE guidance. We reviewed a sample of these and found they were completed thoroughly.

Nursing staff completed a discharge summary letter for the patient's GP. This gave details of the operation performed, any medication required as a continuation of their care and any follow-up requirements. Consultant contact details were provided to GPs, so they could contact them for further advice if required. These letters were given to the patient to take to their GP.

Staff completed and recorded intentional care rounding. Intentional care rounding is a structured process where staff performed regular checks with individual patients at set intervals. For example, we observed HCAs visiting

patients to check that call bells and drinks were within reach and they asked if the patient was comfortable or in any pain. We saw these were documented in the patients' records we reviewed.

Records were stored securely. The hospital used a paper-based system for recording patient care and treatment. We saw these were stored securely to protect confidential patient information.

In quarter one of 2019 an audit of hospital-wide patient records found 64% were fully signed, dated and timed by a consultant against a target of 80%. Consultants were reminded to complete accurate patient records by email.

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. A comprehensive medicines management policy was in place, which covered obtaining, prescribing, recording, handling, storage, security, administration and disposal of medicines. Staff we spoke with were familiar with the policy and aware of their roles in managing medicines safely.

The pharmacy team had a presence in each core service. Staff on the ward and in each department visited were aware of the team and their roles and reported excellent communication.

Pharmacy attended multidisciplinary team meetings across the hospital and the 10 at 10 meetings. The pharmacy team had a daily huddle, a standard agenda included for example staffing, MDT feedback, individual patients of concern, training availability and medication incidents.

The hospital have a stock of pre-labelled medicines that can be given at discharge if the pharmacy is closed. We saw that this process was carefully monitored. There was a post discharge telephone service for patients 48 hours after discharge. Medicines issues could be addressed on these calls and patients can call pharmacy for advice outside of these hours.

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Medicine records were completed appropriately – including allergies, VTE assessments and medicines reconciliations. Audits were completed monthly of patient's medicine records by pharmacy staff. Medicines were stored securely, and access appropriately controlled.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. The pharmacists spoke to patients on the wards and in day-case areas about their medications before admission and those prescribed whilst in the hospital, including medications prescribed for them to take home.

A recent initiative taken by the pharmacy staff, had been to personalise leaflets for patients regarding their medicines following joint surgery. The original patient information leaflet document was held electronically, and pharmacy staff personalised it before printing it to give at discharge. A similar leaflet was provided for bariatric patients where the medicine post-surgery was dependent on the actual procedure undertaken. This gave a bespoke service for these patients.

The pharmacist had also developed a leaflet for patients taking herbal preparations to ensure they do not affect their anticoagulation therapy.

The pharmacist responsible for the pre-op clinic also described linking closely with the community pharmacists, when patients receiving blister packs had planned surgery. This was ensuring patients own medications could be used on admission.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored securely, and access was restricted to authorised staff. Medicine records were held as physical paper charts and kept in patients' private rooms. We observed no medication was left unattended. Staff carried out daily checks on controlled drugs (CDs) and medication stocks to ensure medicines were reconciled appropriately. CD destruction kits were available, and staff could describe how they would destroy them.

Staff monitored, and recorded temperatures where medicines were stored to ensure they were effective and safe for patient use. Medicines that needed to be kept below a certain temperature were stored in locked fridges. The treatment rooms where medicines were stored were air-conditioned, which meant the temperature could be

maintained within the recommended range (below 25°C). Ambient and fridge temperatures were checked daily and stored within the correct temperature range. Staff knew what to do if temperatures were out of range.

All medication checked was in date and the controlled drug balances were correct. Emergency medications were stored in secure containers on the resuscitation trolleys. These were all in date.

Anaesthetic drugs were drawn up in syringes and prepared ready for use on each patient. All syringes were labelled as per hospital policy.

Staff followed current national practice to check patients had the correct medicines. We saw use of national guidance to guide treatment choices, for example, anticoagulation therapy and antibiotic prescribing guidelines. The pharmacy manager was the hospital's antibiotic steward. An antibiotic steward seeks to achieve the optimal clinical outcome related to antibiotic use, to minimise toxicity and other adverse events and limit the selection for antimicrobial restraint strains. This reduces the risk of antibiotics becoming less effective.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We observed a strong reporting culture within the pharmacy department and saw that incidents, including near misses, were routinely reported. Pharmacy staff described examples of incidents they had reported, and actions taken to minimise the risk to patients. Medicine incidents were reported through the hospital's electronic reporting system. Staff could describe how safety alerts are received and disseminated and how actions are assured. The medicine alerts were managed by the pharmacy team. Incidents involving medications were shared at handovers and then at senior management briefings. A daily briefing email was sent to the hospital wide team detailing all incidents reported.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We discussed the use of hypnotic medications (sedatives)– pharmacy staff advised us that these were avoided. We saw evidence of a patient having been prescribed one prior to admission but on discussion this had not been prescribed whilst an inpatient. We spoke with the patient, and she was not worried by this not being prescribed.

Surgery

There has recently been a skill mix review in the pharmacy department, this included the hospital director and was discussed via the medicine's management meeting. This has resulted in recruitment of more pharmacy technicians, there was a process for succession planning as many of the staff have been in their roles for many years.

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 hospital used an electronic reporting system to report all incidents. Staff told us they were encouraged to report incidents and felt confident to do so.

From April 2018 to March 2019, the hospital reported 1010 clinical incidents and 331 non-clinical incidents. Each incident had been reported and investigated in accordance with the hospital's policy for incident management. All clinical incidents were categorised according to their level of harm; the majority were graded as low or no harm.

Staff raised concerns and reported incidents and near misses in line with provider policy. The hospital policy stated that incidents should be reported through the hospital electronic reporting system. All the staff we spoke with told us they were encouraged to report incidents.

Staff reported serious incidents clearly and in line with hospital policy. From July 2018 to June 2019, the hospital notified the Care Quality Commission (CQC) of four serious incidents. Serious incidents were investigated by staff with the appropriate level of seniority, such as the clinical director and managers of departments. Lessons were learned from serious incidents and changes were made to the service. Any immediate learning points for staff in theatres and the wards were raised at the daily huddles.

The hospital had no never events from July 2018 to June 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national

guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

The hospital had a duty of candour policy. We asked a number of staff, both clinical and non-clinical, about their understanding of duty of candour and all staff were able to give examples of how this would be applied. Their responses reflected an approach of openness and transparency. The policy contained a flow chart showing the escalation to candour and a record of notification. The hospital's electronic reporting system included prompts to ensure duty of candour obligations were undertaken, which we saw. We saw five examples of incidents when duty of candour had been exercised appropriately. Verbal discussions were held with the families and then letters sent of the discussions held. The service had standard template letters which were personalised for each individual case, although we saw that these had not been used in one case reviewed.

Managers debriefed and supported staff after any serious incident. This was evident from the investigation reports we reviewed and conversations we had with staff.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were reviewed daily and we saw they were discussed and daily staff huddles and the 10 at 10 daily meeting. Staff were assigned to lead and investigate incidents. We saw lessons had been learnt from incidents, for example the pharmacy team had provided interactive workshops and medicines management training as drop in sessions for all nursing staff, following medicines incidents.

Managers on the wards and across the departments told us they investigated incidents and shared lessons learned with teams and the wider service. We saw how information

Surgery

was cascaded from senior levels through to teams on the wards by newsletters and minutes of governance and departmental meetings. This reflected what staff reported to us on the wards, in the pre-operative assessment unit, and theatres.

There was evidence that changes had been made as a result of feedback. From the result of an incident, changes had been made in training for nurses. There was now regular training in the use of syringe drivers.

Managers shared learning with their staff about never events that happened elsewhere. We saw the corporate Spire newsletter, which shared learning regarding serious incidents or never events across the organisation.

Clinical Quality Dashboard

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

The hospital monitored safety through a quarterly clinical scorecard. The scorecard reported on 47 clinical indicators such as pain scores, complaints, infection control and pressure ulcer incidence.

The scorecard was completed by all the hospitals in the Spire Healthcare organisation which meant that the hospitals could benchmark against each other.

All staff we spoke with were aware of the score card and understood its benefits; we saw the 2019 quarter two score card displayed on notice boards. The provider monitored incidences of venous thromboembolism (VTE) which is a formation of blood clots in the vein), pressure ulcers and falls.

The score card was red, amber, green (RAG) rated, green ratings meant the hospital was performing at or above target for the indicator. Spire Parkway Hospital was performing at or above target level.

The scorecard was discussed at head of department meetings and analysed for areas of improvement. This was then fed back to the local teams. Any measure not meeting the required target had an associated action plan which was reviewed on a monthly basis.

Are surgery services effective?

Good 

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

In this section, we also cover hospital-wide arrangements such as the use of current-evidence based guidance and how they ensure staff are competent to carry out their duties, in the relevant sub-headings within the effective section. The information applies to all services unless we mention an exception.

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies seen were up-to-date and contained current national guidelines and relevant evidence. Policies were stored on an online system which all staff had access to. In theatres, we saw the 'policy of the month' displayed for staff to read and sign to say they had read it. Meeting minutes showed that updated policies were discussed in departmental team meetings. Staff had to sign a monthly policy document to say they had read updated policies. Staff were also informed of new or amended policies at the daily operational meeting.

There was an effective system to ensure policies, standard operating procedures and clinical pathways were up-to-date and reflected national guidance. Most policies were updated by Spire Healthcare and disseminated to each hospital. We reviewed eight policies and found all were within the review date. Policies were current and based on professional guidelines, for example, National Institute for Health and Care Excellence (NICE) and Royal College guidelines.

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From our observations of care and the patient records we reviewed we saw examples of NICE clinical guidelines (CG) being implemented such as CG50, care of the deteriorating patient and CG51, sepsis recognition.

Patients assessed to be at risk of venous thromboembolism (VTE) were offered VTE prophylaxis in accordance with NICE guidance. The VTE audit show 100% compliance from April 2019 to June 2019.

Clinical indicators such as venous thromboembolism assessment compliance, national early warning score documentation, infection control, consent procedures, patient satisfaction and staff training were measured. Managers told us that when hospital heads of departments met they discussed the clinical scorecard and shared best practice with each other.

Staff used surgical pathways which were in line with national guidance. This included for example, integrated care pathways specific for a day case procedure. The day case pathway included the predicted American Society of Anaesthesiologists (ASA) classification. Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. Our review of patient records, guidelines and clinical pathways, and discussions with staff confirmed care was delivered in line with national guidance and standards.

The service used evidence-based guidance and quality standards to inform the delivery of care and treatment. For example, the pre-operative assessment clinic assessed patients in accordance with National Institute for Health and Care Excellence (NICE) guidance (NICE, Routine pre-operative tests for elective surgery [NG45] (April 2016)), and NICE guidance-Recommendations for Specific Surgery ASA grades.

Staff followed guidance regarding the recording and management of medical implants, such as hip implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central database. We saw evidence of this in the notes we reviewed. Relevant paperwork was completed at time of insertion of implant and was documented in the National Joint Register (NJR) by theatre staff within 24 hours of the procedure. The service also participated in the national spine and breast registries.

Staff and managers were aware of the Royal College of Surgeons, standards for cosmetic surgery and we saw

evidence of where the standards had been implemented. For instance, in the patient records we reviewed the two week cooling off period had been explained and documented.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Hospital policies were equality impact assessed to ensure guidance did not discriminate against those with protected characteristics as set out in the Equality Act 2010.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Food was prepared on site in the hospital kitchen by a team of chefs and met the nutritional requirements of patients, staff and visitors to the hospital.

The hospital menu was compiled in consultation with a nutritional dietitian. Patients were able to choose from a variety of meals. The chef told us that they often responded to special requests from patients; Patients were complimentary about the food provided and one patient told us the food was 'equivalent to that of a five star hotel.'

A member of the catering team attended the multi-disciplinary ward round which identified patients with special dietary requirements. This information was also displayed on a notice board in the kitchen.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST) to assess, monitor and record patients' nutrition and hydration needs. This was in line with national guidance (NICE, Patient experience in adult NHS services [QS15] (February 2012)).

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Staff fully and accurately completed patients' fluid and nutrition charts where needed. We observed MUST assessments were completed in all the records we reviewed. These were routinely updated as required. Staff used fluid balance charts to monitor patients' fluid intake.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients waiting to have surgery were kept 'nil by mouth' in accordance with national safety guidance. This was to reduce the risk of aspiration during general anaesthesia. Staff told us of new guidance from the Royal College of Anaesthetists, where patients are allowed 30mls of water every hour up to their admission into theatre. We saw this in practice during the inspection. Patients having elective surgery were given clear instructions about fasting before admission. Information was given verbally at the pre-operative assessment and in writing. Admission times were generally staggered so that patients were fasted for the minimum amount of time. Patients nutrition status was discussed during the daily safety briefing and anaesthetists requested 'pre-operative nutritional drinks' for patients who would be waiting over two hours for their surgery. We observed this happened during team briefs.

Recovery and the ward areas ensured the effective management of nausea and vomiting. We saw staff enquire about patient's appetites and offer anti-sickness medication for patients who reported feeling nauseated. We also saw how staff returned to check the medication had worked and if necessary offer an alternative anti-sickness medicine. For patients able to take their own fluids, drinks were available on bedside tables and within reach.

Patients recovering from surgery had jugs of water within reach. These were regularly refilled. Staff completed hourly care rounds for each patient and checked they had a drink.

Specialist support from staff such as dieticians was available for patients who needed it. The hospital had two dietitians, one of which specialised in oncology.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management to ensure following surgery patients were given effective pain relief. Staff told us they would access the acute pain analgesic ladder for patients which offered advice on appropriate analgesics in relation to an individual pain score.

Ward staff assessed patients' pain and the effectiveness of pain management regularly using a nationally recognised numerical scoring system. We observed nurses checked patient's pain levels during routine observations and interventional rounding.

Patients were asked about pain in the pre-assessment consultation. Anticipatory pain relief was prescribed, and we saw this in the patient records we reviewed and being administered in the operating theatre. Information was given to patients pre-operatively to explain what sort of analgesia they could expect to receive during their operation. This included explanations of epidural, spinal, general and patient controlled analgesia.

Staff prescribed, administered and recorded pain relief accurately. The surgical care pathways used, prompted staff to assess, record and manage pain effectively. We reviewed 10 patient records which showed pain was assessed with the NEWS2 pain scale and hourly on intentional care rounds, high pain scores were acted on promptly. A monthly medical record audit was completed which looked at assessment of patients' pain and use of the pain score, compliance was 100% in June 2019.

Patients received pain relief soon after requesting it. The team discussed the analgesia they were taking to ensure the patients' pain was well managed. One patient on the ward round said to the resident medical officer (RMO), "you are a very nice man as you have taken my pain away". We heard staff asking patients if they had pain and after administering analgesics returned to check if they had been effective.

Patient outcomes

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

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The service participated in relevant national clinical audits. The hospital had a comprehensive audit schedule in place across a 12 month period covering all clinical areas, environmental issues and customer relations. The schedule outlined if an audit was organisationally or externally required, a recommended audit or stipulated as required in a Spire policy. We reviewed eight audits whilst on site and found action plans were in place to address any concerns. Although different templates were used and a variety of monitoring was in place. Following the inspection the provider informed us that a standard template would be used in the future.

Managers used the results to improve services further. The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured. Clinical audits and risk assessments were carried out to facilitate this. The hospital participated in some national audits to monitor patient outcomes including the elective surgery Patient Reported Outcome Measures (PROMs) and QPROMS programmes, Public Health England infection control surveillance, and the National Joint Registry (NJR).

The hospital entered information onto registers such as the national joint register (NJR) and the breast and cosmetic implant registry (BCIR). These registries were set up by the Department of Health and Welsh Government in 2002. Information was collected on all replacement operations and monitored these registries ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects. This allowed for longer term national reporting of outcomes.

The hospital submitted Patient Related Outcome Measures (PROMS), which helped the NHS measure and improve the quality of care patients experienced during and after elective surgery. In the PROMS survey, patients were asked whether they felt better or worse after receiving the following operations:

- Hip replacements
- Knee replacements

The PROMS data showed that the hospital was not an outlier and overall most patients reported an improvement in how they felt after their surgery. The hospital did not currently collect PROMS data for patients having cosmetic surgery

The hospital tracked the completion of questionnaires. The clinical scorecard for quarter one recorded the number of questionnaires completed was 86%, this was above the target of 70% and the overall Spire network of 80%.

The hospital reported surgical site infections (SSI). The aim of the national surveillance program was to enhance the quality of patient care. This was achieved by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.

The surgical site infection surveillance service provides an infrastructure for hospitals to collect data on 17 surgical categories spanning general surgery, cardiothoracic, neurosurgery, gynaecology, vascular, gastroenterology, and orthopaedics.

The hospital reported on categories which included hip and knee operations. Out of approximately 6,630 operations there were 28 surgical site infections over the reporting period of April 2018 to March 2019, this showed a 0.3% infection rate.

There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network (PHIN). They also collected PROMs data for certain surgical procedures, such as hip and knee replacements.

Local audits were managed by the hospital at a local level and all audits were discussed when relevant at the monthly clinical effectiveness meetings. Minutes from the meeting were shared during the governance meetings.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The clinical scorecard enabled the hospital to benchmark its clinical performance indicators against other Spire Healthcare hospitals. The scorecard compared the audit result to the hospitals target, Spire network results, the previous quarters score and if the service/audit had improved.

The hospital monitored any unplanned transfers of care to another hospital, readmission to the hospital and returns to theatre. All occurrences were logged on the hospitals incident system and investigated. During the reporting periods of April 2018 to March 2019 the hospital reported out of 2,559 planned attendances there were;

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- 12 unplanned transfers to another hospital.
- 15 unplanned re-admissions to the hospital (within 28 days of discharge).
- 10 unplanned returns to the operating theatre.

These were better than average within the Spire group.

Managers and staff used the results to improve patients' outcomes. All PROMs data was discussed at the hospital and Spire national governance meetings. A summary of any key action points was then shared at the medical advisory committee (MAC) and actions for improvement were developed if indicated.

Managers used information from the audits to improve care and treatment. The hospital collected clinical performance indicators (CPI) which were reviewed by the hospital governance committee and reported in the governance report. CPIs were organised as hospital wide and at speciality level, reported on and analysed per quarter. This report went into the detail and provided a narrative around, for example, why a patient returned to theatres.

The hospital was working towards being Joint Advisory Group on Gastrointestinal Endoscopy (JAG) compliant.

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. We reviewed six staff files and found they all contained relevant information, such as up-to-date disclosure and barring service (DBS) check, references, curriculum vitae and evidence of registration with the Nursing and Midwifery Council (NMC). Health and Care Professions Council (HCPC) or General Medical Council (GMC). Data submitted showed 100% of eligible staff had completed revalidation with their professional body. Staff completed a variety of mandatory and role specific training through an e-learning system and face-to-face training. Competencies were required for each role and included drug administration, wound care and use of ward equipment. The competencies were recorded in a booklet, scored, with space for reflective assessment, which was completed prior to sign off. We saw evidence of completed competencies for staff in the service.

Senior managers made sure consultants working under practising privileges were experienced, qualified and had the right skills and knowledge to meet the needs of patients. From January 2019 to April 2019, 93% of consultants were compliant with the required evidence for practising privileges, against a compliance of 100%. Practising privileges for consultants were reviewed annually. The review included all aspects of a consultant's performance such as appraisal, revalidation, volume and scope of practice, examples of continuing practice development, any adverse occurrences involving the consultant and any areas of concerns brought to the attention of the medical advisory committee (MAC). In addition, the MAC advised the hospital about continuation of practising privileges. Senior managers used an electronic system to check when privileges were due to expire. We reviewed five consultant files and found they contained all required information such as up-to-date DBS, scope of practice, professional registration, appraisal and indemnity insurance.

RMOs had their competencies assessed, and mandatory training provided and updated by their external agency provider. They worked in line with guidelines and a handbook to ensure they were working within their sphere of knowledge. They had a yearly appraisal completed by their external agency provider and a clinical mentor supported them.

Managers arranged for all new staff to have a full induction tailored to their role and a local orientation to their department before they started work. Dependant on their role, some new staff worked initially in a supernumerary capacity. This allowed them to understand their new environment before having full responsibility for their role. For example, ward nurses were classed as supernumerary for at least the first two weeks of their employment. New theatre and ward staff were assigned a mentor to support them.

There were systems and processes in place to support student nurses who worked on wards and departments. Students were allocated mentors, so they had a point of contact during each shift.

Catering staff we spoke with told us they completed food hygiene standards training and had attended training events delivered by a dietitian.

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Managers supported staff to develop through yearly, constructive appraisals of their work. As of June 2019, 100% of hospital staff had received an appraisal. Staff told us that they found the appraisal process helpful. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers discussed competencies and training needs with staff at their appraisal. Staff we spoke with confirmed this.

Medical and nursing staff told us that they had support to undertake revalidation. Revalidation is a process by which doctors and nurses can demonstrate they have undertaken continuing professional development and maintained their competence to practice safely.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff were given the time to attend departmental meetings and huddles. Communication was disseminated via emails and communication folders in the different areas for staff to read.

Managers identified poor staff performance promptly and supported staff to improve. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and meetings with their managers. There were no formal one-to-ones to read, due to no recent poor performance management had taken place. Staff told us that managers had an open-door policy and felt they addressed any issues promptly.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed effective team working in all areas of the hospital, multidisciplinary team (MDT) meetings, handovers and briefings took place regularly to ensure effective care and treatment was delivered to the patient. There were daily ward and theatre huddles of consultants, the RMO, physiotherapists, pharmacists and ward staff to review care records, identify any deteriorating patients, discuss pain and mobility as an example.

Each department had a daily huddle to discuss specific issues within that department. The hospital then held a daily 10 at 10 operational meeting. It was attended by the senior management team, the RMO and a representative from each department, including theatres, ward, pharmacy, outpatients, physiotherapy, catering, facilities and patient services. We observed a brief overview of hospital activity, utilisation, staffing, incidents, patient feedback, mandatory training compliance and potential risks to services were discussed. This information was documented then cascaded to staff in each department.

Staff worked across health care disciplines and with other agencies when required to care for patients. MDT working started when patients visited the pre-operative assessment unit. Staff worked with the local GP surgeries and would contact them should they pick anything up during a pre-assessment appointment. The team in the pre assessment clinic had a process in place with their local GPs which they told us worked well.

All staff told us they had good working relationships with consultants and the RMO. We saw good interactions between all members of the team. The RMO, consultants, pharmacist and physiotherapists were present on the ward daily and reviewed patients' together as a team. Staff said they were all approachable and they worked well as a team. Patient records we reviewed confirmed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists and occupational therapists.

The service ensured arrangements for discharge were considered prior to elective surgery. Staff on the pre-operative assessment unit started the conversations about discharge. For those patients having day surgery someone to collect them needed to be arranged prior to admission. For those patients who may require help after discharge were encouraged to start arranging this as early as possible.

The inpatient physiotherapy team worked alongside the staff to deliver a flexible service which met the needs of their patients, by often working late to ensure the safe discharge or mobilisation of a patient.

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Staff told us they had an MDT team meeting at midday where all patients were reviewed with the nurses and physiotherapists. There was an agenda to this daily review and it included assessing diet and fluids, mobility, any recovery issues, and a discharge review.

Staff at the hospital worked alongside local GPs to share and invest in learning. 'Hot Topics' that local GPs wanted training on were now delivered alongside a GP monthly newsletter.

Seven-day services

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

The hospital only undertook elective surgery, and operations were planned in advance. The exception to this was if a patient was required to return to theatre due to complications following a procedure.

Theatres sessions were held between 8am to 8:30pm Monday to Friday and from 8am to 6:30pm on a Saturday as service demanded. Theatre staff told us there was the capacity for theatres to run on a Sunday if needed. Wards operated seven days a week to accommodate surgery patients who required nursing over the weekend.

Services at the pre assessment clinic took place from Monday to Saturday. Evening clinics were also available to support patients who were unable to attend during the day due to work or other commitments.

Staff could call for support from doctors 24 hours a day, seven days a week; consultants were always on-call for patients under their care. Patients were seen daily by their consultant, including weekends. If the consultant was not available, they arranged cover by another consultant. We saw this communicated to ward staff. This was a requirement of their practising privileges. The RMO and ward staff had a list of contacts for all consultants and anaesthetists for each patient. Staff told us medical staff could be easily contacted when needed. Anaesthetists were available via an on-call rota if a patient needed to return to theatre. There was 24-hour RMO cover in the hospital to provide clinical support to patients, consultants and staff.

The pathology department was open from 8am to 6pm Monday to Friday, 9am to 1pm on Saturdays and there was an on-call service at all other times. Test results could be obtained out of hours from the pathology report software that was available on the hospital-wide computer system.

The service had 24-hour access to mental health liaison and specialist mental health support.

The pharmacy was open from 8.30am to 5pm, Monday to Friday, and from 8.30am to 12.30pm on a Saturday. Out of hours there was an on call pharmacist for support. If a patient required medicines out of hours, the RMO and a registered nurse went to the pharmacy department and checked out the medicines.

Health promotion

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

The hospital had relevant information promoting healthy lifestyles and support on wards. A wide range of leaflets were available for patients regarding their care and health. Patients received leaflets on patient safety which included how to reduce the risk of developing a VTE, falls prevention, pressure ulcer prevention and recognition of sepsis. In the pre assessment clinic there were leaflets from the Royal College of Anaesthetists (RCoA) on getting; fitter, better and sooner.

There were health promotion and awareness information leaflets displayed around the hospital. These were Spire own information and information from other health charities.

Spire Parkway also had a social media site for the public to use and access regarding health promotion.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients attended pre-operative assessment appointments where their fitness for surgery was checked. Staff asked patients a series of questions about their lifestyle such as smoking and drinking status. Patients were given advice about smoking cessation when required. The service had a standard operating procedure for smoking cessation. It contained information regarding different ways to support a patient giving up smoking. For example, nicotine patches and different doses to prescribe. The hospital was also a non-smoking site therefore staff and patients were all encouraged not to smoke.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Including the Mental Capacity Act (MCA) 2005 and knew who to contact for advice. There was an effective up-to-date consent policy for staff to follow.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records we reviewed showed consent was obtained in accordance with hospital policy. We observed consent being obtained for one patient prior to their surgical procedure. The consultant explained all the risks, gave the patient time to ask questions and spoke in non-medical jargon. We saw an audit for consent gained in medical records for June 2019 and compliance was 100%.

Staff made sure patients consented to treatment based on all the information available. Patients were given information about their proposed treatment both verbally and written, to enable them to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.

We were told patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure, in case they wanted to change their mind. This was in line with national guidance.

The pre assessment clinic used comprehensive leaflets from the Royal College of Anaesthetists (RCOA) to explain to patients the possibility of post-operative confusion, and that behaviour and memory could be affected.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. They would involve the patients' representative(s) and other healthcare professionals. Staff told us the majority of admitted patients had the capacity

to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process, where it was determined whether they could be admitted for treatment at the hospital.

All staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). As of September 2019, 98% of clinical staff had completed training in MCA and DoLS.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were given the appropriate skills and knowledge to seek verbal and written informed consent before providing care and treatment to their patients. Staff were aware of the legal requirements of the MCA and Deprivation of Liberties Safeguards (DoLS).

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Are surgery services caring?

Outstanding



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

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from people who used the service, those close to them and stakeholders was always very positive about the way staff treated people. People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

People felt really cared for and that they matter. Staff were exceptional in enabling people to remain independent.

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Patients valued their relationships with the staff and felt that they went ‘the extra mile’ for them when providing care and support. Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw nurses taking extra care to ensure that patients’ dignity and privacy was maintained.

Staff were extremely motivated to deliver care that was kind and compassionate. They anticipated the needs of their patients and ensured their needs were acknowledged and met. We observed this at the time of our inspection in the way that staff spoke with patients and their carers, and in the way they protected the patient’s privacy and dignity. Consideration of people’s privacy and dignity was consistently embedded in everything that the staff did, including awareness of any specific needs and these were recorded in the patients records.

A patient told us that the staff always knocked on the door before entering their room and we observed this at the time of our inspection. We observed staff spoke with patients discreetly to maintain confidentiality.

Staff did not merely react to patient needs or requests, they consistently anticipated need and ways to help by striving to build personal relationships and understand their patients’ needs and preferences. Staff demonstrated a genuine desire to enhance the patients’ experience and to ensure needs were met and exceeded. A member of staff on the ward ensured that their working days coincided with a particularly nervous patient who required repeat nursing intervention to support them to ensure there was a familiar face to reduce this anxiety.

Patients said staff treated them well and with kindness. We spoke with four patients, all four told us staff were kind and caring, they could not fault the service. They said that they had received excellent care and their hospital experience had been positive. Patients said that all staff were pleasant, and they helped to make them feel relaxed, and theatre staff made them feel looked after.

All patient and relatives responses were positive and patients told us ‘everyone takes time to get to know you, that’s nice’, ‘staff are excellent and this makes all the difference, even the porter that brought me back from theatre just popped his head in to see how I was’, ‘staff are kind and caring’, ‘confidence in staff, they know what they are doing, are experienced, and the food is fantastic’.

We asked patients if there was anything that would improve their care that they had been receiving, and all patients answered ‘no, it is of the highest standard, and I couldn’t ask for more.’ One patient told us that they had come to Spire Parkway specifically to receive their treatment, due to feedback from other patients. They told us they took the time to speak to them and understand their needs and spoke with them about their life and passions. ‘They went above just administering medicines and treatment, I felt I was an individual’.

Patient feedback also confirmed that staff treated patients with compassion, kindness, dignity and respect. Patient feedback was gathered through the Friends and Family Test (FFT). From January 2019 to June 2019 the hospitals performance ranged from 93% to 100%. The average response rate was 22% which was in line with the national average. In June 2019, the hospital scored 98% for FFT with a response rate of 20%.

(Evidence Source: (PIR data received from the hospital)

‘Compassion in Practice’ training was included as part of the hospitals mandatory training. As of July 2019, 96% of ward staff and 95% of theatre staff had completed the training.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We found where patients were anxious about the procedure they were admitted for, staff gave extra care and responded compassionately to put the patient at ease. We observed patients on the ward, in the anaesthetic room and in recovery being reassured by staff that were empathetic when patients were nervous or anxious. A patient told us that they had been very nervous about having an anaesthetic, the nurses on the ward had responded to this and had informed staff in the theatres. The patient told us ‘staff were first class in the anaesthetic room’ and the anaesthetist had been to the ward after the patient returned to see that they were settled.

The pre assessment lead nurse told us that they saw a very worried patient who would be needing surgical drains post

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operatively. The staff spent extra time with them and went and got the actual drains that she would have and talked through the process and how they worked. The patient then felt more relaxed about the surgery.

Staff told us they had time to spend with patients to reassure them and provide emotional support.

Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "I love it here. It is exactly what I would want. It is better for my husband knowing I am being very well cared for." Patients also said that staff were "brilliant" and "nothing was too much trouble."

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. For example, we saw staff supported patients who were anxious or distressed while they were being prepared for surgery. Staff were reassuring and maintained a calm, relaxed environment.

Pre assessment included consideration of patient's emotional well-being. One patient told us that the pre-operative assessment with the nurse was very thorough and everything was explained in detail.

Spiritual care and religious support could be arranged for patients when needed. Chaplaincy services were provided by the local acute NHS trust. Multi-faith options were available.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Staff recognised that people need to have access to, and links with, their advocacy and support networks in the community and they support people to do this. They ensure that people's communication needs were understood and used best practice and learned from it.

Staff made sure patients and those close to them understood their care and treatment. Patients reported that they had all been provided with clear information about their treatment and care by the consultant and

nursing staff, with opportunities available to ask further questions for clarification. Patients felt that they had been fully supported in making decisions regarding their treatment and that they had all that they needed to know for this.

Patients told us nurses explained what they were doing and asked for permission before they did anything. Patients said medical staff explained plans for their treatment and provided opportunities to for them and/or their family members to ask questions when needed.

Patients told us they were given choices regarding their treatment options. We observed the team discussing medicine choices with a patient to ensure they were on medicines that were right for them. Physiotherapists discussed post-operative care needs with patients and relatives to ensure a smooth and safe discharge home.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were a variety of ways patients and families could give feedback. A patient feedback survey was sent electronically to the patients two days after discharge, and patients could access the hospital website and their social media sites to leave feedback. Results showed that over 90% of patients would recommend the service, felt their privacy and dignity was met, consultant information was well communicated and discharge advice was excellent.

Staff supported patients to make informed decisions about their care. Patients felt that they had been fully supported in making decisions regarding their treatment and that they had all that they needed to know for this.

The hospital had an active social media site where patients could comment on their service experiences, and on health promotion activity. This was also available now on the Spire Healthcare website.

All patients were complimentary about the way they had been treated by staff. We observed staff introduce themselves to patients and explain to them and their relatives, care and treatment options.

Patients who paid for their treatment privately, told us costs and payment methods had been discussed with them before their admission.

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Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. The hospital recognised how important relatives were to the rehabilitation and recovery of their patients and allowed flexible visiting.

Are surgery services responsive?

Good 

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

In this section, we also cover hospital-wide arrangements such as service planning and learning from complaints, in the relevant sub-headings within the responsive section. The information applies to all services unless we mention an exception.

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The hospital provided elective surgery to self-funded and NHS patients for a variety of specialities, this included bariatrics, breast surgery, cardiology, general surgery, gynaecology, orthopaedics, vascular, cosmetic, spinal and urology surgery. The hospital worked with the local clinical commission groups (CCGs) and the local acute NHS trust to plan services to meet the needs of the local population. The services provided ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service. Services were also being developed to meet the needs of local people and the wider health economy. For example, they were soon to commence a new urology procedure called SpaceOAR which protects the rectum from radiation exposure in men undergoing radiation therapy for prostate cancer.

During the reporting periods of July 2018 to June 2019, 69% of the hospital inpatients services were provided to non-NHS funded patients and 31% to NHS choose and book patients.

All patients were treated equally whether they were self-funded, privately insured or NHS. The service only received planned admissions. Patients' with specific needs such as learning disabilities, other disabilities or mental capacity issues were identified at pre-assessment. This meant appropriate arrangements could be made to meet individual needs prior to admission.

The hospital had service level agreements with a local acute NHS hospital to provide additional services they were unable to provide themselves. This included the supply of blood products and specialist pathology services.

Managers ensured that patients who did not attend appointments were contacted. The pre-assessment clinic would contact patients who did not attend and made another appointment. If there was further nonattendance, then they would be referred back to their GP.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The pre-operative assessment process identified patient's needs prior to their admission, using specific screening tools. If a patient had specific dietary requirements these would be passed on to the kitchen and the wards. Then bespoke care plans would be commenced, used in conjunction with the patient's 'this is me' booklet.

Once a patient living with dementia or learning disabilities was identified at pre-assessment clinic, a 'best interest' meeting would be held. The patient and their family or carers are invited into the hospital to meet with the staff. They would meet the specific member of the theatre team who would be collecting them from the ward and taking them to theatre, and also the nursing staff from the ward who would be looking after them post operatively. This was

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to ensure they got to know the team and had familiar faces they recognised when they were admitted. They could visit the theatre and ward areas and see which bedroom theirs would be.

The pre-assessment lead nurse gave us an example of how they tailor the clinic appointments depending on the patients' needs and if any anxieties. For example, a patient was worried about being an inpatient due to their food allergies. The pre-assessment nurse arranged for the patient to speak to the chef and they talked through a meal plan during their stay. This immediately lifted any fears they previously had. This was seen as a priority to the patient, so the pre-assessment staff wanted to alleviate this stress before they continued with all the clinical questions, so they would understand and take on board and retain the important information.

The hospital held weekly multi-disciplinary planning meetings to review patients for the coming week and to plan care which would meet people's individual preferences and needs. At these meetings, staff discussed patients who should be first on the list to manage anxiety, those who required rooms near nursing stations, or an additional bed for a relative to stay over, and what other services e.g. community services, may be required on discharge to ensure all was well planned in advance.

Wards were designed to meet the needs of patients living with dementia. Patients relatives or carers were encouraged to stay overnight with patients living with dementia and learning disabilities to provide a patient centred pathway of care. There was a specific room that would be used. All rooms had wheelchair access. Patients with mobility difficulties accessed theatres and the ward via a lift. The corridors and doors were wide, which meant wheelchair users could get through easily.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets the needs and promotes equality. Patients with complex needs had their discharge planned in advance. In the pre-operative assessment, patients were asked about their home situation. Staff could arrange extra support for a patient's discharge when needed, such as social care at home.

The wards had a specific member of staff who would greet all patients and welcome them and show them to their room and make them feel comfortable. All bedrooms were

single occupancy with their own bathroom. There were lights outside every bedroom door, to indicate if a member of staff was in there. This ensured that no one would walk in when treatment or conversations were being carried out.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. These were looked at in detail and discussed with the patient, relatives and/or carers at the 'best interest meeting'. All staff we spoke with had a great understanding of these documents and had received training from the dementia lead for the hospital.

Ward staff showed us a dementia box they had created for patients living with dementia. It contained items that would make the patient's stay in hospital easier such as simple signs and a calendar clock, cup and saucers, and various items and activities to keep patients occupied and relaxed.

There was a nominated lead on the ward for dementia who was a point of contact for other staff if they were nursing a patient with dementia. The lead also ensured the environment was adapted where needed for example placing picture cards on the door to the bathroom and ensured assistance was available at meal times.

The dementia lead had developed local pathways of care identified as best practice within Spire. As a result, the service received an exemplar award in 2018 for Dementia Services.

The ward also had a multi faith resource box. This included a prayer mat, various religious texts and scriptures. There was a specific room that could be used as a 'quiet room' for patients and relatives when needed.

There were a variety of leaflets available for patients living with dementia including topics such as continence, falls and pressure ulcer care.

Spire Parkway had dedicated staff with skills and interests in the management of patients with mobility and cognitive issues due to a disability.

The hospital had specialised bariatric equipment to care for and treat obese patients (who have a BMI (Body Mass Index) exceeding a healthy range) and we saw electronic hoists ready for use. Instead of using special bariatric chairs, that could make patients feel excluded, or different, sofas were available.

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Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Access to interpreting services could be arranged by telephone or face to face for those patients who did not speak English. Staff were aware of the service and reported no delays with access.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The ward hostess would meet with the ward sister after each handover to understand all the dietary requirements, such as allergies, for the patients and then speak with the chef. Menus were coded to indicate meals that were gluten free, foods that were easier to chew, vegetarian and vegan options, or meals suitable as part of a healthy balanced diet. There was a large variety of hot food options available. This encouraged patients to eat and ensured their nutritional needs were met. If there was nothing on the menu for a patient, then the chef would make bespoke meals if needed. The ward was able to supply food out of hours if required, which included sandwiches, toast, fruit and biscuits.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Monthly diagnostic waiting times and activity reports were submitted. Spire Parkway kept a detailed spreadsheet of all NHS patients and their 18-week breach deadline. We saw that no patients breached this target. Any patients that were approaching a breach, had steps taken to expedite their admission dates. We saw that most patients were nowhere near their breach date when they were seen at the hospital. The average wait from referral to treatment (RTT) was twelve weeks for NHS patients.

There was no formal mechanism similar to the NHS RTT targets for private patients. However, we saw there were no waiting lists and patients were generally seen within one to two weeks from their referral.

Discharge planning started at the pre-operative assessment stage. Length of the patient's expected stay was discussed. This helped patients plan for any additional support they might require at home. Patient records showed staff completed discharge checklists, which covered take home medicines, communication provided to the patient and other healthcare professionals, such as GPs. This ensured patients were discharged in a planned and organised manner. Pharmacy staff conducted daily ward rounds and prioritised the review of urgent take home medication to allow patients to be discharged quickly.

NHS patients were referred to the service by their GP via the NHS e-referral system (ERS). These referrals were screened to ensure patients were appropriate for the services and facilities provided at the hospital.

The service had invested in technology to ensure people have timely access to treatment, support and care. For example, patient's GPs could access direct online bookings and make secure referrals through Spire's GP Connect system and Insurance companies could now make direct bookings via a dedicated portal.

Patients were given a choice of dates for their planned surgery. Patients we spoke with confirmed they were given a choice of appointment times and could schedule procedures at a time convenient to them.

All five patients we spoke with told us that they were seen in a time scale that suited them. A patient we spoke with had travelled some distance to have their care and treatment at Spire Parkway, this was due to being recommended by a friend and the specialist consultant that operated there.

Managers and staff worked to keep the number of cancelled procedures to a minimum. When patients had their procedure cancelled at the last minute, staff made sure they were rearranged as soon as possible. The service monitored the number of cancellations and procedures were only delayed or cancelled when necessary. There had been no recent cancellations at the time of inspection. The pre-assessment clinic staff told us that text reminders were sent to patients in advance of their appointment. Patients would also be telephoned if they did not attend to ascertain the reason and to see if any adjustments could be made to help them attend.

Staff did not move patients at night. All inpatients were admitted to their own, private room.

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The theatre manager said they did not have any concerns with theatre delays or overruns. Theatre delays and overruns were recorded on an electronic monitoring system which was reviewed on a weekly basis by the theatre manager and had not highlighted any outliers.

Theatre staff worked flexibly to ensure that scheduled and emergency operations ran on time. An on-call theatre team was available to attend any emergency readmissions to theatre. Anaesthetists would only leave the site once the patient was stable and staff were satisfied the patient was safe. Additionally, in the event of a patient deteriorating and requiring higher levels of care, the patient was transferred to the local NHS trust via ambulance.

The hospital had its own pathology services on site which reduced the time taken to obtain test results.

Staff informed us they were under capacity for car park availability for both patients and staff and managers were currently reviewing the car parking facilities and liaising with the local authority regarding renting a local car park and obtaining quotes to possibly provide a taxi service for a specific cohort of patients.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received and the service encouraged it. The service treated concerns and complaints seriously, investigated them promptly and thoroughly, and included patients and families in the process. The service shared lessons learned with all staff in the service and more widely.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with were aware of how they could raise concerns or make a formal complaint.

The hospital clearly displayed information about how to raise a concern or complaint in public and patient areas. We found hospital information leaflets about raising concerns and complaints were available on the leaflet racks within the outpatient department. Feedback concerns and complaints could be made in a variety of ways including in person, by telephone, letter, email, text, patient survey and social media. All patients received a 'patient guide' which had details of how to make a formal complaint, called 'please talk to us'.

All patients who stayed overnight were telephoned two days and 30 days after their procedure to ensure they were recovering well and were asked for feedback about the service. If any issues were raised during these phone calls, staff would attempt to resolve them. If they were unable to, they would escalate the concerns to the senior team to manage.

Staff understood the policy on complaints and knew how to handle them. The hospital had a complaints policy (HOP 02) which set out the arrangements for the management of patient complaints, including timescales. Staff told us that where possible, concerns were resolved immediately. The head of department for the specific area was notified, and details of the concern were logged on the electronic reporting system. If any concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint.

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

Managers investigated complaints and identified themes. The hospital director had overall responsibility for the management of complaints. Complaints were acknowledged within two days of receipt and a senior member of staff was assigned to investigate the complaint. The investigating officer contacted the complainant to confirm their understanding of the complaint, advise when the investigation would be completed, and discuss the complainant's desired outcome. Complaints were investigated and responded to within 20 working days. Where this was not possible, a letter was sent to the complainant explaining the reason for the delay. All complainants were invited to a face-to-face meeting with staff involved at the hospital. If the complainant was dissatisfied with the hospital's response, stage two of the complaints process was instigated by a senior executive within Spire Healthcare, supported by a national complaints lead. If the complainant remained dissatisfied they were signposted to independent external adjudicators, such as the Independent Sector Complaints Adjudication Service (ISCAS).

Managers shared feedback from complaints with staff and learning was used to improve the service. New complaints were raised at the daily morning safety huddle, and also at the weekly rapid response meeting to ensure they had been correctly allocated and any immediate actions taken,

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including an acknowledgement letter. Complaints were investigated by the relevant department head or team leader, so that changes could be made, and learning shared within departmental huddles and departmental meetings. Complaints were a standing agenda item for the heads of department and senior management team meetings and departmental team meetings. Complaints trends and themes were also discussed at the clinical governance and medical advisory committee meetings that took place on a quarterly basis.

Staff could give examples of how they used patient feedback to improve daily practice. These included, improved communication post-surgery for patients and reminders for appointments so they were not missed.

From July 2018 to June 2019, the hospital received 108 complaints, none of which were referred to the Ombudsman or ISCAS. The hospital monitored compliance with the 20-day target date for a final response from a complaint to be received. In quarter 2 of 2019, 58% of complaints were responded to against a 75% target. We observed action had been taken to improve compliance. In quarter 3, this improved to 78% compliance.

We did not receive a breakdown for the number of complaints specific to the surgery service. However, staff told us complaints were rare and if there were issues arising on the ward, they would be dealt with promptly. This negated the need for further formal processes.

Are surgery services well-led?

Good 

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

In this section, we also cover hospital-wide arrangements such as, leadership, the management of risks and governance processes, in the relevant sub-headings within the well-led section. The information applies to all services unless we mention an exception.

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

Leadership

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

There was a clear management structure with defining lines of responsibility and accountability. The hospital's senior management team consisted of the hospital director, who had overall responsibility for the hospital, and the director of clinical services. The medical advisory committee (MAC) chair and heads of department supported the senior management team. Each head of department reported to one of the senior managers. For example, heads of department in the surgery service reported to the director of clinical services. The ward and theatres were led by ward and theatre manager.

Staff told us leaders were well respected, very visible, approachable and supportive. Departmental managers worked clinically and provided clinical cover for sickness when required. Ward and theatre staff worked together effectively.

Heads of department attended a monthly meeting with the senior leadership team. They received an update on the hospital, audits, complaints and all gave an update on their areas.

The managers understood the service and had developed their team. We observed staff frequently came to speak to the senior managers during our inspection.

The consultants we spoke with felt the hospital was very well run, and managers were responsive.

Staff received regular communication from the directors and senior managers to understand how the service was performing, its plans and the challenges it faced.

The hospital director held a daily meeting for managers from all areas, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Managers cascaded the key messages from the huddle at local staff meetings.

The hospital director and director of clinical services attended regular meetings with their counterparts at the

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other hospital site and Spire Healthcare executive team. They told us there was effective working relationships across sites and corporate support was readily available. We met corporate staff on site during our inspection.

Vision and strategy

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

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.

The hospital had a vision “To become the go to private healthcare brand in the West Midlands, famous for clinical quality and customer care”.

This vision was underpinned by; strength in clinical governance, an open reporting and safety culture with continuous learning to improve the patient experience and offering.

The values were part of the Spire Healthcare organisation, which were:

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

All staff we spoke with were aware of and felt involved in the vision and strategic objectives and understood how these related to their individual performance.

All staff we spoke with told us they were proud of working at Spire Parkway Hospital and the visions and values were displayed in clinical areas.

The enabling excellence program ensured staff had personalised objectives aligned with the vision and hospital values.

New staff told us they were made aware of the provider’s vision and values at induction and this was reinforced through the appraisal programme. Staff were encouraged to demonstrate the values through their behaviours.

Staff spoke with overwhelming pride in how they provided care for patients. Staff talked about their dedication and commitment of teams to provide the best patient experience.

The hospital had a template for 2019-2020, which outlined the long-term strategy and the objectives set to achieve them, this was monitored during the quarterly hospital management (HMT) meetings.

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 we met with, were welcoming, friendly and passionate. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.

The service had a caring culture. Staff told us that they enjoyed working in the department and felt supported by their departmental managers. Department managers told us that they had an open-door policy and they were proud of their staff and their departments.

All staff told us that they enjoyed their job because they liked their teams and they were described as a “family”. We were told by some staff that there was “nothing” they would change about the hospital and they were proud of the way it was run.

When asked what they were most proud of, the senior leadership team told us it was their staff and the caring, passionate nature of them all to provide quality care for their patients. They said it was, “a privilege to work at the hospital”.

There were cooperative, supportive and appreciative relationships among staff. They worked collaboratively, shared responsibility and resolved conflict quickly and constructively. The director of clinical services held regular

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meetings with department managers. They felt that this kept them well informed. They discussed the risk register, staffing levels and any feedback from audits and meetings. The managers in turn held meetings with their staff groups. Staff felt they were kept up-to-date and were made aware of changes needed within practice. We observed positive and supportive relationships between the leaders, consultants and staff at all levels and from all departments.

The hospital culture encouraged openness and honesty at all levels. Staff, patients and families were encouraged to provide feedback and raise concerns without fear of reprisal. Processes and procedures were in place to meet the duty of candour. Where errors had been made or where a patients' experience fell short of what was expected, apologies were given, and action was taken to rectify concerns raised. When incidents had caused harm, the duty of candour was applied in accordance with the regulation. Staff confirmed there was a culture of openness and honesty and they felt they could raise concerns without fear of blame. The hospital had a freedom to speak up guardian and staff were aware of who it was. All staff said they felt that the senior leadership team and their managers were very approachable and felt they could raise any concerns.

The culture across all the areas in the surgical department was centred on the needs and experience of people who used the services. Staff of all levels showed patient care and treatment was a priority and told us they wanted to provide the best possible service.

Most staff felt valued and supported to deliver care to the best of their ability. Quotes from staff, were, "lovely team and everyone works well together", "everyone is friendly", and "I love working here." A student nurse told us staff had approached her and made her feel welcome, they also offered learning opportunities within their departments. Staff also said they enjoyed caring for their patients and we observed positive interactions during our inspection.

The safety and wellbeing of staff was promoted. Staff felt safe whilst at work. They were given regular debriefs when needed after specific incidents or upsetting shifts. There had been recent marriages and birthdays, the chef made a wedding and birthday cakes for these members of staffs and the management teams bought bouquets of flowers.

Staff success was celebrated. The hospital had recently introduced staff excellence awards, to recognise an individual and/or team who had gone above and beyond.

Staff told us leaders promoted a 'no blame culture' and felt supported to speak out when patients were at risk of harm or they had concerns about their colleague's behaviour.

Staff knew about the service's whistleblowing policy and said they felt they would be supported by senior managers to express their views about the service without fear of threat or retribution.

There was a freedom to speak up guardian (FTSUG) who staff knew they could approach confidentially about concerns and poor practice. Most staff we spoke with said they would not have any concerns in contacting the FTSUG if required. The FTSUG had monthly meetings with the hospital director to discuss any concerns and had direct access to the Spire Healthcare FTSUG. There were also meetings held as required when a concern was raised.

As part of their partnership with the NHS, they were required to comply with the Workforce Race Equality Standards (WRES) and they have now completed two reports, the second report stated that they have made notable progress in WRES. This information was collated by Spire Healthcare and not for each individual hospital. There was an action plan in place for 2019, which included, for example, equality, diversity and inclusion strategy, new reporting systems to accurately collect the data and training to raise awareness.

Governance

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

There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard high standards of care. The hospital's governance and assurance framework were supported on site and by Spire Healthcare, such as medicines management, infection control, and health and safety. Each committee had terms of reference which were reviewed annually. The committees met regularly and fed to the MAC, and corporate quality governance board.

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The clinical leadership group met monthly. The group discussed clinical incidents, accidents and near-misses. It also discussed medicines management, patient safety issues and reviewed new policies and procedures. Any action arising from the meeting were placed and tracked on an action log. The log contained details of the agenda item, action required and action owner, and target date for completion. The log also contained details of the progress to date.

The hospital held quarterly infection control committee meeting, which was attended by the lead ICN, microbiologist and representative from each department within the hospital. The interim director of clinical services was the director of infection prevention and control (DIPC). The hospital had an annual infection control plan which included for example frequency of meeting, annual audits, patient infection leaflets and environmental controls. We saw minutes from the ICP committee which included, policy updates, decontamination issues, ICP incidents, audits and training. The ICP committee fed into the clinical governance committee which fed into the MAC. The ICP lead also attended the clinical audit and effectiveness committee and the health and safety group.

The hospital had a robust system for reviewing potential new surgical procedures. Consultants wanting to introduce a new procedure had to follow a strict pathway. They had to set out the risks and benefits to patients of the procedure, as well as the costs. There was involvement from the sterile services department and the stores department. The report had to detail any research about the effectiveness and benefits of the procedure and set out how the procedure could be audited. The final sign off came from the clinical director of services, hospital director, and a representative from the medical advisory committee.

There was a corporate "Spire Healthcare" practising privileges policy including consultants and medical and dental practitioners' which was reviewed in December 2018. Practising privileges is a term used when doctors have been granted the right to practice at an independent hospital. The policy included the granting of practising privileges, and roles and responsibilities. The hospital director and medical advisory committee (MAC) had oversight of practising privileges arrangements for

consultants. We saw evidence in MAC meeting minutes of discussion about renewing or granting of practising privileges. Most consultants also worked at other NHS trusts in the area.

To maintain practising privileges, medical staff had to provide evidence of an annual whole practice appraisal, indemnity cover, an up to date disclosure and barring service (DBS) check and evidence of completed training. The quarter two (April to June 2019) clinical governance report identified that 96% of consultants were compliant with mandated documents. In July 2019, 310 consultants held practicing privileges at the hospital.

In line with the consultant's handbook, a biennial review was undertaken for each consultant's practice by the hospital director, clinical director of services and medical advisory committee (MAC) representative. This was completed annually for those consultants treating patients under 18 years.

Fourteen consultants were suspended during the 12 month time period due to a mandatory document (appraisal, indemnity insurance, DBS) expiring and failure to supply evidence of current document as per Clinical Policy 16, Consultants Handbook.

There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network (PHIN). They also collected PROMs data for certain surgical procedures, such as hip and knee replacements.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and patient pathways. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Results were shared at relevant meetings such as governance meetings.

The service participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMs) and Friends and Family Test (FFT).

Managers maintained a governance dashboard which reported on clinical activity, workforce and compliance with a wide range of safety and quality indicators covering incidents, audit outcomes, infection prevention and control, patient experience and medicines management. The dashboard tracked monthly performance against

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locally agreed thresholds and national targets, where available. A traffic light system was used to flag performance against agreed thresholds. A 'red flag' indicated areas that required action to ensure safety and quality was maintained. Exceptions (red flags) were reviewed at heads of department and governance meetings and action was taken to address performance issues when indicated.

All areas in the surgical division held team meetings. Monthly ward meetings were held for all the wards to attend. Ward minutes were reflective of the five domains of safe, effective, caring, responsive and well-led. Information was recorded in reflection of these and covered such things as incidents, training, medicines, audit results, complaints and patient feedback.

Senior staff had regular meetings with the chair of the medical advisory committee (MAC) and with the hospital director at the health and safety risk committee meeting to review the performance of the surgical services. The outcome of quality reviews was communicated at handovers and by emails, newsletters and staff/public notice boards.

The hospital contributed governance data to the Spire organisation to provide additional oversight and external scrutiny of the services performance.

Managing risks, issues and performance

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

There were clear and effective processes for identifying, recording and managing risks. Each department had a local risk register, alongside a hospital-wide risk register.

Known risks and mitigation in the surgical service were discussed at senior team governance meetings such as the monthly clinical audit and effectiveness committee and the medical advisory committee.

Staff had access to information relating to risk management, information governance and how to raise concerns. Staff were knowledgeable about the service's incident reporting process.

Each ward and theatre maintained a risk register which was reviewed and discussed at staff meetings. Concerns were rated and prioritised against a set of clinical indicators to ensure those which presented a higher risk to patient care were prioritised. At the time of our inspection all risks were categorised as low.

Risk registers were held at departmental level and reviewed at quarterly governance committee meetings. The service had arrangements in place for identifying, recording and managing risks. Staff told us that the risks they were concerned about were accurately reflected on the risk register. We saw that each risk had been approved for entry onto the register and had a rating, a named risk owner and a review date

Risks were displayed on staff boards and staff were aware of the main risks within the service and hospital. For example, malignant hyperthermia was a risk in the theatre department.

There were local safety standards for invasive procedures in place within theatre in line with national guidance. These were displayed on the notice board for staff to see and detailed in the standard operating procedure document.

The fire alarm system was checked weekly and all other fire safety equipment was checked annually. A fire co-ordinator for the hospital was allocated at the daily operational meeting.

There were clear processes to manage performance effectively. The hospital had an annual audit programme to monitor performance across departments. Outcomes of audits were used to benchmark performance against the other hospital in the Spire Healthcare group. Results were also used to highlight any areas where standards were not being met and corrective actions were implemented to ensure a return to expected standards.

Staff told us they received feedback on risk, incidents, performance and complaints in a variety of ways, such as the daily operational meeting, noticeboards, social media platforms and newsletters.

The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) audit. The assessments

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involve patients and staff who assessed the hospital and how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. We saw the results for 2018 which are set out below.

Patient-Led Assessments of the Care Environment (PLACE) audit 2018:

- Cleanliness - 99.4%
- Food - 95.4%
- Privacy, dignity and wellbeing - 59.7%
- Condition, appearance and maintenance - 90.4%
- Dementia - 64.2%
- Disability - 67.8%

(Source: <https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place/2018---england>)

The hospital scored higher than the national average in three out of six (50%) of the measures, and below the national average on privacy, dignity, wellbeing; dementia; and disability. An action plan was in place to address gaps in service provision, for example, hand rails had been fitted on the entrance to the physiotherapy department to assist people with reduced mobility; and repairs to the car park/pavement surface to improve ease of access for wheelchair users remained under review subject to funding being secured.

Managing information

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

Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The service used paper records. Nursing and medical patient records were combined within the same record. This meant all health care professionals could follow the patient pathway clearly.

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

The service had a website where people could access information about the surgical procedures available and which would be useful when visiting the hospital.

Staff had access to the intranet to gain information relating to policies, procedures, professional guidance and training.

Staff across the hospital described information technology (IT) systems as fit for purpose. A range of IT systems were used to monitor the quality of care.

An electronic staffing safe care tool was used by the hospital to analyse staffing ratios against the acuity of patients. This information was collected twice daily at the point of care, to monitor, manage and report on safety.

There were arrangements to submit relevant data to national audit programmes. The provider had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

Staff had their own email account and received regular updates on training courses they could attend and when their mandatory training had expired.

Staff could access the hospitals intranet system and told us there were enough computers for their needs. Staff showed us how they accessed policies and documents on the intranet. Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems when they had finished.

The hospital shared information with the local clinical commissioning group (CCG) in relation to NHS patients such as waiting times and returns to theatre.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought in various means, including the Friends and Family Test (FFT), social media, and the

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hospital website. Patients' were encouraged to give feedback on the quality of service they received. From January 2019 to June 2019, the average monthly response rate for the hospital was 22%. Senior staff told us they had taken action to improve this, with competitions held for which department could get the highest FFT response rate.

The hospital provided details of several support groups for patients and families, including information about early onset dementia.

Spire Parkway had a variety of talks led by consultants for members of the public. As well as providing training for local GPs.

There was a patient experience committee for patients to provide first hand feedback to senior staff and influence the direction of the service.

The hospital operated a "You Said We Did" engagement initiative with patients, seeking their views on how to improve the service. This included introducing changes to the menu offered to patients.

Staff reported that there was good engagement from their managers and from the senior leadership team, which we observed during our inspection. From the conversations we had with staff, it was evident staff were engaged in the service and hospital development. Staff told us they felt confident to raise concerns and were encouraged to come up with ways in which the service could be improved.

Staff stated they felt encouraged, supported and helped with professional revalidation. Staff had access to study days and were encouraged to develop their skills.

The hospital worked with the local Partnership Assurance Group with representatives from NHS, private providers and voluntary sector. Meetings focus on safety, performance and intelligence.

The hospital hold open health information session for patients to attend and ask questions. At a cancer prostate open day there was over 700 attendees, blood tests were undertaken to help with early diagnosis.

Learning, continuous improvement and innovation

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

There was a focus on continuous improvement and quality. Leaders were responsive to concerns raised and performance issues and sought to learn from them and improve services. The service had learnt from our last inspection and acted to address concerns raised in our last report.

There were practices on wards and in theatres to review performance and identify how their services could be improved. Improvement plans were displayed along with action improvement plans.

Incidents and good practice from the Spire organisation's other locations was shared as learning material for staff to prevent similar incidents happening at the service.

The service produced 48-hour flash reports to share best practice to encourage improvement. The 48-hour flash reports were shared throughout every hospital within the group. Each hospital had to acknowledge it had read and distributed the report to the local teams.

The hospital supported the enhanced recovery programme including pre-assessment of health, fluid management, and early mobilisation. Physiotherapy was available several times a day to contribute towards enhanced recovery.

The provider ran a staff reward scheme called 'Spire for You.' Nominations were received from all hospital staff and each month members of staff from various departments was selected to receive a gift voucher in appreciation of what they had achieved. Staff could also nominate colleagues to the annual Spire Healthcare award scheme.

The hospital had been awarded the Spire Exemplar award for its services for dementia.

The hospital participated in several accreditation schemes to identify and apply best practice. These included accreditation for sterile services which reduced the risk of patients acquiring an infection during surgery.

The hospital delivered a regular GP education programme. GP's were invited to attend education sessions run by specialist consultants with an aim to working with them more holistically to improve patient outcomes. The hospital also worked closely with the local CCG and a GP representative advisor to ensure that any programs of education met with the needs of local GPs with the

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underpinning objective of retaining patients at primary care, up-skilling GP's and avoiding hospital admissions to secondary care, in turn supporting the local health care economy.

The hospital has a quarterly consultant newsletter that includes information such as learning from complaints, patient stories and marketing.

Services for children & young people

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

Are services for children & young people safe?

Good 

We rated it as good.

Mandatory training

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

The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. Staff received training through the Spire online learning package, face-to-face and in practical sessions. Staff who looked after children and young people worked across all departments and their mandatory training was managed by the relevant department lead. Staff told us they received an email to remind them to complete mandatory training and refresher training. Staff were also reminded at safety huddles and team meetings. See the surgical report for full details of mandatory training.

The children and young people's lead (CYP) ensured that specialist staff in the CYP department completed all their mandatory training. Mandatory training included infection prevention and control, moving and handling, adult and children's safeguarding training, equality and diversity, fire safety, health and safety and information governance. Information provided by the children and young people's lead showed that specialist staff in the CYP service had completed mandatory training which showed that staff were compliant with the 100% target.

Resident Medical Officers (RMO's), the lead CYP nurse, a theatre recovery practitioner, and the resuscitation lead had completed Advanced Paediatric Life Support (APLS) or European Paediatric Advanced Life Support (EPALS). One of them was always on duty when a child or young person was attending the hospital.

(source: Provider information request).

Safeguarding

Staff understood how to protect children and young people 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.

The service had an up to date safeguarding children policy in place (2019) and a child protection flow chart, with contact details, for referral to the local authority safeguarding team. The policy reflected relevant legislation and local requirements for safeguarding including child sexual exploitation (CSE), human slavery and trafficking, female genital mutilation (FGM), and domestic abuse. The policy identified how to seek advice from the safeguarding team including advice on 'did not attend/was not brought' and described the system for following up children who missed one or more outpatient appointments. Out of hours contact details were also included.

The hospital director was the safeguarding responsible manager, and the matron was the safeguarding responsible person. The lead CYP nurse and the matron were the leads for children and young people's safeguarding. Both the CYP lead and the matron were trained to safeguarding level four.

Services for children & young people

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff were able to explain safeguarding arrangements and said they would raise any queries with the lead CYP nurse. Staff were able to describe when they might be required to report issues to protect the safety of vulnerable patients. The child protection flowchart was displayed across the hospital which identified what to do if staff had concerns or were worried about a CYP (0-18 years). Staff were able to name the CYP safeguarding lead and the hospital safeguarding lead for the organisation.

Effective systems were in place to ensure that staff received safeguarding training. All staff were required to receive level one and two safeguarding training. All staff who were involved in the care of children and young people were trained to safeguarding level three. This was in line with Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014) and Spire policies.

There was visible signage throughout the hospital regarding safeguarding. This included information about action to take about all forms of safeguarding including domestic abuse, child trafficking and reporting duties. The hospital had a chaperoning policy and we saw notices and information about chaperoning throughout the hospital.

The lead CYP nurse attended the local safeguarding children's and adult's partnership meetings four times a year. Learning was shared with all staff through emails, meeting minutes and a newsletter. This included information about, for example, transition pathways for children and young people entering adult care pathways, CSE and wider exploitation, the use of regional screening tools for exploitation, missing children, support for young homeless people and discussion about serious case reviews.

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. At the time of the

inspection all areas in children's services were seen to be visibly clean and dust and clutter free. There were no reported cases of MRSA, MSSA, E coli or Clostridium difficile in the previous 12 months in CYP services.

Handwashing facilities and sanitising dispensers were available throughout the children's area. Hand sanitising dispensers were available at the entrance and exits to the departments. Brightly coloured and low-level hand sanitising dispensers especially for children were available where ever adult hand sanitisers were in place. Handwashing technique information posters were displayed in the CYP areas.

Hand hygiene audits for CYP were undertaken quarterly. Results from April to June 2019 demonstrated 100% compliance. Staff received annual training on infection prevention and control (IPC) as part of their mandatory training. Staff were observed to be 'bare below the elbows' and in line with the hospital infection policy.

There were cleaning schedules displayed in the CYP area. We noted they were all signed and dated to evidence regular cleaning took place. We noted that 'I am clean' stickers were used to indicate that equipment had been cleaned and these stated the date the equipment had last been cleaned.

We saw the weekly toy cleaning log; in addition, toys were cleaned after use and before being put away.

We noted personal and protective equipment (PPE) such as gloves and aprons were readily available in consulting and CYPs rooms through the use of wall dispensers. We saw that staff used PPE.

The service had an up to date infection prevention and control policy. Staff were able to access the policy through the intranet.

Environment and equipment

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

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

Specialist equipment for all age ranges cared for in the hospital, including that required for resuscitation was available and fit for purpose. Where children were

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anaesthetised, resuscitation drugs and equipment including an appropriate defibrillator were available. Paediatric resuscitation equipment was available in all areas where children and young people were treated. A colour coding system was in place to immediately identify a child's weight to ensure the correct size of equipment and drug dosage was used. A paediatric anaphylaxis box was also available in the theatre department in the event of a child or young person having an anaphylactic reaction to medicines. There was no intraosseous access equipment available as required on the resuscitation trolleys for children and young people. Intraosseous (IO) access is an effective route for fluid resuscitation, drug delivery and laboratory evaluation that may be attained in all age groups. We raised this with the outpatient manager during our inspection who was going to raise this with managers. Following our inspection, managers told us that intraosseous equipment was available in the recovery room and on the first floor of the hospital and was stored with the resuscitation trolleys.

Emergency paediatric resuscitation equipment was checked and seen to be 'sealed, tagged and clean'. We saw that daily checks were undertaken, the numbered tag was checked and changed monthly unless the trolley was used. Additional equipment was available if a child was difficult to intubate (have a breathing tube inserted into their airway).

Consideration had been given regarding risks presented to children by sharing the same facilities as adults. When CYP were admitted for day case surgery no adult patients were admitted onto the day surgery unit. Paediatric resuscitation equipment was brought into the day unit. Children and young people were nursed in single bays with facilities for parents to stay with them. There were designated play areas for young children in both the day unit and the out-patient's department.

The designated children and young people's bays in the day surgery unit were risk assessed before admission. Adaptations had been made to facilitate the environment for CYP. The hospital had met the Department of Health guidance (HBN 23 Hospital accommodation for children and young people 2004 states, "Door control systems should be provided to all entrance/exit doors to prevent accidental egress"). Electronic security operated doors at

the entry to the area where designated bays for CYP were sited, were in place. Cleaning materials which could be hazardous to children were stored in locked (keypad) rooms on the main ward.

There was a dedicated area for children in the recovery area. This was child friendly with pictures painted on the wall. The theatre curtains were coloured and had child friendly pictures on them. When children were in the recovery area they were screened from adults who were recovered at the same time and were supervised at all times by appropriately trained recovery staff.

Children and young people were seen in the main out-patients department. There was a designated area for young children with appropriate furniture. There was a baby changing area and rooms were made available which could be used for breastfeeding.

The day surgery unit, out patients department and physiotherapy department had specific adaptations for children and young people. The toilets contained raised toilet seats, steps and a potty. There was a baby changing area which was also available to be used for breastfeeding. Doors had soft hinges to prevent slamming, and emergency pull bells were evident in the toilets.

There were systems to maintain and service equipment as required. Equipment had undergone safety testing to ensure it was safe to use. All equipment we checked had been electronically tested and was in date.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child or young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

During our inspection we saw systems and procedures to assess, monitor and manage risks to patients. For example, the service used a Paediatric Early Warning Score (PEWS) system to alert if a child or young person's clinical condition deteriorated. Nursing staff we spoke with were aware of the appropriate actions to take if the patient's score was higher than expected. Age appropriate PEWS charts were used. We reviewed four PEWS charts and saw they were completed correctly. We requested data for PEWS audits following our inspection. Monthly audits from April 2019 to June 2019 demonstrated compliance with

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PEWS completion and escalation where a patient deteriorated was 100%. During March 2019 the clinical audit for PEWS demonstrated a 94.2% compliance (based on 10 patients under 18 years old).

The service did not undertake acute or emergency surgical admissions for children and young people. The service had strict admission criteria. All surgical interventions for children aged 0 to 16 years were undertaken as day cases. However, children and young people aged 16 to 18 years would be nursed on the adult ward if risk assessed as appropriate. Children were seen from 0 to 18 years of age. No children under three were operated on in this hospital, they would be referred to an appropriate NHS hospital if surgery was required. Children with additional medical needs, for example those with cardiac illness were referred to the appropriate hospital NHS trust for treatment.

A service level agreement was in place with the children's acute transport service (CATS), if the condition of a child or young person deteriorated and they required an urgent transfer to an NHS acute hospital. There had not been any reported transfers for CYP in the last 12 months.

Children and young people were screened at pre-assessment to ensure the hospital had suitable facilities to treat them. The children and young people's lead nurse oversaw the pre-assessment and booking arrangements for any procedure planned for children under 16 years of age. However, there were no pre-assessment clinics for children and young people held at the hospital. A face to face pre-assessment would take place opportunistically if a child or young person attended the outpatient department and the CYP nurse was available. Most pre-assessment screening took place through a telephone consultation with a child's parents. If a child was over 12 years old, they were included in the telephone consultation. This meant that younger children did not have the opportunity to ask any questions, the child could not be observed by the lead nurse for children and young people and potential health or social issues may not be identified. Therefore, we were not reassured that the needs of the child were always identified and being met. This was not recorded on the risk register.

The lead nurse for children and young people told us that if there were any health concerns identified information would be requested from the GP and any other consultant involved with the child or young person. The child would be invited for a face to face assessment and there would be

a discussion with the anaesthetist in case further anaesthetic assessment was required. The lead nurse for CYP told us that another CYP nurse was currently being recruited and when the post was filled a face to face pre-assessment clinic would be implemented.

Children who were 16 to 18 years old were pre-assessed to ensure they could follow an adult pathway unless issues were detected at pre-assessment which identified them as requiring children and young people's services. If an older child required overnight care they were nursed on the adult surgical ward in a single room. A paediatric trained nurse was always available for advice and support. Children under 18 years old were accompanied by an adult at all times.

The pre-operative assessment for children and young people included detailed data about safeguarding, pre-operative fasting guidance, a pain assessment score, height, weight, allergy status, pregnancy assessment for females over 12 years old and the WETFLAG framework. WETFLAG is a framework to help reduce the risk of error in a stressful situation and applies to children between the ages of one and 10. It stands for weight, energy/electricity, tube (endotracheal), fluids, adrenaline and glucose and enabled accurate calculations of tube sizes, drug and fluid doses could be made. This meant nursing staff (child branch) were able to respond promptly to children whose condition suddenly deteriorated.

Wristbands and records had a colour coded spot according to weight. This meant it was clear to clinicians which weight range a child was in. This was an additional safety tool to ensure the correct dosage of fluids and medicines were prescribed according to weight. Specific pink significant risk sheets were completed where details of specific risks for example allergy status, learning disabilities or safeguarding concerns were clearly identified. If a child or young person had a known allergy they wore a red wristband.

Staff in the service had received sepsis awareness training and knew how to escalate the sepsis screening tool if PEWS did not trigger it. The service had an up-to-date policy about paediatric sepsis which included full assessment information and the use of the sepsis six bundle. The sepsis six bundle is a resuscitation bundle of investigations and treatment designed to offer basic intervention within the first hour. Posters from the UK Sepsis Trust were displayed throughout the hospital. Managers undertook PEWS audits

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but sepsis audits were not undertaken. Managers told us that due to the elective service provided to CYP they did not have children with sepsis. Managers told us that if there was an incidence of sepsis it would be fully investigated.

There were emergency procedures in place including call bells to alert other staff in the case of a deteriorating patient or in an emergency. The service always had access to a resident medical officer (RMO) who was trained in EPALS (European paediatric advanced life support). When children or young people were admitted to the hospital there were always staff on duty trained in EPALS

The RMO provided support to the children and young people's service if a patient became unwell. Patients who became medically unwell were transferred to a local NHS acute trust using the children's acute transport service (CATS) in line with the emergency transfer policy.

The service used the 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. We observed three WHO surgical safety checklists were fully completed and signed in theatre. We saw the use of the checklist being carried out efficiently and effectively. Following surgery, the patient handover from theatre staff to recovery staff was thorough. Children and young people did not leave the recovery area until they were awake, talking, pain controlled, and observations were within normal parameters.

National Safety Standards for Invasive Procedures (NatSSIPs) were available in the theatre department. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). Theatre staff were aware of national and local safety standards. The theatres department operation policy was updated in February 2019 to ensure it was NatSSIPs and LocSSIPs compliant. For example, it discussed specific procedures within the local area including the five steps to safer surgery, resuscitation provision which included having one member of staff trained in PILS per theatre and two in the recovery area on days when paediatric surgery took place.

Staff in the imaging department maintained a 'holding record' to capture the details of all parents who held their child during x-ray. This was a check to ensure parents or carers were not repeatedly exposed to radiation. Parents and carers were also given suitable protection such as lead

aprons. There was a chaperone exposure form which included the name, type of radiation, apron and doses given and a carers and comforters policy in place. The service had undertaken risk assessments for imaging children and young people. Additional care was taken with children and young people to keep their x-ray exposure to a minimum (Source: IRMER Procedure 14. Providing Information Risk and Benefit of Radiation Exposures).

Staff shared key information to keep patients safe when handing over their care to others. The service held a daily communication meeting to identify, for example, activity within the hospital, daily risks, mandatory training updates and visitors to the hospital. The heads of department, lead nurse for children and young people and any other available staff attended the daily communication meeting, updated local safety and information boards and shared this information with clinical staff. The lead nurse for children and young people visited each department on a daily basis to ensure there were no concerns about any CYP attending the service that day.

The anaesthetic consultant remained in the hospital until children and young people were discharged from recovery and had been reviewed on the ward.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. 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 staff of relevant grades to keep patients safe. The service had recruited a part time lead children and young people's nurse who managed the CYP service. The lead CYP nurse was a registered nurse (child branch). At the time of inspection there were three registered nurse (child branch) bank nurses who worked in the department on a regular basis and all general nurses who worked with children and young people had successfully completed paediatric competencies.

There were always a minimum of two registered nurses (child branch) on duty if a child or young person was admitted for surgery. A registered nurse (child branch) was assigned to a child for the duration of their stay if they

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required surgery. This meant the service was meeting the Royal College of Nursing guidance on 'Defining staffing levels for children and young people's services' (2013) which states, 'for dedicated children's wards there is a minimum of 70%: 30% registered (child branch) to unregistered staff with a higher proportion of registered nurses (child branch).', There was not always a registered nurse (child branch) on duty in the hospital if a child was being seen for a consultation in outpatients. However, the lead nurse for children and young people was always available for advice if necessary over a 24-hour period. A further full-time registered nurse (child branch) was to be recruited to the service. At the time of our inspection the post had been advertised. Managers told us that there was always a registered nurse (child branch) on duty when any interventional procedures were undertaken in outpatients or the imaging department. If it became necessary for a child to remain in the hospital overnight a registered nurse (child branch) would be rostered on duty or the children would be transferred to a local NHS children's hospital.

The lead nurse for children and young people reviewed the electronic data base of forthcoming admissions to review when children were being admitted to the service. Staff rotas were arranged on a weekly basis in accordance with this to ensure that registered nurses (child branch) were on duty. Safeguarding level three trained staff were on duty and on site in compliance with safety and standards of care.

There was always a registered nurse (child branch) per shift trained in APLS when a child was at the hospital.

No agency nurses were used in the children and young people's department.

Medical staffing

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

See the surgery report for information relating to practicing privileges and the Resident Medical Officer (RMO).

There were 52 consultants employed under practising privileges who treated children and young people from

three to 18 years of age. They had all completed safeguarding level three training and provided evidence of updates for paediatric life support training. This included paediatric basic life support (PBLs), paediatric immediate life support (PILS) and advanced paediatric life support (APLS). It was a requirement for practitioners to be included on both the General Medical Council (GMC) general, and the GMC specialist registers. All anaesthetists who saw children specialised in paediatrics.

Practising privileges were reviewed annually for consultants seeing children and young people. This was recorded on the risk register to ensure that consultants did not work outside their scope of practice.

All consultants who worked under practising privileges were required to have a named covering consultant in the event that they could not be contacted. It was a requirement of the practising privileges policy that consultants remain on call whilst they had a patient in the hospital and attend on request. A hospital wide contact list was maintained for all surgeons and physicians with practising privileges.

The hospital had resident medical officers (RMOs) who provided a 24-hour a day, seven days a week service on a rotational basis. The RMO provided support to the clinical team and in the event of an emergency or with patients requiring additional medical support. During our inspection we saw the RMOs had undertaken paediatric resuscitation training and were supported by the lead professional nurse and a recovery nurse who were trained in European paediatric advanced life support (EPALS)

The service was supported by a named paediatric consultant who was available for advice regarding paediatric care. The named paediatrician sat on the Medical Advisory Committee (MAC), which formed part of the overall paediatric governance process.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The service used paper records. We saw these were locked securely in the day surgery unit. In the outpatient's department patient records were stored in a

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trolley which was kept in a locked clinical room. Patient records contained information of the patients' pathway through the service including pre-assessment, investigations, test results, treatment and care provided. Theatre records included the five steps to safer surgery checklist. We saw these were completed fully and appropriately.

We reviewed 10 sets of records and saw evidence of clear pathways. Records were legible and up-to-date, with signatory lists included. Patients heights, weights and allergy status were recorded in all records, prescription charts and anaesthetic charts. Audit results for records audited in March 2019 demonstrated 100% compliance in undertaking risk assessments including pre-assessment, safeguarding and environment but only 93% for consultant documentation, 83% for intraoperative temperature recording and 65% for children and young people fasted within guidelines. (source Provider Information request Clinical Governance report D25). Following our inspection managers provided updated information regarding audit compliance. Audit results for records audited in June 2019 demonstrated 100% compliance in undertaking risk assessments including pre-assessment, safeguarding and environment (target 95%), 93% for consultant documentation (target 80%), 94% for intraoperative temperature recording (95% target) and 80% for children and young people fasted within guidelines (target 65%). Of the 12 audits completed, 11 were above target and one was one percent below target."

There was an electronic database for patients, so staff had oversight of who was in the hospital and who was being admitted.

Electronic copies of discharge letters were sent to the patients' GP immediately after discharge, with details of the treatment, including follow-up care and medications provided. Children, young people and their families were also provided with a paper copy of the discharge letter and a discharge pack containing details of any medicines and when these should be taken, out-patient appointment and contact details for the consultant and the hospital.

Medicines

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

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines

The service prescribed, gave, recorded and stored medicines well. Pharmacists provided support when required and reviewed medicines.

Children and young people's heights, weights and allergy status were recorded on the anaesthetic record and prescription charts. This enabled correct calculations to be made and appropriate medication to be given. We saw the weight, height and allergy status recorded in the 10 records we reviewed during our inspection.

Parents were provided with discharge information which included pain relief and management. Medicines to take out (TTO's) when children and young people were discharged were discussed with parents and recorded in the patient record.

Pharmacy support was available. A pharmacist was available to speak with children and their parents as appropriate and counsel them about their medicines.

Pharmacy staff ensured that treatment room and fridge temperatures were checked and recorded daily to ensure medicines were kept at the correct temperature. Staff understood the procedures to follow if temperatures were not correct.

For our detailed findings on medicines please see the Safe section in the surgery report

Incidents

The service managed children and young people 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 children, young people and their families 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. During our inspection we observed staff understood their responsibilities for reporting incidents and to inform patients if things went wrong. In the event of an incident the lead paediatric nurse would investigate, undertake a review and share learning with staff. There had been three incidents reported for the service from June to September 2019.

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The service had an electronic system for reporting incidents. All staff were able to report incidents and staff we spoke with described how they would report an incident. Staff told us learning from incidents within the hospital was shared at team meetings, through emails and during the safety huddle. If necessary learning would be shared on a one to one basis. Minutes of meetings including the paediatric team, heads of department and MAC meeting minutes confirmed incidents were discussed and learning shared. For example, a consultant had seen a child but did not have practising privileges for CYP. Managers told us of the actions taken.

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 described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened.

For our detailed findings on incidents, please see the corresponding sub-heading in the surgery report.

Safety Thermometer (or equivalent)

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

The service continually monitored safety performance.

The service monitored and displayed information in the clinical areas to monitor safety compliance. This included information for parents and carers to supervise children and young people at all times.

Information displayed included data and audit results for:

- Cleaning rotas
- Hand hygiene audits
- No incidents of MRSA /MSSA/E. Coli and C. Diff
- 99% positive patient feedback about privacy and dignity

Are services for children & young people effective?

We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service provided care and treatment based on national guidance and evidence of its effectiveness. Policies and standard operating procedures were discussed at medical advisory committee (MAC) meetings. Changes to policies were also discussed at daily huddle meetings, reported in the daily briefing sheet and newsletters.

Corporate policies and standard operating procedures were assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief or sexual orientation or age and were up-to-date. There were clinical policies in place specifically for children and young people. These included information about, for example, pre-assessment processes, safeguarding procedures, health and safety and safe discharge and transfer to other services of CYP.

Staff were able to access policies on the hospitals intranet system. We saw policies and audit processes were regularly discussed at the children and young people's meetings.

There was a clinical audit schedule which identified when specific audits were due to be undertaken. We saw this included hand hygiene, controlled drugs, and the theatre WHO five-point audit. The service undertook specific clinical audits for children and young people which included audit of the paediatric theatre starve times, pregnancy testing, pain, consent, pre-assessment, safeguarding and the environmental risk assessment. These were led and completed by the paediatric lead.

Anaesthetists undertaking procedures on children worked within the Royal College of Anaesthetists "Guidance on the Provision of Paediatric Anaesthesia Services," 2013.

Services for children & young people

Staff in the service understood the rights of children and young people under the Mental Health Act 1983. Children and young people were screened during the pre-operative assessment process for mental health issues. Staff told us there had not been any children admitted with mental health issues.

Nutrition and hydration

Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children and young people's religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. The service had standard operating procedures in place which identified how long children and young people should be kept nil by mouth before surgery. Fasting times were audited monthly as part of the CYP audit programme. Results for April to June 2019 indicated that the service had exceeded the target of 65% with a score of 80% compliance.

Children and young people's nutrition and hydration needs were assessed at the pre-assessment appointment and documented on their care record. Where children and young people had specific dietary requirements, appropriate arrangements were put in place.

The service used the PNST nutritional screening tool. The Paediatric Nutrition Screening Tool (PNST) aims to identify hospital inpatients at nutritional risk. The tool consists of four questions which can be completed by nurses or parents to assist in the clinical diagnosis of patients up to 16 years. We saw assessments had been undertaken and were recorded in the records we reviewed.

Menus had been created that were suitable for all dietary requirements and there were links with the community dietitian service if required. There was a specific menu for children and young people. They could also request food that was not detailed on the menu. Additional food or drinks could be ordered as required.

We saw that post operatively children were provided with their choice of meal and drinks as soon as it was safe for them to eat. Patients and their relatives told us they were provided with sufficient food and drink.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain was monitored pre and post operatively through to discharge and at out-patient appointments. Both the surgeon and anaesthetist were available in the hospital until the child left hospital should there be any issues with pain before discharge. We saw clear handovers were given to recovery staff about pain relief given in theatre and pain assessments were undertaken.

Pain assessment charts were embedded into the paediatric pathway. The assessment tool used 'smiley faces' where children were asked to choose the face that best described how comfortable or uncomfortable they were feeling.

Parents told us their child's pain had been managed well. We saw topical anaesthetic cream was used before blood was taken or cannula were inserted (a small tube inserted into a vein to give medicine or fluid).

Preparations of medicines were available in a suitable format for young children, for example pain relief was available in suspension form.

Pain audits were undertaken as part of the children and young people's audit schedule. Data provided by the hospital from April to June 2019 identified that the service was 100% compliant with monitoring pain.

Children, young people and their parents were given information within their discharge pack with advice about pain relief, frequency of dosage and contact details if they had any concerns.

Patient outcomes

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

Please see the surgery report for more details on patient outcomes

Services for children & young people

No national audits were undertaken by the hospital specifically involving children and young people. The service had a local audit programme which was incorporated into the hospital audit schedule.

Children and young people's audits were reported through the CYP dashboard. These included audits of unplanned returns to theatre, compliance with paediatric early warning scores (PEWS), acute pain management and surgical site infection within 31 days of surgery. Written and verbal information was provided to families on discharge of who to contact in the event of an emergency.

Changes in practice were planned to promote positive patient outcomes for children and young people. For example, the service planned to introduce face to face pre-assessment clinics for children and young people to assess their suitability for surgery. This was to be implemented following the recruitment of a second permanent paediatric nurse.

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.

For our detailed findings on competent staff, please see the corresponding sub-heading in the surgery report.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All new staff to the service had an induction, this included a corporate induction and a local orientation. Staff confirmed they had completed all mandatory training and received reminders by email and from their managers if they were due to update their training. Staff told us they were given time to complete their electronic or face-to-face learning. New starters received induction information in hard copy format.

There was one permanent member of paediatric trained staff within the department and two registered nurses (child branch) who worked regular hours. A further full-time registered nurse (child branch) post was being recruited to at the time of our inspection. All nursing staff who saw children had completed paediatric competencies. We saw that competencies were completed and assessed. The paediatric lead nurse assessed staff competencies, these included communication skills, monitoring vital signs,

assessment of health needs including mental health and safeguarding. Competency levels were measured between levels one to four depending on the role of the practitioner. For example, unregistered staff would be assessed as competent up to level one, registered nurses were assessed to level two, CYP practitioners to level three and lead and advanced practitioners to level four. Assessment processes included discussion and observation of practice.

The children and young people's nurse had undertaken European paediatric advanced life support (EPALS). Five members of staff had completed advanced paediatric life support (APLS). When children and young people were in the hospital there were always two staff on duty with EPALS/APLS.

Paediatric immediate life support training (PILS), paediatric basic life support training (PBLS) and acute illness management training was provided by the resuscitation trainer officer. The resuscitation training officer was due to commence a Generic Instructor Course (GIC), a national course teaching the principles of adult learning in collaboration with the Resuscitation Council (UK) and the Advanced Life Support Group (ALSG).

Staff undertook regular resuscitation scenarios, any learning from these was identified and addressed. Minutes of children and young people's meetings confirmed this.

There were always registered nurses (child branch) on duty when children and young people were admitted to the hospital. Staffing rotas were arranged in advance to ensure that a team of appropriately trained staff were available. This included ensuring the availability of a paediatric anaesthetist, theatre and ward staff.

Adults were also nursed in the theatre recovery area at the same time as children and young people. Children and young people were screened from adult patients and accompanied at all times by staff with paediatric competencies.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff received a six-monthly appraisal. Staff we spoke with told us they found the appraisal process useful and were able to identify their individual learning and development needs through the appraisal process.

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It was a requirement of the practising privileges contract for practitioners to be included on both the General Medical Council (GMC) general and GMC specialist registers. All anaesthetists who saw children specialised in paediatrics. All resident medical officers had EPALS and experience of working with children and young people.

The children and young people's lead nurse was available to provide support to all staff within the hospital when children or young people were seen and treated.

Safeguarding training provided by the local safeguarding partnership was available for all staff to access. This included information on neglect, child sexual exploitation (CSE), domestic abuse, serious case reviews and child protection investigations. However, there was no safeguarding supervision available for the CYP lead nurse although the corporate lead for CYP and the matron were available for support.

There was a corporate lead children and young people's nurse who provided support to the children and young people's lead nurse. The service's children and young people's lead nurse met with CYP lead nurses throughout the organisation. Annual away days were held to provide support, education and develop care pathways.

Student nurses were allocated placements within the service. Staff had undertaken mentorship training to support them in practice. Staff told us they liaised with and received support from the university tutors.

Multidisciplinary working

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

There was a strong multidisciplinary (MDT) approach across all areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. Staff reported effective multidisciplinary working with access to medical staff and audiology staff as required.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Children and young people were discussed at monthly CYP team meetings, six monthly CYP steering group meetings and at the quarterly medical advisory committee (MAC). The CYP steering group committee was

chaired by the lead paediatrician. Meetings were attended by team leaders from across the hospital including the lead nurse for children and young people, heads of departments and paediatricians.

Weekly theatre planning meetings and daily MDT meetings were conducted to discuss patient flows and ensure an effective patient journey. This involved ensuring that all relevant and appropriately trained staff were available for children and young people and they were prioritised on the theatre lists.

The lead paediatric nurse was developing relationships with all heads of department, medical staff, nurses and clerical staff to develop the service.

Patient records we reviewed showed GPs were kept informed of treatments provided, follow-up appointments and medicines to take home on discharge.

Seven-day services

Key services were available seven days a week to support timely care for children, young people and their families.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. The Resident medical officers (RMOs) provided a 24-hour a day, seven days a week service on a rotational basis. The RMOs were paediatric resuscitation trained and had undertaken level three safeguarding training

Children's surgery was planned and took place on the first Saturday morning and third Thursday morning of each month.

Parents, children and young people were able to access clinics outside of working hours. Outpatient appointments were held in the evenings and on Saturday mornings.

Parents, children and young people were able to access ward staff 24 hours a day for advice if required

There was an on-call radiographer available from Monday to Sunday in the event of a child requiring this service.

Health promotion

Staff gave children and young people practical support and advice to lead healthier lives.

Services for children & young people

Admission criteria were in place for children and young people undergoing a day surgery procedure. This was to ensure children and young people with additional pre-existing conditions for example cardiac issues, were not operated on.

Staff assessed each child and young person's health when they were admitted and provided support to enable individuals to lead healthier lives.

Parents were given a booklet when their child was discharged with information about post anaesthetic care.

Information booklets were available throughout the hospital about a range of health and social care issues including mental health. For example, we saw up to date information about immunisations, sepsis, managing attention deficit hyperactivity disorder (ADHD) and PANTS "five rules for staying safe".

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Medical and nursing staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. We saw consent forms were fully completed, signed and dated by the consultant and patient/parent. The planned procedure was identified, the associated risks, benefits and intent of treatment was described. In addition, the patients had been assessed as having capacity to consent for treatment. Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Consent audits undertaken between April and July 2019 demonstrated 100% compliance with obtaining consent.

Staff clearly recorded consent in the 10 records we reviewed.

There was an up-to-date consent policy which included consent for the examination and treatment of children and

young people. Staff were aware of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood Gillick competence and Fraser guidelines. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser guidelines relate to contraception and sexual health and addresses the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent.

Staff received Mental Capacity Act training as part of their induction and received annual online updates.

Nurses were aware of the appropriate procedures in obtaining consent. They talked to children and explained procedures to them in a way they could understand. We saw examples of how nurses would seek a child's consent before doing anything.

Are services for children & young people caring?

Good 

We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Feedback from patients and their families was positive about the way staff treated them. Parents told us that they were "happy with the care" given and were given "clear explanations".

Staff consistently provided care that was kind and compassionate and respected children's and young people's privacy and dignity.

Staff were discreet and responsive when caring for children, young people and families. Staff took time to interact with

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patients and those close to them in a respectful and considerate way. We saw that all staff responded to children kindly and positively and used age appropriate language when discussing their care and treatment.

Children, young people and their families said staff treated them well and with kindness. We observed staff responded quickly and compassionately to patients who called for assistance.

Staff told us they were given sufficient time to ensure that they were able to provide care that was children and young person centred.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff throughout the hospital understood the need for emotional support for parents and their families. We spoke with children and their relatives who all felt staff cared for their emotional wellbeing.

Staff were able to build relationships very quickly with children, young people and their parents and families. For example, in day surgery staff were able to support the child and parent and ensured they (both) understood the procedure.

Staff used distraction equipment to support children who were having procedures, such as venepuncture (taking blood). Families were also encouraged to bring distraction materials or toys with them to appointments.

Children and young people requiring day surgery were accompanied by a parent to the anaesthetic room and stayed with them until they were asleep. This ensured parents were able to continue to provide emotional support for their child. Parents were able to see their children in the recovery area as soon as they were awake to provide reassurance and support. We saw that parents could lie on the bed with their child to cuddle them and reduce their distress.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff 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 made sure children, young people and families understood their care and treatment. We saw staff clearly explaining treatment and supporting parents while their child was recovering from a general anaesthetic. Parents we spoke with told us they felt very involved and supported by nursing and theatre staff.

Staff talked with children, young people and families in a way they could understand. Staff supported them to make informed decisions about their care.

Children, young people and their families could give feedback on the service and their treatment.

All parents we spoke with told us how they were fully involved in the assessment, planning and delivery of the care and support to their child throughout their hospital experience. We observed medical staff visiting children and their parents post operatively to review the child and inform the parents about the operation.

We observed nurses walking parents back from the anaesthetic room, talking to them and giving them information about how long their child was likely to be in theatre.

Are services for children & young people responsive?

Good 

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The service was

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flexible to meet the needs of children and young people seen. The service only saw children and young people who were funded privately and through insurance. Children and young people accessed services in outpatients, physiotherapy, diagnostics and the day case unit.

Processes were organised for care and treatment to be provided by the hospital in a timely way. General paediatric outpatient care assessed children from birth to 18 years of age with symptoms across the general paediatric spectrum. Commonly managed problems included dermatology (eczema, skin rashes, lumps and bumps), respiratory complaints (asthma, chronic cough, and exercise limitation), cardiology, ear, nose and throat (ENT) including audiology, gastro-oesophageal reflux, tonsillectomy and orthopaedics. Physiotherapy and radiology were also available.

Consideration had been given to the risks of children sharing the same facilities as adults. Operating theatre lists for children and young people were held twice monthly with occasional additional theatre lists. On these occasions children and young people were prioritised on the operating list. There was a specified area in the recovery room and a paediatric nurse and staff with paediatric competencies were always present. Although adults were also recovering from an anaesthetic, children were screened from them and returned to the day surgery unit as soon as possible. No adults were nursed in the day unit at the same time as children and young people.

Adolescents aged 16 to 18 years could also be nursed on the ward if necessary. They were always nursed in single en-suite rooms and their parents were able to stay with them. A paediatric nurse was always available to oversee care.

Children and young people could access services at a time to suit them. Children and young people were pre-assessed by the paediatric team, however most of these were telephone contacts. Children aged birth to three years old were seen in the out patients' department. Children and young people aged from three to 18 years could access the service for surgical procedures

Adolescents aged 16-18 years were pre-assessed by the paediatric team. During pre-assessment the young person was given the option regarding their choice of care, if

deemed competent to make this decision. Within this age group young people could be nursed within the paediatric or adult setting. A paediatric risk assessment was undertaken to support this decision.

Facilities and premises were appropriate for the services being delivered. There were children's areas in all departments which were decorated with murals and had toys, books and activities to distract children and young people. Child friendly information leaflets were clearly displayed and accessible in all departments. Children were not seen alongside adults in the physiotherapy gym. A distraction box which included a variety of toys and activities was available in the phlebotomy room to distract children when having blood sampling undertaken. Facilities were more limited for adolescents, some books and activity packs were available, however they were encouraged to bring in electronic devices to distract them. Children and young people had access to the internet, wi-fi and mobile phones. However, there were no parental controls on the internet connection and parents were advised that it was their responsibility to ensure that children and young people had access to appropriate content if bringing in their own mobile devices to the hospital. There was a filter on the Wi-Fi across the hospital to block access to inappropriate content. . Mobile hand held devices had been ordered for children and young people to use.

Children and young people attending the day surgery unit were nursed in individual bays. There was a play area with a range of books, toys including a peddle car and age appropriate activity packs containing quizzes, colouring books and crayons. There was a baby changing area, child friendly cloakroom with toileting aids. Staff also ensured duvet covers were appropriate for the child's age.

The out-patients department had an area specifically designed for children, baby changing facilities were available. There were toys for toddlers and young children, age appropriate books and colouring books and activities. Hot drinks were available for children, young people and their parents in the out-patients department. Signage indicated that parents were responsible for their children and must supervise them at all times were displayed throughout the hospital. These included warnings about the dangers of hot drinks throughout the department.

All children and young people who attended the service were overseen by the lead paediatric nurse. The lead

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paediatric nurse ensured that children's requirements were assessed and considered before booking a child for surgery or for an out-patients appointment. Trained paediatric nurses were always on duty when children attended the service for surgery or radiology. Staff with paediatric competencies were always available when children and young people attended the out-patients or physiotherapy departments.

Parents could accompany their children to the anaesthetic room prior to surgery. We saw parents were accompanied back to the day unit and supported while their child was anaesthetised. Recovery staff informed the day unit once surgery was complete. Ward staff escorted one parent to the recovery area, where they could stay with their child until they were fit to return to the day unit. Parents stayed with their child throughout their recovery until discharge. Arm chairs were available for parents to use.

Longer appointments were offered for children attending day services. Staff told us that this was to ensure there was sufficient time to answer all questions and to reassure children and young people. We saw that all staff took time to explain things to children and young people and engage them fully in the delivery of their care.

Children and young people were offered the opportunity to visit the service and meet staff before their procedures to reduce their anxiety. Parents that we spoke with confirmed that they had been offered the opportunity to visit the service, however they had not all taken up this offer.

If mothers who brought children to appointments were breastfeeding, staff told us they would offer them the use of an unoccupied consulting room or the baby changing area to feed their babies.

All families were contacted 24 hours after discharge to review their condition. This provided them with the opportunity to discuss any concerns they had. All families were provided with contact details for the hospital and the consultant and could contact the lead nurse for children and young people for advice. Staff told us that they would continue to contact families for up to two weeks post operatively if necessary.

A patient experience committee had been developed which included families. Following the involvement of families, a "15 steps walkaround" booklet had been

introduced. This included parent's impressions and provided information about the journey through the hospital stay to help reduce anxiety in children and young people.

There were clear processes to liaise with other health services, for example there were links with dietetic services, mental health services, links with the local safeguarding children's partnership, school nurses, health visitors and GP's

When children and young people were discharged they were given a certificate and a blue model elephant. The elephant was the motif for Spire.

The service offered free car parking for CYP and their families.

Meeting people's individual needs

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

The children and young people's service was being developed, and children with complex needs were not seen at the hospital. However, there were wide corridors and low access desks if a child attended and used a wheelchair.

All children and young people had a pre-assessment telephone call from the paediatric lead nurse. However, face to face pre-assessment appointments were not routinely offered. The National Institute of Health and Care Excellence (NICE) guidelines were used to assess patient's anaesthetic risk at pre-assessment. The service had strict admission criteria and did not admit patients with complex co-morbidities.

Children and young people were nursed in single bays on the day surgery unit. Parents were able to stay in the bays with their child and there were armchairs for them to use. Up to two parents or carers were allowed to stay with their children at any time.

The service had a hearing loop for people with hearing difficulties. This was available in the main waiting area, outpatients and ward. Resources had been developed for children and young people with additional needs. These were available throughout the hospital where CYP were seen. These included flashcards for children and young

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people with learning difficulties to support understanding of their care pathway, makaton cards containing emotions and feelings pictures and braille cards for children and young people with visual impairments. Information was also available about how to use sign language.

We saw there were information booklets specifically designed for children. These had pictures and cartoons and were available for a variety of age groups from toddlers to adolescents.

Patient information we saw was only available in English. However, staff told us this could be translated into other languages on request. Staff were able to access a language interpreting service for families whose first language was not English. Staff told us they could access this very easily and did not need to pre-book the service.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. We saw children had drinks and food was delivered for them from the kitchen as required. Catering staff had designed a menu especially for children. The menu included healthy options as well as more traditional children's foods. Hot and cold drinks were also freely available for adults accompanying children and young people to the day surgery unit.

Hot drinks machines were available in the outpatient's department where parents, children and young people could access drinks. Water coolers and disposable cups for the patients were in outpatient waiting areas or jugs of water and paper cups where fountains were not available.

Thank-you letters were being devised and were to be posted to children who had attended the phlebotomy service. This was to improve their experience and were to be sent in addition to the certificates provided.

Books for younger children were available, older children could bring in their own electronic devices.

A distraction box of toys was used for children and young people undergoing blood tests. Older children were distracted with hand held electronic devices and age appropriate videos.

Children and young people were invited to the hospital to meet staff and look around the department before attending for any procedures to reduce their anxiety. Staff told us of adjustments that had been made for a child with learning difficulties to enable them to access the service,

visit the specific department and become familiar with the equipment that would be used. Staff told us that, because the child was relaxed, this resulted in them being able to undergo an investigation during the initial visit.

The lead nurse for CYP was developing a youth folder which included information about CYP and their rights. It included information about confidentiality, consent and feedback. Additionally, there was information for young people which included exam stress, on line safety and child safeguarding telephone helpline leaflets. Material for parents included health information about for example the general anaesthetic as well as social information such as teenage risky behaviours, cyberbullying, and sibling rivalry. This information was displayed on notice boards throughout the hospital and in hand held folders.

The service had introduced a 15 step challenge for children and young people. This included 15 steps through the child or young person's hospital journey. For example, there were pictorial welcome cards, CYP were asked if they felt cared for and involved, whether they felt safe and whether the service was calm and organised.

A turquoise elephant, which was a hospital mascot, was presented to children when they were discharged from hospital or left the out-patient department.

Access and flow

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

A number of surgical treatments were offered for children and young people over three years of age. These included ENT, ophthalmology, urology, general surgery, gastroenterology and orthopaedics. These were provided by consultant surgeons who specialised in childhood conditions. Children were seen from the age of three to 18 years unless assessed to be treated on the adult pathway (between the ages of 16 and 18 years) by the paediatric team.

Patients' had timely access to initial assessment and treatment through a private paediatric referral pathway. Patients and parents could access care and treatment at a

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time that suited them. Patients and parents could select times and dates for appointments to suit their child's family or school commitments. Appointments could be arranged after school and at weekends.

Parents told us that they did not have to wait long for appointments and were seen within a week of making the initial appointment. Average waiting times in the out-patient department was five minutes. Parents said that they were seen promptly in the out-patients department. All children and young people were contacted within 48 hours of a referral being received by the radiology department. Information provided following our inspection identified that the waiting time for a computerised tomography (CT) scan was four days and the waiting time for magnetic resonance imaging (MRI) was 4.7 days.

There were two planned CYP surgical lists per month. Occasionally additional lists would be planned. A maximum of five children were placed on the operating list each session. Children were prioritised on the theatre lists. No adults were admitted to the day unit when children or young people were admitted. However, adults were also nursed in the recovery area at the same time as children and young people. Children and young people were screened from adult patients and accompanied at all times by staff with paediatric competencies.

From July 2018 to June 2019, there were 256 children under two years of age, 1457 children between the ages of three and 15 years, and 327 young people between the ages of 16 and 17 years who attended outpatient clinics. There were 89 children and young people between the ages of three and 17 years who underwent day case procedures and two inpatients aged 16 to 18 years. From July 2018 to June 2019 207 children and young people aged 0-15 and 57 teenagers aged 16 to 17 years had attended the radiology department.

The service had a "was not brought" policy. If a child was not brought for an outpatient appointment contact would be made with the child's parent to identify the reason for non-attendance. If concerns were identified or it was not possible to contact the parent by telephone, there were processes to follow this up and ensure there were no safeguarding or other concerns identified.

If procedures were cancelled or delayed they were rescheduled as soon as possible in discussion with the lead paediatric nurse, paediatric team, child or young person and their family.

Managers and staff worked to make sure they started discharge planning as early as possible. We saw discharge planning began as part of the pre-assessment process.

Learning from complaints and concerns

It was easy for children and young people and their families 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 children, young people and their families in the investigation of their complaint.

The hospital had a clear process in place for dealing with complaints. There was a complaints policy in place and staff we spoke to were aware of the complaints procedure. We saw information on how to make a complaint throughout the hospital.

Patients, relatives and carers knew how to complain or raise concerns. If a child, young person, parent or carer wanted to make an informal complaint they would be directed to the lead paediatric nurse or a senior staff member. Patients would be advised to make a formal complaint if their concerns could not be resolved informally.

From April to July 2019 there had been zero complaints in relation to children and young people.

Managers investigated complaints and identified themes. Staff we spoke with told us they received feedback from any complaints through ward meetings, the one to one process if necessary and at the daily communication meeting. We saw complaints were discussed at the children and young people's team meeting, senior management and the medical advisory committee (MAC) meetings.

Staff we spoke to were aware of the duty of candour regulations and explained what they would do if something went wrong. The duty of candour is a statutory duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

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For our detailed findings on learning from complaints and concerns, please see the corresponding sub-heading in the surgery report.

Are services for children & young people well-led?

Good 

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 children, young people, their families and staff. They supported staff to develop their skills and take on more senior roles.

The service had appointed a children and young people's lead nurse who reported to the director of clinical services. The children and young people's lead nurse liaised with leaders of theatres, outpatients and other departments to enable the effective running of the service. The children and young people's lead nurse worked clinical shifts and ensured there was sufficient paediatric nurse cover for the service. Staff of all grades and roles worked closely together within each department to provide the service.

Staff told us they felt leaders were visible and approachable. Leaders were passionate about their roles, effective multidisciplinary working and development of the service. There was a focus on the development of the service among senior medical and nursing staff.

Staff we spoke to told us the senior management team were visible and had an open-door policy. If staff had ideas about service development, they were able to raise these with local leaders and the senior management team. All staff felt they could be open with colleagues and managers and were able to raise concerns and felt they would be listened to.

Formal leadership courses were available for staff to access to enable staff development and leadership skills. The children and young people's lead nurse was investigating relevant leadership courses.

A corporate lead nurse for children and young people was in post and provided support and development opportunities for the children and young people's team. This included arranging annual lead days for the children and young people's lead nurses throughout the Spire group to share learning, encourage peer support and development of individuals and services. The corporate lead nurse for children and young people also provided support with the recruitment process of children and young people's nurses.

For our detailed findings on leadership, please see the corresponding sub-heading in the surgery report.

Vision and strategy

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

The hospital had a vision to be recognised as a world class healthcare business and the mission was 'to bring together the best people who were dedicated to developing excellent clinical environments and delivering the highest quality patient care'. The vision was supported by six values which were: "caring is our passion, succeeding and celebrating together, driving clinical excellence, doing the right thing, delivering on our promises and keeping it simple". Nursing staff we spoke to were aware of the hospitals and services vision and values.

The service had developed its own strategy which was displayed within the hospital. These were aligned to safeguarding training and the environment, meeting patient specific needs and staff competency training, ensuring patient care continuity post discharge, consultant support and engagement, improving care quality and regulatory and financial compliance. The lead nurse for children and young people told us that the vision was to provide outstanding provision for the children and young people's service so that those using the service had good memories and that all staff had the right skills.

For our detailed findings on vision and strategy, please see the corresponding sub-heading of the surgery report.

Culture

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

Staff spoke positively about working in the hospital and described a culture that was open and friendly with an emphasis on delivering high quality care to adults, children and young people.

Staff told us that they felt well supported by the management team. The hospital director and heads of department were visible throughout the hospital. Staff told us that they had opportunities to meet and have tea with the hospital director and senior management to make suggestions and discuss any concerns. Staff told us that if they had any concerns they would feel happy to raise them.

Staff told us that the culture was positive and “I enjoy coming to work”, “there is lots of support” and “there is good team work”. Staff had development opportunities and told us these were identified during the appraisal process. There were opportunities for staff to develop their knowledge and skills in the care of children and young people through the completion of competencies and staff specific training.

All staff involved in the care of children and young people worked collaboratively across the departments to ensure the safe and effective care of children and young people.

For our detailed findings on culture, please see the corresponding sub-heading in the surgery report.

Governance

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

The service had clear governance systems in place. The hospital held meetings through which governance issues were addressed. The meetings included clinical governance, medical advisory committee (MAC), heads of departments and children and young people’s meeting. The lead children and young people’s nurse chaired the children and young people’s meeting and attended head of

department (HOD’s) meetings to represent children and young people. The lead children and young people’s nurse also attended the infection prevention and control (IPC), health and safety (H&S), clinical effectiveness, CYP steering group, patient experience and medicines management committees where possible. The lead paediatric consultant attended the MAC meetings. Strategic planning, paediatric pathways and development was discussed at these meetings.

Managers discussed the strategic planning, assessment and delivery of the service at the quarterly CYP steering group meeting. This ensured there was robust oversight of the service to assure quality of overall care for paediatric patients and families

A quarterly CYP governance report was produced which monitored and reported on key aspects of CYP governance. The service was benchmarked against other Spire hospitals through the quarterly CYP quality dashboard. The dashboard from April to June 2019 demonstrated that the service was meeting or exceeding the set targets in all metrics including the percentage of patients fasted within guidelines, full compliance with consent forms in the records and fully completed safeguarding and environmental risk assessments. The service was just below the target of 95% for intraoperative temperature control with a score of 94%.

The service had a named paediatrician, who was a paediatric consultant at a local NHS trust. The named paediatrician was a member of the CYP steering group, which formed part of the overall paediatric governance process.

The lead paediatric nurse undertook monthly reviews and audits of the service to ensure performance was effectively managed in all areas of care.

The service had a safeguarding responsible manager who was the clinical director, and the matron was the safeguarding responsible person. The lead CYP nurse and the matron were the leads for children and young people’s safeguarding. The CYP lead, matron and the deputy matron were trained to safeguarding level four. The lead children and young people’s nurse liaised and met with the local safeguarding children’s partnership. This covered the local NHS and clinical commissioning group (CCG) areas.

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The heads of department met monthly and the minutes showed items discussed included complaints, clinical governance, audit results and key departmental feedback. These meetings also shared staff experiences and information was shared with staff in departments.

Heads of department identified training needs with staff through appraisal. Training needs were also discussed at the CYP and heads of department meetings.

Children's services were audited in line with the hospitals governance policy. For example, patient documentation and infection control audits to ensure continuous monitoring and enhancement of the quality of care delivered to children and young people.

For our detailed findings on governance, please see the corresponding sub-heading in the surgery report.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a risk assessment process. Identified risks had been assessed using a standardised template which scored the risk as low, medium or high. We saw a copy of the hospital risk register and noted each risk identified had a list of associated mitigating actions to reduce the risk. In addition, a responsible person was identified against the risks.

There was one specific risk to children and young people recorded on the risk register. This related to ensuring that all consultants who saw children and young people had the appropriate practising privileges. There was no risk recorded regarding children and young people not routinely being offered face to face pre-operative assessment appointments. However, following our inspection the service provided information documenting that face to face pre-operative assessments for children and young people would commence in January 2020 following the recruitment of a second permanent paediatric nurse.

Staff within the service were aware of local risks and mitigating actions. For example, Risk assessments had been undertaken of the environment to ensure it was safe

for children and young people. Controls were in place to minimise the risk of children being scalded by hot drinks or of injury by slips, trips and falls. We observed signage asking parents and carers to supervise children at all times.

The service participated in the hospital's annual audit programme. Audits undertaken included infection control, record keeping, medicines administration, the percentage of consultants who treat children fully compliant with resuscitation training requirements and CYP inpatients and out patients risk assessments undertaken. Any performance issues or concerns were escalated through monthly departmental review meetings held between the heads of department, clinical lead and hospital director. However, although the service exceeded the target for compliance with fasting times with a score of 80%, the corporate target was 65%

The senior management team held daily communication meetings which were attended by representatives from all departments to identify issues that could impact on the delivery of patient services. For example, staffing levels, patient dependency, availability of beds and patient safety incidents.

For our detailed findings on managing risks, issues and performance, please see the corresponding sub-heading in the surgery report.

Managing information

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

There were clinical and non-clinical information technology (IT) systems which directly contributed to the quality of patient care through the identification of themes and trends, such as incident reporting. These helped develop safer working practices.

There were electronic systems to manage and monitor data. These included systems to monitor compliance with training, appraisal and audits. Policies and procedures

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were available on the hospital intranet and staff could access these easily. Minutes of meetings were also accessible electronically. We saw there were electronic systems to monitor activity within the hospital.

For our detailed findings on managing information, please see the corresponding sub-heading in the surgery report.

Engagement

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

Staff were engaged in the development of the service. They told us they felt well supported by managers and were actively encouraged to share ideas for the development of the service. Staff told us senior managers had an open-door policy.

The service actively encouraged feedback to support continual improvement. Children, young people and their families were able to provide feedback in a variety of ways. Feedback forms were provided for adults and children. Child friendly feedback forms were provided. A feedback “tops or pants” magnetic washing line board was clearly displayed on the day ward wall and children and young people could add comments about their experience, what they liked and what they disliked. Patients were encouraged to complete the online feedback form as well as complete local comment cards. We saw comment cards were widely available throughout the hospital. Staff told us that children and young people would also be able to provide feedback on hand held electronic devices when they were available.

Staff were rewarded through a system of recognition for going above and beyond their normal duties. Staff excellence was recognised in newsletters and displayed on notice boards in the staff dining room. Staff were also thanked for their work by the nurse in charge. The lead nurse for CYP had received the award twice within the last two years for her work in developing the CYP service.

Management coaching and team events were offered to all heads of department and team leaders. There was a focus on developing staff and to encourage internal promotion. Team leader and nursing forums had been introduced

which had received positive team feedback. The corporate lead for CYP arranged annual away days for all lead CYP nurses to encourage learning, development and sharing of best practice.

The children and young people’s lead nurse attended the patient experience committee and was encouraging children, young people and their families to engage with the process. A child friendly booklet detailing the CYP’s hospital journey had been developed following family engagement.

Staff worked closely and co-operated with partner and external services such as the local safeguarding partnership, to promote, safeguard and support the wellbeing of children. Learning was shared with staff and links were made with other providers, the local authority, police and schools.

The lead CYP nurse and CYP nurses were arranging a collaborative event with a local school. The CYP nurses had arranged to go into a local school and talk about topics such as careers in nursing and health promotion for example healthy eating and the importance of good hand hygiene.

The hospital engaged with the PAG (Partnership Assurance Group) a group in the NHS and local CCG area consisting of NHS and independent sector organisations to discuss consultant and clinical governance issues.

A GP education programme had been established and a quarterly newsletter was produced to provide updated information about the services provided. An annual programme of GP educational events was produced for GP’s to attend. The newsletter for quarter three featured the lead nurse for children and young people and the treatments provided.

For our detailed findings on engagement, please see the corresponding sub-heading in the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.






The service was new to the hospital and was being developed. We saw staff of all disciplines were engaged in

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the process and had a vision for a high-quality service. Medical staff told us that there were clear processes in place to ensure that there were sufficient staff and all relevant equipment was available for treatments.

The service was actively recruiting for a second permanent registered nurse (child branch) to support the development of the service. This was to include the development of a face to face pre-operative assessment clinic for children and young people.

Outpatients

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

Are outpatients services safe?

Good 

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last 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.

During our visit information provided showed that nursing staff, pathology staff and physiotherapists received and kept up-to-date with their mandatory training. For example: both the outpatients department and physiotherapists had achieved 99% while the pathology training levels were at 98% from July 2018 to June 2019. Senior staff confirmed that the shortfall was due to staff either being on maternity leave or long-term sickness. (Source: D14)

The physiotherapy team told us they had an hour of protected training time weekly which enabled them to keep up to date with their training and access any additional training as required.

Medical staff received and kept up-to-date with their mandatory training. Records of mandatory training for visiting consultants were held on site.

The mandatory training was comprehensive and met the needs of patients and staff. Training courses were either

completed online or at face-to-face learning sessions as appropriate. Examples of areas covered included; health and safety, manual handling, basic life support and violence and aggression. (Source: D14)

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All staff we spoke with confirmed they had received training on mental health and dementia. They demonstrated a good understanding of patients with complex needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Line managers had access to up-to-date training data, which showed mandatory training compliance for their staff. Managers informed us they reviewed and booked staff onto their training as required. We saw training schedules on display within the outpatient's and physiotherapy departments. We observed staff being informed to complete their information governance training during a staff huddle.

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 and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding formed part of the department's mandatory training programme and we saw that nursing staff; pathology staff and physiotherapists had achieved 100% for their adult and children and young people safeguarding level two training. Records of safeguarding training for medical staff were held on site.

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Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The hospital had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. We saw these had been reviewed and were up to date. Staff we spoke with showed us how they would locate them on the hospital electronic system.

Prevent is one of the arms of the government's anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being radicalised into supporting terrorism or being terrorists themselves. We saw that anti-bribery training for the outpatient, pathology and physiotherapy departments had achieved 100%. During the inspection nursing staff explained how they protected patients and the processes to follow should they have any concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse, using local safeguarding procedures whenever necessary. Staff took a proactive approach to safeguarding and focused on early identification. All areas visited had up to date information regarding safeguarding which included whom to contact and how to make referrals.

The interim director of clinical services was the safeguarding responsible manager, and the clinical director of services was the safeguarding responsible person. The lead children and young people (CYP) nurse and the interim director of clinical services were the leads for children and young people's safeguarding. Both the CYP lead and the interim director of clinical services were trained to safeguarding level four.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff confirmed they had access to the safeguarding leads for the hospital and had established links with external providers where required.

Staff followed safe procedures for children visiting the service /department. During our visit we did not observe any children visiting the departments. Staff informed us

that all children were to be supervised by the accompanying adult which was in line with the hospital's policy. Staff confirmed they had not had any issues or concerns regarding children visiting.

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. Consultation and treatment rooms were clean and uncluttered. All furniture was wipe clean and there were hard, washable floors throughout the outpatient department.

The service score for cleanliness was better than the England average. We saw the Patient-Led Assessments of the Care Environment (PLACE) audit for 2018 which showed the hospital had scored 99% for cleanliness which was on par with the national average. We inspected three clinical rooms and found them to be visibly clean and to have cleaning wipes, alcohol gel or foam and hand washing facilities available.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed cleaning schedules displayed throughout the outpatient's department which included the door of clinical rooms and children's toys in the waiting area. We saw that the records were completed daily.

Staff followed infection control principles including the use of personal protective equipment (PPE). Personal protective equipment, such as gloves and aprons were available in enough quantities throughout the service. The hospital had an infection prevention and control (IPC) lead, with the IPC committee responsible for ensuring that the service delivered IPC requirements in line with regulation.

Nursing staff wore short sleeve uniforms and were 'arms bare below the elbow' which is good infection control practice. However, we observed one consultant who had long sleeves while examining patients and did not follow correct hand hygiene procedures. This was brought to the attention of the manager who told us that the hospital policy was that they should remove jackets and roll back

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shirt sleeves and tuck in ties whenever they were examining or treating a patient. They immediately addressed our concern and reminded the consultant of the hospital policy.

The hospital undertook staff hand hygiene audits quarterly. For quarter two (July to September 2019) the hospital scored 100% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw equipment with dated “I am clean” stickers which enabled staff to instantly recognise when equipment was last cleaned. There were stocks of single use equipment in treatment rooms as well as sharps and clinical waste bins to separate from general waste. We found no issues or concerns during the inspection.

The national target for MRSA bacteraemia (blood stream infections) is zero and there had been no (hospital acquired) cases reported from January to March 2019.

There had been zero cases reported of C. Difficile or E. Coli infections from January to March 2019. C. Difficile is a bacterium that can infect the bowel and cause diarrhoea while E. Coli bacteria can cause a range of infections including urinary tract and intestinal infections.

Environment and equipment

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

Staff responded quickly when the call bell was pushed. While attending the outpatient department, staff demonstrated the effectiveness of the call bell when this was pressed. Staff from across the hospital immediately descended on the outpatient department in response to the call.

The design of the environment followed national guidance. We observed the layout and design of the outpatient and physiotherapy services had been considered to ensure that the environment was suitable to making patients feel at ease and give them confidence. For example, we found the atmosphere of the outpatient reception area to be airy and calm with natural lighting.

Staff carried out daily safety checks of specialist equipment. All equipment in the outpatient, physiotherapy and pathology service had a service record and all were in date.

The service had suitable facilities to meet the needs of patients' families. Staff within the outpatient department said they aimed to provide a patient-centred system which considered the patients' and their families' individual needs. Staff confirmed that they put the patient's individual needs first and where required spoke with them beforehand to ensure that they had all the necessary procedures in place to ensure a smooth visit to the service. This included for example easy wheelchair access to the clinic. We observed a wheelchair ramp in situ to ensure patients with disabilities could access easily and safely.

The service had enough suitable equipment to help them to safely care for patients. The resuscitation equipment trolley in outpatients was clean and tidy and weekly checks recorded. We checked random pieces of equipment in unattended clinical rooms and found them all to be in date and the sterile packaging to be intact.

Staff within the pathology service informed us that some equipment was coming to the end of its life in 2020 and there was a corporate business plan being created to replace the equipment. We noted this was included on the hospital's risk register.

Staff disposed of clinical waste safely. We saw guidance within the service for the segregation, storage and the transportation and disposal of clinical waste.

Sharps bins were readily accessible with lids temporarily closed for safety with no issues or concerns identified.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. There were clear pathways and processes for the assessment of people within outpatient clinics or who were clinically unwell and required hospital admission. Staff demonstrated the systems and processes they would take should a patient's health deteriorate which included calling the resident medical

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officer (RMO) or doctors who were attending clinics to assist in the event of medical emergencies. Staff confirmed they had a good working relationship with the RMO who was very responsive to any issues or concerns. The RMO provides day and overnight cover at hospitals, providing safe practice care while the consultants are not on site

Staff were trained in life support techniques and had access to emergency resuscitation equipment. Resuscitation trolleys all contained adult and paediatric emergency equipment.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. We saw that risks to patients who used the service were assessed, monitored and managed as appropriate. Management plans were developed in line with national guidance. There were clear pathways and processes for the assessment of patients within the outpatient department.

Staff knew about and dealt with any specific risk issues. Risk assessments were carried out on patients when they attended the outpatient's and physiotherapy departments. We saw the patients' care records included risk assessments for moving and handling, pressure areas (Waterlow skin care assessments) and venous thromboembolism (VTE) (blood clots). Outpatient staff also completed risk assessments including national early warning score (NEWS), pre-assessment for procedures and pain assessments. These were recorded appropriately in the medical records and nurses escalated any concerns to either medical staff in clinics or the RMO.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff said they could place an alert on patients if they were identified or thought to be at risk of having the following symptoms: self-harm, suicide, dementia, learning disability, deafness or severe blindness. During the inspection we did not see any records which required the patient to be placed on an alert.

During the inspection, we found that the patient's capacity to consent to treatment was routinely checked. Staff said they completed Deprivation of Liberty Safeguards (DoLS) documentation for patients if

applicable. They confirmed this was preceded with a mental capacity assessment to assess the patient's ability to consent for treatment and whether this was in their best interest. We found no issues or concerns in the records seen.

Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Staff told us they could access the psychology team who could assess and support patients' mental health when required.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The medical staff took the lead in completing psychosocial assessments and make the necessary referrals.

Staff shared key information to keep patients safe when handing over their care to others. Safety huddles occurred daily. These huddles described key matters of concern such as staffing levels or demands on the service. The aim of the huddle was to focus on the effective delivery of service, the identification of risks and the opportunity to communicate hospital and group wide risks, good practices, celebrate success. It was also the opportunity to provide feedback on issues and departmental matters. We attended a staff huddle and found it to be informative and included praise for staff achievement, raised staffing concerns and reviewed patients who may require support.

Nurse staffing

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

The service had enough nursing staff of relevant grades to keep patients safe. We spoke with senior staff to establish how staffing requirements were ascertained, as there are no national standards or guidelines for how outpatient clinics should be staffed. Senior staff informed us they used an outpatient department staffing tool. This was based on the dependency list of consultants from which staffing levels could be calculated. If there was a shortage

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of staff, agency staff known to the service would be requested. Staffing was planned to always include qualified nurses to coordinate the clinics. We saw staffing rotas and found no issues or concerns. We observed that there were reception and nursing staff available to support all clinics that were running during the inspection.

Sickness was managed well by senior staff, there were regular reviews of sickness, and these were clearly documented alongside outcomes of meetings and discussions. Staff were referred to occupational health and phased returns were offered to help them back into work.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The manager could adjust staffing levels daily according to the needs of patients. The outpatient department used a safety staffing tool which took into consideration actual patient numbers and the dependency of the patients in line with the Spire's safe staffing policy. The tool calculated the recommended number of staff dependent on patient bookings and expected demand on services.

The number of nurses and healthcare assistants on all shifts matched the planned numbers.

The service had a low vacancy rate. The current vacancies across the outpatient department included: one whole time equivalent and one vacancy for 20 hours. However, the outpatient manager had recently left the hospital in September 2019 and this post was vacant. The department was being supported by the deputy director of clinical services (DDCS) and a manager from another Spire hospital who visited regularly. In addition, the department had a full-time sister who provided day to day leadership and support to staff with the support of the DDCS.

Recruitment plans were in place supported by the Spire group recruitment team, and staffing was reviewed during the daily huddle. There were internal incentives for staff to recommend a friend or family member to work at the hospital. Senior staff informed us that the manager vacancy was currently being advertised. (Source: DR06 and D07)

Managers made sure all bank and agency staff had a full induction and understood the service. We saw completed agency staff induction folders available within the outpatient's department.

The service had low sickness rates which was confirmed by senior staff spoken with.

Managers limited their use of bank and agency staff and where possible requested staff familiar with the service. Senior staff informed us that they utilised agency staff already known to and familiar with the hospital ways of working and were block-booked to ensure continuity of the service.

The use of bank and agency staff as a share of total staff at the hospital was low. From April to June 2019, the average rate of registered nursing staff was 10% and 1% for healthcare assistants.

The number of shifts covered by bank and agency staff was low. From April to June 2019, the number of bank registered staff shifts was 12 and agency nursing staff shifts at 57. The number of bank healthcare workers shifts was seven. There had been no shifts covered by agency healthcare workers during this period.

The service had increased their staffing turnover rates in the period July 2017 to June 2018. There was a high turnover of registered nurses (83%) compared to the previous year. Turnover for healthcare assistants was low (11.8%). However, staff numbers were low and this equates to five staff members. The hospital informed us they had put in place measures to stabilise the team which included the manager of the specialist care centre taking on the role of an interim out-patient manager to ensure the department was managed safely and staff were supported through the changes during this period.

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.

For more detailed findings on medical staffing please see the Safe section in the surgery report

Medical staffing was provided to the outpatient department by the various specialties that had clinics.

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Doctors who attended the outpatient's department were associated to the various core services rather than the outpatient department, so this data was not collected or monitored by the outpatient department.

Medical staff were asked to give six weeks' notice of any leave for clinics to be managed or adjusted. Consultants spoken with confirmed how they arranged for their colleagues to cover when away from the hospital when for example, on annual leave or away for other business.

Medical staff gave two weeks' notice to add any ad-hoc clinics to their list; this was so that staff in outpatients could coordinate rotas accordingly. This was confirmed by the booking team who managed the availability of records for additional clinics.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, they were not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. The July 2015 inspection report identified that the hospital should maintain complete sets of patient records on site to ensure that patient confidentiality was maintained. During this inspection we saw the hospital had updated their policy to ensure that no records were to be taken off site by any member of staff. This was confirmed by the staff within the records department. Medical records were stored on site for three months following a patient's attendance at the hospital. Older records were stored in a secure storage off-site and were available on 24-hour request, or a copy could be faxed on request if needed.

A full-time medical records supervisor was onsite to ensure the records were obtained for the consultant prior to seeing the patient. If these are required out of hours or when the medical records supervisor was not available, other staff members were trained to access and track medical records. If medical records still could not be found, a risk-based discussion was held with the consultant as to whether the patient needed to be re-booked. This process was also followed for follow up appointments. This process was confirmed by staff spoken with.

We saw the records audits for September 2019 which showed the outpatient service at 97% and the physiotherapy department at 96%. This was above the hospital target of 95%.

When patients transferred to a new team, there were no delays in staff accessing their records. Due to non-digitisation of records, it was on occasions difficult to ensure that all records of clinical interventions were present within patient notes. The hospital had implemented an audit tool to monitor single patient record compliance. All filing of records was done daily and the documentation for any files not in the department were filed for efficient retrieval when notes were on site.

While records were stored securely we observed records on view in a room behind the nurse's station. These records could be seen and were not in lockable cabinets. However, we noted that while the notes could be seen from the nurse's station, the distance did not allow labels on the outside of the records to be read. This was brought to the attention of senior staff. We attended a staff huddle and observed that the interim manager addressed our concern during the huddle and requested that all staff attended additional information governance training.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients were counselled when medicines were collected. Outpatient prescription forms were logged on receipt and on distribution to different departments where they would be stored securely.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. There were effective systems in place regarding the handling of medicines. Outpatient nursing staff did not administer medicines but consultants and the clinical nurse specialists working in the clinics did use some medicines for injection, such as local anaesthetic. They followed the hospital's, and national guidance for these. The storage and security of medicines department check within outpatients for July 2019 showed 94% compliance. It was

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identified that signage where medical gas cylinders were stored required checking. (Source A10) During the inspection we reviewed the signage of medical gas cylinders and found no issues or concerns.

Staff followed current national practice to check patients had the correct medicines. Prescriptions for outpatients were clinically checked in pharmacy if patients brought these to be dispensed in-house. Copies of prescriptions not dispensed in-house were also seen by the pharmacy team which enabled intervention if necessary.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were discussed at the daily huddle and reported in the quarterly safety scorecard. These were available at the nurse's station for all staff to read. We found no issues or concerns during the inspection. If there were any national medicines safety alerts, these were disseminated to the department through the pharmacy team and shared.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

For our detailed findings on medicines please see the Safe section in the surgery report

Incidents

The service managed patient safety incidents well. Staff recognised 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. This was an improvement from our last inspection in July 2015 that identified incident reporting was not well embedded. The service had processes in place to prevent harm to patients and staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally.

The hospital used an electronic online system for reporting incidents. During this inspection all staff spoken with were able to describe the process they would take should they need to report an incident.

Staff reported all incidents that they should report. Staff told us that there was a positive incident reporting culture, that had improved since the last inspection in 2015. The hospital grouped the clinical and non-clinical incidents for the outpatients and diagnostic imaging service together. During the inspection, we did not find any issues or concerns with the reporting of incidents with staff having a good knowledge of what they should report.

Incidents from April 2018 to March 2019

From April 2018 to March 2019 the outpatient and diagnostic imaging departments reported 416 incidents, 285 clinical and 131 non-clinical.

We discussed patient records with the records administration team who confirmed that they had processes in place to manage the booking forms and patient records. There were daily huddles to discuss any concerns or issues to ensure shared learning. The team audited their service and we saw actions in place to manage patients' notes which included feeding back to the department relevant for the error.

The service had no never events. However, managers would share learning with their staff about never events that happened elsewhere if applicable.

Staff reported serious incidents clearly and in line with hospital policy. All incidents and near misses were reported onto the hospital's electronic system and were subject to a risk-appropriate level of investigation with serious incidents requiring investigation (SIRI) subject to root cause analysis. There were mechanisms to ensure lessons were learned and improvements made where necessary, including group-wide learning from adverse events.

Key Performance Indicators (KPI's) were reported every quarter. Results were benchmarked nationally and performance against targets rated. Information from the incidents were used to direct improvements.

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 told us

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they were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Staff knew what duty of candour meant and could describe their responsibilities relating to it which included approaching patients when things go wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that changes had been made because of feedback. This included the discussion of incidents and the actions taken through staff meetings, daily huddles and information on staff noticeboards. Staff working in the outpatient department told us that learning from incidents was fed back and disseminated through daily huddles and staff meetings. We observed that the reporting of incidents was discussed at daily huddles with the opportunity for staff to receive learning.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw an example of an investigation into an incident. We saw that the patient was involved at all stages and there was an analysis to determine whether the incident was preventable. The patient was informed of the result and there was evidence that learning was shared with the rest of the hospital.

Managers debriefed and supported staff after any serious incident. Staff explained an incident whereby a patient became disruptive and abusive to staff. Senior management confirmed that all staff would receive a debrief to ensure they were well and to explore which further support they may require. This process was confirmed by staff spoken with.

Safety Thermometer (or equivalent)

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

The service continually monitored safety performance. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Staff collected safety

information and shared it with staff, patients and visitors. This information was intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide. For example, the hospital reported outpatient monthly RTT performance levels and did not attend rates within each clinical area.

Staff used the safety thermometer data to further improve services. Nursing staff explained the actions they took to minimise the risk of avoidable harms. Where they found issues relating to care, they raised them either with staff directly or reinforced the messages at the morning safety brief. These were documented for staff to review and read which meant that there were processes to review and manage safety across the service.

Are outpatients services effective?

Not sufficient evidence to rate 

We currently report but do not rate effective in outpatient services – not rated

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service used evidence-based care pathways as commissioned and developed by Spire's central clinical team. These were based on clinical guidelines from established and recognised bodies and ratified. The care pathways covered a range of procedures and were located on the Spire intranet and could be downloaded and printed locally for use within departments. Pathways were updated in line with changes to national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). Spire's central team issued a monthly safety bulletin which included updates around NICE guidance.

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice. Staff informed us that patients who may be frail or vulnerable

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received or were referred for a comprehensive assessment for their mental well-being. We did not see any records of patient's subject to a Mental Health Act assessment during the inspection. However, staff described what processes they would follow which meant the hospital had systems in place to ensure that all patients received the appropriate quality of care.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a staff huddle which reviewed the patients attending clinics that day and discussed the care and treatment required for specific patient. Staff said they would refer to the patient's psychological and emotional needs as required.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. We noted that there were signs to hospital refreshment facilities in the outpatient department where patients could purchase food and drink. Water coolers and disposable cups for the patients were in outpatient waiting areas or jugs of water and paper cups where fountains were not available. We observed nursing staff ensuring that patients had access to water if required.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff informed us that they could refer patients for dietary and nutritional support when needed.

Pain relief

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

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

practice. Patients we spoke with had not required pain relief during their attendance in the outpatient clinics. However, patients told us the consultants routinely asked them about their pain and pain management.

Staff within the physiotherapy department said they focussed on a patient's pain when they attended their appointment. They confirmed they could contact the RMO or consultant with support for pain management when necessary.

Staff prescribed, administered and recorded pain relief accurately. Nursing staff told us if a patient presented in pain, they would score using a pain score tool. They would then ask the consultant or clinical nurse specialist in the patient's relevant clinic, to prescribe an appropriate pain relief medication and record this in the patient records.

Patients were referred to pain management clinics if needed.

Patient outcomes

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

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. Managers carried out a comprehensive audit programme. We saw that there were audit calendars in place in the outpatient and pathology departments. The hospital had an annual clinical audit schedule which included both national and local audits which were discussed at relevant governance meetings. The hospital also monitored and benchmarked performance against targets and other hospitals/providers. This included: medicines management and administration, record keeping and policy management. For example, we saw the results of the March 2019 outpatient consent audit for interventional procedures. This was based on six records resulting in 100% compliance.

The physiotherapy department completed a functional score indicator to measure a patient's outcome from arrival to discharge. This was based on a scale of zero to

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ten. We saw the results for quarter two (July to September 2019) which showed that 94% of patients had made improvements in everyday function after their hip surgery and 100% of patients had improved after undergoing spinal, shoulder, elbow, foot and ankle surgery.

Managers used information from the audits to improve care and treatment. For example, measures such as referral to treatment times and other clinical scorecard indicators were discussed at clinical governance and operational meetings. We saw the clinical scorecard results for quarter two (July to September 2019). For example; we noted that the pathology regulatory audit completion and infection control (hand hygiene) were at 100%.

We saw the site self-assessment documentation for November 2018 based on the PLACE assessment which showed no issues or concerns for the outpatient service. Areas covered included: cleanliness, condition/appearance, access, hand hygiene and equipment cleanliness and privacy, dignity and well-being. We saw areas which required action were addressed which included for example, foot pedal bins for waste management

Managers shared and made sure staff understood information from the audits. Staff informed us that they were given feedback at daily huddles should a concern or issue be identified. Staff also said that managers fed back lessons learnt from meetings they attended.

Improvement was checked and monitored. The pathology service was accredited by the United Kingdom Accreditation Service (UKAS) to standard ISO 15189. We saw the action plan based on the UKAS recommendations and noted that all actions had been completed and closed. The service informed us they were due to be re-inspected in October 2019 and had implemented all the requirements needed to maintain their accreditation. This was outlined in the information seen during the inspection.

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. All clinics were run by clinicians with the appropriate experience and training in the field.

Managers gave all new staff a full induction tailored to their role before they started work. Staff received a comprehensive induction when they commenced work at the hospital. This included both a corporate and local induction. The local induction included orientation to the area and support to complete local competencies.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data seen showed that 100% of registered nursing and midwifery staff and health care assistants had received their appraisal.

Managers supported nursing staff to develop through regular supervision of their work. Medical and nursing staff told us that they had support to undertake revalidation. Revalidation is a process by which doctors and nurses can demonstrate they have undertaken continuing professional development and maintained their competence to practice safely.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers said that the monthly meetings and/or one-to-one meetings adopted a coaching style approach to develop and promote development and outcomes. This was confirmed by staff we spoke with. We saw that previous staff meeting minutes and staff bulletins were available at the nurse's station for all staff to read.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Regular team leader forums (every six weeks) and a recently established nurses forum provided development for key staff as well as offering opportunities to progress and improve. Nursing and therapies staff told us they were encouraged to access additional training and development to extend their skills. Staff told us their training and development needs were discussed during their appraisal. For example, staff told us they had been encouraged to attend dermatology and skin integrity training and to also assist in the carrying out of minor procedures under supervision.

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Managers made sure staff received any specialist training for their role. Senior staff showed us competency folders which they had created to ensure that staff had the skills and knowledge for their role. Staff confirmed they had received additional training in for example; sepsis awareness and venepuncture (blood taking).

Managers identified poor staff performance promptly and supported staff to improve. The senior sister told us there were processes and procedures for the management of poor staff performance. They informed us that this had not been utilised during their role as senior staff.

Multidisciplinary working

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

We saw that care was delivered in a coordinated way and that staff in different teams were involved in providing person centred care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Throughout the inspection, we saw that effective multidisciplinary team (MDT) working practices were established and teams worked well together to improve the efficiency and timeliness of care. Staff could access dietitians and physiotherapists who were able to provide support and advice when required

Patients could see all the health professionals involved in their care at one-stop clinics. These included for example; joint injection and colposcopy clinics. Colposcopy is a procedure used to look at the cervix, the lower part of the womb at the top of the vagina. The one-stop clinics were led by a multidisciplinary team which included doctors, specialist nurses and radiographers who worked together to ensure patients had their initial consultation, diagnostic tests, investigations and follow-up consultation on the same day. This meant a more efficient service for patients, with fewer appointments needed, prompt diagnosis and in some instances, immediate treatment. We attended a clinic and observed good interaction between the doctor and radiologists who arranged an immediate x-ray for their patients with follow up available later in the day.

Staff worked across health care disciplines and with other agencies when required to care for patients. It was clear from observed interactions, that there was mutual respect for all team members. Staff were listened to, and senior team members made time for all staff, despite the increased activity and demand. Doctors were considered part of the team, with many speciality doctors basing themselves within the department. This ensured that they were available to discuss patients and offer support. Multidisciplinary meetings were well embedded which supported an effective review of the patients' care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

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 mental health services and diagnostic tests. The pathology department was open from 8am to 6pm Monday to Friday, 9am to 1pm on Saturdays and there was an on-call service at all other times.. Test results could be obtained out of hours from the pathology report software that was available on the hospital-wide computer system.

The outpatient department was available from 8am to 9pm Monday to Friday and on Saturdays from 8am to 4pm. The booking/records team were available from 7am to 6pm Monday to Friday. They normally provided records 48 hours in advance which enabled them to ensure doctors had access to records when attending weekend clinics. The records department could also be accessed by key personnel at any time for urgent situations.

The physiotherapy department was available Monday to Friday with the occasional weekend working. They provided a seven-day service for the wards.

The ward was open 24 hours a day if patients required advice outside of the department opening hours.

Health promotion

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

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The service had relevant information promoting healthy lifestyles and support in patient areas. We saw various leaflets in the department on subjects such as smoking cessation and mental wellbeing. The service also took part in monthly health promotion events, for example, National Heart Month in February 2019, Prostate Cancer Awareness in March 2019 and displayed posters on notice boards.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients.

Consent and Mental Capacity Act

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Medical and nursing staff outlined the principles of the Mental Capacity Act (MCA) and the processes of how to support, assess and record decisions about care and treatment if patients lacked mental capacity and how to make "best interest" decisions. They spoke about how they supported patients to make decisions and knew of the role of the independent mental capacity advocates (IMCAs).

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we spoke with said they had been asked for their consent prior to interventions. Patients told us they were given full explanations, together with the risks and benefits of the procedure. When alternative options were available these were discussed with them.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Nursing staff explained the consent procedures and what to do if a patient lacked

capacity to consent for care and treatment. Nurses understood when a patient might need to be assessed for a Deprivation of Liberty Safeguard (DoLS) and understood what might constitute a deprivation of liberty.

Staff made sure patients consented to treatment based on all the information available. Staff told us that all patients were given information leaflets before their clinic appointments with all the relevant information. If patients needed more time or wanted to discuss treatments further, this would take place before consent was taken. This was confirmed with patients spoken with during the inspection.

Staff clearly recorded consent in the patients' records. Most consent for outpatient appointments that did not require an invasive procedure was implied consent. We heard consultants explaining examinations to patients, and observed patients complying with requests to be examined, we did see consent routinely documented in the patients' medical records when required.

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. This was included in the annual mandatory training for all staff and documentation seen showed 100% compliance.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the hospital's target. To maintain practising privileges, medical staff had to provide evidence of completed training. For our detailed findings on medical training please see the Safe section in the surgery report.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff explained how they would support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff could describe and knew how to access the hospital's policy on Mental Capacity Act (MCA) and DoLS. Staff implemented DoLS in line with approved documentation.

Outpatients

Are outpatients services caring?

Good 

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last 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 observed staff members being courteous and helpful to patients and treating them with dignity and respect. During our inspection, we observed that staff of all levels introduced themselves and took time to interact in a considerate and sensitive manner. Staff spoke with patients in a respectful way and interacted well with them. Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way.

Staff within the physiotherapy department confirmed that they supported patients to complete their assessment questionnaire.

Patients said staff treated them well and with kindness. Care was tailored to the individual patient with all patient's pre-assessed and care planned to meet their needs using a multidisciplinary approach. Family members were encouraged to attend the hospital with their relative. Patients praised staff for their kindness and understanding of their needs and were complimentary about the care they had received. One patient said that staff were "funny and likeable" while another said, "all staff I've met have been welcoming, polite, professional and respected my dignity." We saw numerous thank you cards on display throughout the service. Feedback included "staff are helpful and showed empathy" and "my stay was marvellous."

Staff followed policy to keep patient care and treatment confidential. Patient dignity and privacy was maintained during episodes of physical and intimate care, doors were always closed. Patients who required intimate examinations were offered the option of a chaperone.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff said that all patients were equal and that they did not differentiate should a patient have complex needs such as mental health. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. This was done in a way which was suitable to the patient's individual needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients' spiritual needs were considered irrespective of any religious affiliation or belief.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients were given information about relevant counselling services and peer support groups where applicable.

We saw both nursing and medical staff involving patients and their relatives during assessments and when taking observations. If the patient's or their relative had any questions they were able to discuss these during their appointment.

Patients told us that they felt that their emotional well-being was cared for. One patient said that the nursing staff were very patient with them during a consultation when they had been anxious. We saw that staff were kind and smiling during appointments to reassure patients.

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

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of patients attending their appointments. We observed staff being supportive and reassuring patients before and after their appointment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, “staff are really helpful, and I can ask them anything” while another said that staff were “were approachable and provided support when required.” Staff were also aware of patients with complex needs and explained how they would support patients displaying difficult behaviours. We were given examples of when staff had recognised and supported the additional needs of patients with autism/ learning disability, by treating them in areas that were quieter.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Senior nursing staff informed us they had received difficult conversation training but confirmed they were usually present with the doctor when delivering bad news. They said this enabled them to provide additional emotional support to patients when required.

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 said they could guide patients, their relatives and/or carers to advisory groups who could provide both practical advice and emotional support as required.

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. The service had processes to ensure that it worked and engaged with patients receiving care, their families and carers. Patients we spoke with told us that they were kept informed about their treatment. Patients said they had been asked for permission and agreement first which meant that the views and preferences of patients were considered. Patients and relatives had been given the opportunity to speak with the consultant looking after them and they were complimentary about the way they had been treated by staff.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. Staff confirmed they had systems in place to identify and support the communication needs of patients which included language interpreters, specialist advice or advocates. This meant the service was compliant with the Accessible Information Standards (2015). These standards direct and define a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

We saw that consultants took time to introduce themselves to patients and asked them how they were feeling. We heard simple language being used to explain procedures and that the risks and benefits were explained, enabling patients to make informed decisions.

Staff supported patients to make advanced decisions about their care. Patients were encouraged to ask questions and were repeatedly asked whether they had understood the information given to them. In appointments we also heard discussions about accessing other support for example community teams.

Staff supported patients to make informed decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had recently introduced an online survey and encouraged patients to complete this following attendance at the hospital.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. Patients were encouraged to tell the service about their experience.

Outpatients

Are outpatients services responsive?

Outstanding



We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last inspection. We rated it as outstanding.

Service delivery to meet the needs of local people

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Senior staff informed us that there currently was limited patient involvement in the development of services, but the hospital was working on improving their patient experience committee and patient forums. However, the service was flexible, provided informed choice and ensured continuity of care. For example, the service offered flexibility of appointment times in most specialities including evening and weekend clinics and on Saturdays. Assessment clinics could be completed by telephone where clinically appropriate. Patients told us that they were offered a range of appointments and could choose one that was convenient for them.

Technology was used innovatively to ensure people had timely access to treatment support and care. For example, the booking system enabled patients to be seen at a time that was suitable for them. 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. A wide range of services were available for NHS patients where commissioners had identified capacity shortfalls. This included several one-stop clinics to reduce the need for patients to attend on numerous occasions. These included joint injection and colposcopy clinics.

People's individual needs and preferences were central to the delivery of tailored services. For example, to meet the needs of patients the physiotherapy team had developed

a multi-disciplinary joint school which included physiotherapists, occupational therapists and pharmacy. The aim of the joint school was to deliver up to six different advisory sessions on the same day pre-operatively to ensure patients and relatives had as much information as possible for an effective journey from different sources.

The physiotherapy team had also developed and offered group-based rehabilitation classes. We saw the pathway was aligned to the NHS and allowed patients to undergo group therapy and support. Staff confirmed that this continued to be a work in progress and were going to utilise the patient satisfaction feedback to measure their outcomes.

Facilities and premises were appropriate for the services being delivered. The department was on the ground floor of the hospital and was accessible to those using mobility aids. It had its own entrance from the car park with dedicated disabled parking bays. Some patients' we spoke with told us they never had problems finding a parking space, while others said parking was difficult. Everyone we spoke with had found a parking space on-site.

The environment was appropriate, and patient centred. It was comfortable with enough space and seating. A further waiting room was available within the physiotherapy suite. There was a small play area in the outpatient's department which assisted with distraction for children either while visiting the hospital or as a patient.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Reception staff told us that they would inform patients if clinics were running excessively late. We saw this in use during the inspection, with one clinic running over 30 minutes late due to the late arrival of a consultant who had been held up.

Staff told us if a patient became distressed in the waiting area, they would try and take them to a quiet room as

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soon as possible to reduce their anxiety. Staff described situations when this approach had been required, for example with patients living with dementia, autism, learning disability or mental health conditions.

Where possible, the service provided same day services for patients for convenience and to provide continuity of care. The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions. The outpatient services worked closely with the physiotherapy and community teams to improve discharge arrangements.

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.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had processes and procedures in place which showed they made reasonable adjustments to care pathways to ensure patients in these groups could access highly personalised care and achieve equality of outcomes. People could access services and appointments in a way and at a time that suited them. The booking team said they could allocate earlier or later appointments to support each patients' individual needs.

The department was able to accommodate patients in wheelchairs or who needed specialist equipment. There was enough space to manoeuvre and position a person using a wheelchair in a safe manner.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff confirmed that they encouraged patients to bring in their patient passports, if applicable, when attending the hospital as this enabled them to support the needs of the patient. Staff received training to recognise and care for patients who may require additional support, such as those with dementia or greater co-morbidities. There was a dementia lead in post

who had developed local pathways to care identified as best practice within Spire. As a result, the hospital had received an Exemplar Award in 2018 for dementia services.

Nursing staff were able to contact dietitians and speech and language therapists who visited patients to provide advice and support on eating, drinking and swallowing.

We saw a list of staff on duty together with staff photographs on display within the department which helped patients to identify the different staff roles. Patients said they felt welcomed and treated as important partners in the delivery of their care

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were able to guide us to the documentation relevant to the patient's individual care pathways. Documents seen clearly identified the sensory needs of patients which included for example the use of hearing aids and spectacles. Physiotherapy staff confirmed they had bought reading glasses as an aid for some patients who found the wording difficult to read, to assist them with completing the feedback questionnaire. These were available for patients in reception and staff ensured they were cleaned with alcohol wipes between uses.

Staff had access to a range of communication aids, there was a folder containing easy to read information and symbols. They had access to interpreters, both online and over the telephone. The interpreting service could also send clinic letters to patients in their own language, if required.

The service had information leaflets available in different languages and staff informed us they could obtain information leaflets in other languages upon request. The hospital said they frequently reviewed the information available to patients and had recently undertaken a review of their public patient information and safety boards to ensure the information was as helpful as possible for patients.

Staff could access a multi faith box when required. This included a prayer mat and other items such as religious texts. The hospital did not have a permanent prayer

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room, but patients could access the multi faith box when requesting a quiet room for religious use. A quiet room was allocated for use during the ten at ten morning huddles.

During our visit to the outpatient department we saw the service provided a wide range of paper-based information leaflets for patients within each speciality. We found they were all current and relevant. Information was available in accessible formats.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patients were provided with either face to face or a telephone-based translation service. Staff had a good understanding of how to access the service and in consultation rooms contact details for the interpreter service and a hands-free telephone to use for this service was on display.

Staff told us that the requirement for an interpreter was usually identified either before or during their outpatient appointment which meant that usually patients had access to a pre-booked interpreter prior to their appointment.

Access and flow

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

A review of access and flow of all services including outpatients and radiology was underway to maximise the use of the available space.

Managers monitored and took action to minimise missed appointments. The booking team provided data for forthcoming appointments to the outpatient teams. This meant they service could plan appointments and make the required reasonable adjustments to minimise missed appointments. Patients were sent reminders about their appointments by text message and email to those who had provided their details. Patients that we spoke with confirmed that they had received these reminders. Since the roll out of this system staff said there had been a reduction in missed appointments.

Managers ensured that patients who did not attend appointments were contacted. Staff informed us that when a patient did not attend (DNA) an appointment, they liaised with the patient's consultant and requested an update as to the urgency of the appointment. This meant that staff were fully informed prior to contacting the patient to make the relevant re-arrangements. All patients who missed appointments were contacted by hospital administrators the following day.

Outpatient attendances for the period January to March 2019 was 19,441. We saw the key performance indicators for this period which showed an overall DNA rate of 2.47%. (Source: DR05).

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Services were provided to patients who were self-funding, those covered by private medical insurance and to NHS patients who had been referred by their GP or who had booked via the NHS "choose and book" service. The receiving of clinic letters from consultants were monitored for timely receipt and any discrepancies fed back to the consultant secretaries. Appointments were then managed by the booking centre staff.

We discussed waiting times with senior management, who confirmed that they monitored the standard length of time that patients were waiting to be seen. They informed us that no patient exceeded the 18-week pathway unless due to patient choice or where the hospital had inherited the breach from an inter-provider transfer.

Most patients in the department were seen within 15 minutes of their appointment times unless there was an unavoidable delay for the consultant. In such cases the service communicated with the patients so that they are aware of any delay and had the option to reschedule. There were signs in place across the service to encourage patients to notify reception if they have been waiting for longer than 15 minutes. This meant the service was proactive with a view of trying to provide a solution where possible. Patient feedback and complaints suggested there was no concern regarding waiting times and the service monitored the time patients were kept waiting.

The booking team maintained a register of clinic cancellations so that any trends could be identified and

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appropriately addressed. We saw the results for February 2019 and found the following results: eight consultants turning up late for their outpatient clinic and five incidents where patients were booked by a secretary and when patient arrived there was no record of them on the system. The booking team confirmed they continued to monitor the data for trends or themes and were looking at ways whereby they could be more efficient in the service provided. They confirmed this continued to be a work in progress.

We saw the clinical scorecard for quarter two (April to June 2019) which showed that the pathology request for turnaround times (blood sciences) was at 91% which was just below the hospital target of 95% while the turnaround times for microbiology was at 79% which was below the hospital target of 95%. We visited the pathology department and saw an action plan in place to manage the shortfall with processes in place to promote greater efficiency in the service. We found no issues or concerns during the inspection with turnaround times.

Managers worked to keep the number of cancelled appointments to a minimum. This was done through the text messaging or email service.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We saw there had been 10 incidents relating to consultants cancelling a clinic on the day or not arriving during February 2019. Senior staff confirmed they continued to monitor the service to review trends.

Staff supported patients when they were referred or transferred between services. When patients became unwell in the outpatient department staff supported them and arranged for their admission to the inpatient wards or transfer to another hospital when this was necessary. A decision flow chart was available to guide staff in the process.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with said they knew what to do if they wished to make a complaint and confirmed that they would talk to the person in charge. Patients could also provide feedback through the hospital's website, patient feedback forms, social media and verbally to any member of staff as well as in writing and by e-mail.

The service clearly displayed information about how to raise a concern in patient areas. We found hospital information leaflets about raising concerns and complaints were available on the leaflet racks within the outpatient department. 'Please talk to us leaflets' explained the complaints process and were widely available throughout the hospital. These provided information encouraging people to make comments and to raise a concern and described the complaints process.

All complainants were invited to a face to face discussion about their concerns which enabled them to be involved and confirm that the hospital had taken the appropriate action.

From July 2018 to June 2019, the hospital received 108 complaints, none of which were referred to the Ombudsman or the Independent Sector Complaints Adjudication Services (ISCAS). ISCAS provides independent adjudication on complaints about ISCAS subscribers. The hospital informed us that the number of complaints had increased since quarter one 2018 (April to June 2018). The identified increase related to documentation and letters being sent to the incorrect patient. Senior staff said that the increase could be attributed down to patients' awareness of the general data protection regulation 2016/679. GDPR is a legal framework that sets guidelines for the collection and processing of personal information for individual who live in the European Union. (Source: clinical governance meeting minutes April 2019, D09). We saw three complaints within the outpatient service relating to information governance for the period January to June 2019.

We reviewed the complaints (63) from January to June 2019 of which 11 (17%) related to the outpatient's department. (Source: D13) The hospital monitored compliance with the 20-day target for a final response

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from a complaint to be received. We reviewed the 11 complaints relevant to the outpatient service and found that three had not been completed within the 20-day target.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff explained that on receipt of a complaint this was entered onto the hospital's electronic incident system.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed during daily morning safety huddle, and at the weekly rapid response meeting to ensure they have been correctly allocated and any immediate actions taken, including an acknowledgement letter.

Are outpatients services well-led?

Good 

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last inspection. We rated it as good.

Leadership

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

The outpatient manager had recently left the service which was being overseen by the deputy manager of clinical services (DDCS) and an outpatient manager from another Spire hospital who was providing support to staff through regular visits. In addition, the department had a full-time sister who provided day to day leadership and support to staff with the support of the DDCS. During the inspection, we observed the team working together as a cohesive team with no concern or issues highlighted.

We saw the team was committed and determined to drive forward improvements to the service and tackle issues. Staff spoke about the new leadership team and

how they felt confident and empowered with their ability to move the service forward. They expressed the hope that the service would soon have some stability to support the continuity of approach.

Most of the staff we spoke with were very positive about the interim manager and felt they provided a unified team which was grounded and willing to face the challenges. Staff said the manager was visible, supportive, and approachable and felt that they were aware of the pressures on the service and took prompt action to address any problems.

Regular team leader forums (every six weeks) and a recently established nurses forum provided development for key staff, with staff offered opportunities to progress and improve.

For our detailed findings on leadership, please see the corresponding sub-heading in the surgery report.

Vision and strategy

The service had a vision for what it wanted to achieve and aligned to the hospital strategy. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

We saw the actions for the clinical strategy for outpatients which included the:

- Appointment of a new manager to ensure a stabilised team
- Ensure all clinical standards are in line with the Spire policy
- Review hours of service
- Improve staff engagement
- Improve consultant engagement

For our detailed findings on vision and strategy, please see the corresponding sub-heading of the surgery report.

Culture

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

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We observed a culture of commitment, teamwork and support across all departments. All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the care they provided to people who used the service and were proud to work at the hospital. One member of staff told us, “I love coming to work each day”. Another said, “We all work as a team, we help each other.”

Staff told us they felt well supported, valued and respected. Staff confirmed the interim manager had an open-door policy and actively encouraged staff to be open and honest with any concerns or issues identified. Senior staff said they were extremely proud of their staff and the service they provided.

Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision. During our inspection, we observed positive and respectful interactions which were focused on meeting patients’ needs and providing safe care and treatment.

There were arrangements in place to promote the safety and wellbeing of staff. Staff could contact the hospital’s security team for support and assistance if patients or visitors became verbally and/or physically abusive.

The outpatients’ service celebrated staff success. Compliments received were shared with staff at safety huddles, team meetings and monthly newsletters. Examples of compliments received were also displayed publicly on noticeboards.

There were mechanisms for providing staff with the development they needed. These included personal development reviews and appraisals. The hospital director presented staff induction days, with a focus on culture and ethos.

There was a culture of striving for quality through challenge, review and innovation. There was a culture of openness and transparency and teams were actively encouraged, and confident to raise issues with incident rates increasing through confidence in a learning and open culture. There was an established ‘freedom to speak up guardian’ (FTSUG) to further support this. Staff we spoke with said they would not have any concerns in contacting the FTSUG if required.

For our detailed findings on culture, please see the corresponding sub-heading in the surgery report.

Governance

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

Senior staff said that the service had made significant progress around strengthening its governance and risk frameworks, and the reporting of safety and quality. This has been reflected in improved timeliness of serious incident investigations and submission to commissioning bodies.

The outpatient departments’ performance was outlined in the quarterly clinical scorecard. Areas covered included: hand hygiene, pathology turnaround times and the response times for complaints.

The service participated in safety huddles so that information from the various governance meetings, heads of department and senior team management meetings could be shared with staff. Those who did not attend were able to read the safety huddle sheet.

The outpatient’s department held daily staff huddles and monthly staff meetings. We attended a huddle and observed that staff were provided with up to date information which included: performance issues, concerns, complaints and staffing levels. When staff were unable to attend these meetings, steps were taken to communicate key messages to them, which included e-mails and minutes of the meetings.

Managers attended heads of department and clinical governance meetings, where they discussed complaints, incidents, audits, risks and shared information. This information fed into the senior management team meetings and the medical advisory committee.

The pathology team attended weekly manager’s conference call, quarterly cluster meetings and discussion group which reviewed the blood and transfusion service. Staff confirmed they were also able to email colleagues within the Spire group with any concerns or issues.

For our detailed findings on governance, please see the corresponding sub-heading in the surgery report.

Managing risks, issues and performance

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Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We observed that staff completed internal audits with oversight within the clinical scorecard. This was on display for staff to see and discussed during daily huddles.

Risk registers were held at divisional level and reviewed at quarterly governance committee meetings. The service had arrangements in place for identifying, recording and managing risks. Staff told us that the risks they were concerned about were accurately reflected on the risk register for their division. We saw that each risk had been approved for entry onto the register and had a rating, a named risk owner and a review date. Risks associated with the outpatient department included: staffing, non-compliance of Spire requirements in respect of single patient records and breaching GDPR regulation.

Clinical and non-clinical incidents were reviewed and discussed at the clinical governance meetings and highlighted in the quarterly clinical scorecard. This team were responsible for highlighting any trends or concerns about staffing, they reviewed incidents and policies. Minutes from meetings acknowledged the risks documented on the risk register and had actions in place to address them.

We saw here had been several concerns from consultants regarding the turnaround times of tests within pathology. Most complaints referred to the delay of results being processed. We discussed this with the pathology team who confirmed they were aware of the concerns and had implemented an action plan and processes to record and monitor test results. We saw the system being used and the data provided showed an improvement in the turnaround time.

For our detailed findings on managing risks, issues and performance, please see the corresponding sub-heading in the surgery report.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance,

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

The service had a wide range of information available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances. Each of the indicators was given an equal rating. The hospital produced a quarterly clinical scorecard which listed performance. We saw action plans in place to manage areas which performed below the hospital target for example, the pathology department's turnaround time.

The outpatient service did not have a manager in post but the interim manager we spoke with had a good knowledge of performance and where further improvements were needed to address these. We saw the quality performance displayed within the outpatient department. We also observed staff being informed of outpatients' performance at daily huddles.

Staff received training on information governance as part of their mandatory training. Information technology systems were used effectively to monitor and improve patient care. There were effective arrangements in place, which ensured data was submitted to external providers as required such as serious incidents.

Performance measures were reported and monitored. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements, where indicated. Performance targets were set in line with national targets where available. The hospital had implemented key performance indicators (KPIs). They would monitor items such as, short notice cancellations, did not attend, and records management.

There were effective arrangements to ensure referral to treatment (RTT) performance data was accurate, valid and timely. We saw the RTT data across the hospital, for example, data seen showed that for August 2019, 94% of patients had been seen within the 18-week waiting target.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. There were arrangements in place to ensure confidentiality of patient information and we found staff

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were aware of how to use and store confidential information. Computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information.

For our detailed findings on managing information, please see the corresponding sub-heading in the surgery report.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the services and culture. People who used outpatient services were encouraged to give feedback on the quality of service they received. We saw comment cards were available in all outpatient waiting areas and posters were displayed encouraging patients to leave feedback. Staff also monitored patient reviews posted on social media platforms.

The patient satisfaction survey across the hospital for quarter two (July to September 2019) showed that 97% of patients were "extremely likely" to recommend the hospital to friends and family. The data showed that the hospital had not met the hospital target of 95% and 86% respectively for the following: needs met, discharge, aftercare explained, nursing care and pain management. The clinical scorecard outlining the patient satisfaction survey had actions/recommendations in place as to how they were going to improve the service. However, all patients spoken said that they had no concerns and would recommend the hospital to their friends and family.

The nursing leadership used safety huddles as key ways of sharing important messages and regular meetings were held for staff to learn from each other and enable them to cascade the information.

A patient experience committee was established with a focus on improving patient feedback. Patients were invited to support specific initiatives, such as the Patient-Led Assessments of the Care Environment (PLACE) audit.

Opportunities for improvement were disseminated to staff and displayed throughout the hospital. Senior staff

said they offered equal importance to the things that staff did well to encourage and motivate the team; we share plaudits and compliments widely. Staff participated in the Spire scheme 'Spire for You' awards to promote the top performing team members.

The physiotherapy service met six-monthly to peer review case studies to ensure shared learning. They had also set up a national hand therapist meeting with their colleagues which took place in July 2019. They confirmed it was good get the hand therapists together to share experiences and review new treatments and look at what worked best. Staff said the next meeting was due in January 2020 and would include splinting.

From the conversations we had with staff and observations we made during our inspection, it was evident that staff were engaged in the service and empowered to help improve services.

For our detailed findings on engagement, please see the corresponding sub-heading in the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

At the last inspection in July 2015, we identified several areas where improvement was needed. At this inspection we found all identified areas had improved:

- Risk recording, and assessments were consistent and effective.
- All staff had access to the incident reporting system and could demonstrate how and when this would be used.
- The hospital had improved its record management system and there were processes in place to monitor and store records appropriately.
- Resuscitation equipment was all in date with no issues or concerns identified.

Leaders acted to make improvements in the running of the service. They had regular meetings where learning was discussed in a variety of forums. For example, senior management meetings and clinical governance meetings.

The service was committed to training and staff development. Most staff told us they were encouraged and supported to complete additional training.

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Patients were offered a multi-disciplinary one stop clinic for example, joint injection and colposcopy. This meant a more efficient service for patients, with fewer appointments needed, prompt diagnosis and in some instances, immediate treatment.






To meet the needs of patients the physiotherapy team had developed a multi-disciplinary joint school which included physiotherapists, occupational therapists and pharmacy. The aim of the joint school was to deliver up

to six different advisory sessions on the same day pre-operatively to ensure patients and relatives had as much information as possible for an effective journey from different sources.

The physiotherapy team had also developed and offered group-based rehabilitation classes which was aligned to the NHS and allowed patients to undergo group therapy and support.

For our detailed findings on learning, continuous improvement and innovation, please see the corresponding sub-heading in the surgery report.

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good 

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last 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.

Allied health professionals received and kept up-to-date with their mandatory training. The hospital had 11 training modules for radiographers and radiology assistants which were mandatory. Data provided by the hospital prior to the inspection showed that the 95% target was met for eight of the mandatory training modules for which allied health professionals in the Parkway Hospital radiology department were eligible. Across all 11 modules, the data provided showed an overall compliance of 96% for allied health professionals.

Medical staff received and kept up-to-date with their mandatory training. Radiologists worked for the hospital under practising privileges and did not receive mandatory training from the service. They received training from their substantive NHS employer and the hospital and imaging manager had oversight of their completed training records.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training courses in key skills were provided to staff and delivered either face to face or by e-learning training modules. Mandatory

training topics covered key areas such as manual handling, infection prevention and control, health and safety, fire safety, information governance, and safeguarding. Staff were allocated dedicated time to complete 'face to face' mandatory training. Training was completed and entered onto the hospitals electronic system where competences achieved following training could then be awarded.

Staff working with radiation had appropriate training in the regulations, radiation risk and use of radiation. All staff working as operators under IR(ME)R (Ionising Radiation (Medical Exposure) Regulations 2017) had undertaken a recognised academic course of training and were registered with the HCPC (Health and Care Professions Council).

Radiographers who inserted intravenous access devices to patients requiring contrast medium had received cannulation training and were up to date with refresher training. Contrast medium is a substance administered into a part of the body to improve the visibility of internal structures during radiography.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. While there were training modules for mental health and dementia which were mandatory every three years, they were also included in the Mental Capacity Act (2005) and adult safeguarding training, along with learning disabilities and autism. The diagnostic imaging department had link nurses who attended additional training, for example for learning disabilities and dementia, who fed back and supported staff throughout the department.

Diagnostic imaging

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was reviewed and completed on an annual basis for all staff. All staff were expected to complete mandatory training modules, and compliance was monitored by managers. All staff and their managers received reminders of when training was due to expire, and staff that we spoke to told us that mandatory training was discussed at their appraisals.

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.

Allied health professionals received training specific for their role on how to recognise and report abuse. The hospital had two safeguarding training modules for radiographers and radiology assistants which were mandatory. Data provided by the hospital prior to the inspection showed that the 95% target was met for both mandatory training modules for which allied health in the Parkway Hospital radiology department were eligible. Across safeguarding level 2 for adults and children, the data provided showed an overall compliance of 100% for allied health professionals. Records of safeguarding training for medical staff were held on site.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Radiology and administrative staff regularly checked waiting areas and monitored the well-being of patients prior to their scan. When asked, staff were aware and could give examples of protected characteristics and potentially vulnerable patients.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described how they identified patients at risk of harm and how they would make a safeguarding referral. Staff understood how to protect patients from potential abuse. They were aware of their responsibilities to report safeguarding concerns and knew whom to contact for advice. All staff knew who the hospital director was the safeguarding lead within the hospital and had been trained to safeguarding children level four. 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). The lead CYP nurse and director for clinical services were also leads for children and young people's safeguarding and were trained to safeguarding level four.

Staff were also aware of the concerns around child sexual exploitation (CSE) and female genital mutilation (FGM). Staff had access to a flow chart for escalating concerns. If staff were concerned about any patients, they would refer to the safeguarding lead for the hospital.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff could explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients. Staff explained the process for making a safeguarding referral and who they would immediately raise their concerns with. Staff described examples of when they would raise a safeguarding concern. Staff were supported with safeguarding policies and procedures which were available to staff on the intranet, and details of who to contact in the event of a safeguarding concern. Contact numbers for making safeguarding referrals were displayed across the radiology department. Staff could name the safeguarding lead for the organisation.

Staff followed safe procedures for children visiting the radiology department. All radiology staff were aware of the requirement to ensure the safety of children visiting the department, and appropriate arrangements were in place to safeguard children and young people under the age of 18. Children were accompanied to appointments by a parent or guardian. When a child was due for a scan, the CYP lead nurse would attend on the request of radiographers but could always be contactable for advice and support.

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. The radiology

Diagnostic imaging

department was visibly clean, tidy and well maintained. The general cleaning of the department was done by housekeeping staff. Clinical equipment in scanning rooms were cleaned by radiology staff. Records were in place to show that housekeepers maintained a regular cleaning schedule. We found 'I am clean' stickers on equipment throughout the service with a date showing when equipment was last cleaned. Cleaning equipment was available and stored securely.

The service score for cleanliness was better than the England average. We inspected all scanning rooms throughout the radiology department and found them to be clean and tidy, have handwashing facilities and a supply of personal protective equipment (PPE), which included latex-free gloves and aprons available and accessible.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Signed and dated daily cleaning schedules were in place throughout all areas such as the scanning rooms. We found no gaps in these schedules at the time of the inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff follow infection control practices. This included wearing the correct personal protective equipment (PPE), such as gloves and aprons. We saw staff wearing gloves for all patient contact, and routinely sanitised their hands using either hand gel or handwashing facilities. Clinical staff adhered to the hospital's being bare below the elbows policy. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from staff who wear gloves or decontaminate their hands immediately before and after every episode of direct contact or care.

Staff received training about infection prevention and control (IPC) and hand hygiene during their initial induction and annual mandatory training. Data provided by the hospital showed as of July 2019, 96% of radiology staff had completed this training. This met the hospital target of 95%. We saw all staff using either hand gel or washing their hands at the appropriate time. The hospital completed hand hygiene audits quarterly. Data provided by the hospital showed between July and September 2019 (quarter two) the hospital achieved 100% compliance.

Handwashing facilities and hand gel sanitisers were available throughout the radiology department. All hand wash sinks were HBN compliant to allow correct hand hygiene and could be operated without the use of hands and had separate hot and cold taps. Hand washing posters were displayed throughout the department.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff followed best practice guidance for the routine disinfection of ultrasound equipment (European Society of Radiology Ultrasound Working Group, Infection prevention and control in ultrasound – best practice recommendations from the European Society of Radiology Ultrasound Working Group (2017)). The ultrasound probes were decontaminated using three step disinfectant wipes between each patient and at the end of each day.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Emergency pull cords were available in areas where patients were left alone, such as toilets, and emergency call buzzers were available within the MRI and CT scanning rooms to alert staff. Microphones were built into the scanners to enable two-way communication between the radiographer and the patient.

The design of the environment followed national guidance. Diagnostic services were located across the ground floor within the hospital, and included magnetic resonance imaging (MRI), computerised tomography (CT), mammography, ultrasound, fluoroscopy and x-ray suites. The diagnostic suites were not centralised in one location and could be found at either end of the hospital. The service had a separate reception and waiting area that was accessible to all, however it was small and cramped. It was clear of clutter and contained a suitable number of chairs to meet patient needs. Staff told us they planned to increase the space within the waiting area by removing two patient changing cubicles located along the back

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wall and extending into this new space. There was a separate MRI sub wait area adjacent to the mammography and MRI suites, and there were patient changing facilities for each of the modalities.

There was clear signage and visual prompts to assist with patients and visitors attending the department. Patients were asked to wait in the waiting area until they were called through to the relevant diagnostic imaging suite.

The design of the environment within the radiology department kept people safe from avoidable harm. Rooms where ionising radiation exposures occurred were clearly signposted with warning lights. These were in place in all relevant modalities to warn people about potential radiation exposure. Illuminated no entry signs were clearly visible and in use throughout the department at the time of our inspection to ensure that staff or patients did not enter rooms whilst imaging was taking place. We saw staff testing the warning lights which they told us was performed daily. Access to the diagnostic suites and patient changing rooms were protected with doors secured with a keypad entry or swipe card system, which restricted unauthorised access.

There were appropriate warning notices in different languages to advise people about the risks of the MRI scanner and its strong magnetic field on the door to the MRI suite. This was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) national guidance. The service displayed a five-gauss line plan diagram and was marked on the floor within MRI suite to demonstrate the perimeter of the magnetic field, outside of which is considered a safe level of exposure.

Radiographers performed adequate screening by means of safety questionnaires to ensure anybody entering imaging suites were kept safe. For example, to ensure patients and visitors entering MRI were kept safe from the high magnetic field. The safety questionnaire also asked female patients if they were pregnant prior to any scan.

Risk assessments had been carried out on all new or modified imaging equipment. Risk assessments addressed occupational safety, as well as considering risks to people who use services. We saw evidence of a new risks assessment which had been completed for the fluoroscopy suite as it had recently been refurbished and a new machine installed. Radiographers and radiology assistants wore radiation badges or TLD's

(thermoluminescent dosimeter) to monitor any occupational doses and to ensure that staff were not over exposed. These were changed every two months and we saw the service completed regular radiation dose monitoring reports. Radiologists with one exception were not provided with radiation badges by the hospital as they instead wore ones provided in their substantive NHS employment. Monitoring of radiation doses for radiologists was the responsibility of the individuals and the NHS employers. We saw that lead aprons were used, and routinely checked to ensure they were not damaged. Appropriate personal protective equipment (PPE) was used. Lead aprons were available in x-ray and used by staff when needed. Aprons were checked annually to ensure they were not damaged. There were regular annual audits and testing of lead aprons; the most recent radiation safety PPE audit was completed in May 2019 and found no adverse findings.

Staff carried out daily safety checks of specialist equipment. The diagnostic service had an equipment quality assurance (QA) programme in place, with all radiographers involved in daily, weekly and monthly QA processes. The service maintained a record of quality assurance testing and we saw evidence that quality assurance testing was completed at regular intervals in line with the Institute of Physics and Medical Engineering.

Servicing and maintenance of the premises and equipment was carried out using a planned preventative maintenance (PPM) programme. The service completed PPM checks regularly and in line with manufacturer's guidelines, which included checks by medical physics experts and were replicated in each modality. Diagnostic imaging equipment used at the hospital was serviced regularly as required and maintained by a recognised service team. We saw evidence MRI and x-ray equipment had the necessary acceptance checks and critical examination reports to demonstrate the outcome of testing safety features and warning devices.

There was a system to ensure repairs to broken equipment were carried out quickly, so patients did not experience delays to treatment. Staff told us they had a good relationship with the external provider and when contacted, they were onsite the same or next day to complete repairs. A mobile MRI has only been requested once due to failure of equipment, which staff told us is very rare.

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Equipment issues were discussed at the daily radiology huddle, including visits from contractors and engineered to performance maintenance or repairs.

The service had enough suitable equipment to help them to safely care for patients. All equipment belonging to the diagnostics service was labelled in line with Medicines Healthcare products Regulatory Agency (MHRA) recommendations, for example, 'MR safe', 'MR conditional' and 'MR unsafe'. This ensured all staff knew which items could and could not be safely taken into the scanning room. Staff we spoke with understood their responsibilities relating to the use of equipment in an MRI environment.

Adult and paediatric resuscitation equipment, for use in an emergency, was not stored within the department. The nearest resuscitation equipment was located on the inpatient ward on the ground floor. During our inspection we raised our concerns around the length of time taken for staff to respond to a deteriorating patient with the resuscitation equipment due to the spread-out layout of the imaging department. The hospital performed a scenario and the time taken to arrive with the resuscitation equipment was one minute and 24 seconds, with staff arriving soon. This response time was within Resus Council UK guidelines. Resuscitation equipment was checked daily by the ward staff and was safe and ready for use in an emergency. Staff maintained an up-to-date checklist for all equipment. Staff were able to unlock the MRI table from the magnet which they could use to transfer a patient out of the scanner during a medical emergency.

An observation area allowed visibility of all patients during MRI scans. There was sufficient space around the scanners for staff to move and for scans to be carried out safely. Patients had access to an emergency call buzzer and during scanning. A microphone enabled contact between the radiographer and the patient.

The service had 24 hour support for all IT equipment including for the Picture Archiving and Communication System (PACS). There was a 24 hour helpline which was used to provide assistance with any IT problems.

The hospital had a backup generator in case of a power cut which could support all diagnostic equipment and would allow the department to keep functioning, with the exception of the MRI scanner which was not linked to the emergency system.

Staff disposed of clinical waste safely. There was correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with the Health Technical Memorandum 07-01, 'Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations'. Sharps bins were labelled, the bins were not overfilled and were closed when not in use.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. There were clear pathways and processes in place for the assessment of patients who became unwell within the radiology department. In the event of a patient expressing that they felt unwell, staff had access to radiologists, consultants working in outpatient clinics and the resident medical officer (RMO). For children, the children and young peoples (CYP) lead was contacted immediately, to review the child. All staff were aware and could demonstrate the systems and process in place should a patient's health deteriorate, this included transfers to other providers. In an emergency, staff called an ambulance and patients were transferred to the emergency department of a local NHS hospital.

All diagnostic imaging staff were trained in life support techniques and paediatric basic life support (PBLIS). The CYP lead was also trained in advanced paediatric life support (APLS).

Emergency equipment such as a resuscitation trolley located on the inpatient ward, were in date and available to staff in a medical emergency. They were well equipped and maintained, with daily and weekly checks recorded. We found no issues or concerns with the recordings. A resuscitation trolley audit was completed monthly.

Anaphylaxis emergency boxes were also accessible and located throughout the department to respond to

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deteriorating patients. For example, the anaphylaxis box was used for patients requiring contrast medium prior to an MRI scan should they experience a reaction. Staff had not yet needed to use these, however were trained and felt confident to use them in an emergency.

Emergency pull cords were available in areas where patients were left alone, such as toilets, and emergency call buzzers were available within the MRI and CT scanning rooms to alert staff. There was an emergency 'stop' switch located in the MRI imaging suite, which staff could activate if they needed to urgently stop the scan, for example to access the room in an emergency. The radiographers could confidently describe the process to quench the magnet.

Staff completed risk assessments for each patient on arrival and updated them when necessary and used recognised tools and staff knew about and dealt with any specific risk issues. All patients were asked to complete a safety questionnaire upon arrival to identify any potential risks undergoing specific diagnostic imaging procedures. For example, the magnetic resonance imaging (MRI) safety questionnaire asked whether the patient (or visitor) had a pacemaker, a prosthesis, if they were pregnant, if they had any shrapnel injuries or any known allergies. Furthermore, patients were advised of the risks of having any MRI unsafe equipment and clothing on them.

Referrals to the imaging service were received via several methods, including patients GPs and consultants. The service maintained a master copy of staff who were eligible to refer patients for investigations according to the staff members competency and training, including non medical referrers. For example, physiotherapists were able to request a modified list of tests, such as MRI scans of the spine, while consultants could request any investigation. On receipt of the referral, the investigation was screened against set criteria for appropriateness, to ensure that the right investigation was being requested according to the patient's complaint. If there were any concerns, the screening radiographer or radiologist would contact the referrer to discuss alternatives.

In line with IRR17, the diagnostics service appointed a radiation protection supervisor (RPS) whose role was to ensure staff followed the hospital and Spire standard operating procedures and adhered to the radiation protection procedures. IRR17 guidance states that the number of RPS' should be determined by the number of

different locations, the range and complexity of radiation work undertaken, and factors, such as shift work, and any planned/ unplanned staff absence. IRR17 also requires employers to keep exposure to ionising radiations as low as reasonably practicable. The role of radiation protection advisor (RPA) and medical physics expert (MPE) were fulfilled by an external provider, and staff described them as readily accessible and there was a good working relationship.

The hospital employed a MRSO (Magnetic Resonance Safety Officer) who provided a level of expertise which enhanced the patient and staff safety across the service.

Local rules were available in all imaging suites. Local rules identified risks, including steps taken by staff to ensure scanning procedures were completed safely. For example, the service had local rules (IRR) and employers' procedures (IR(ME)R) in place to protect staff and patients from ionising radiation. The service had a health and safety executive (HSE) registration certificate for use of ionising radiation, which they provided us following the inspection.

Records showed radiographers had been inducted and trained on the imaging equipment they used. Data provided by the service showed all staff working as operators under IR(ME)R had undertaken a recognised academic course of training and were registered with the Health & Care Professions Council (HCPC). We observed records indicating staff had read the local IR(ME)R procedures.

The diagnostic service used World Health Organisation (WHO) safety checklists, and we saw completed checklists were used when appropriate. An audit of the WHO safety checklists was completed to ensure appropriate safety checks had been completed and documented before, during and after a scan. Audits from July to September 2019 demonstrated 100% compliance.

There was a defined pathway to guide staff on what actions to take if unexpected or abnormal findings were found on a scan. Scans were reviewed by the radiologist within 24 hours and staff described examples where they have contacted consultants to escalate concerns. Reports for such findings were completed urgently to ensure further investigations or treatment was provided promptly. Patients were also added to an urgent findings log, where a letter was sent to their GP and referring

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clinician to update them on the situation and to escalate their concerns. If staff were unable to escalate to the appropriate or referring clinician, they handed over to the patients GP to arrange for urgent follow up action.

Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Staff told us they could access the psychology team who could assess and support patients' mental health when required.

Staff shared key information to keep patients safe when handing over their care to others. Staff copied letters to other professionals including colleagues involved in the care of patients, and to the patients' GP to ensure key information was shared. Information was also shared across the department during multidisciplinary team (MDT) meetings and staff interactions during scans. The service had daily safety huddles where concerns around staffing, the number of expected patients, equipment and patients who potentially required additional support were discussed. We attended a staff huddle which was informative, covered a range of potential challenges, but also celebrated success and provided a good method of feedback for staff.

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 staff of relevant grades to keep patients safe. The radiology department was safely staffed daily, Monday to Saturday, with Sunday services also available for MRI appointments. Each modality was staffed by two radiographers, except for ultrasound which was managed by a radiology assistant. Staff were flexible dependent on the number of patient bookings and expected demand on the service. Radiographers typically worked three long days. There was an on call radiographer available for out of hours emergency requests. The service had 25 consultant radiologists who regularly worked at the hospital but were not directly employed as they worked under practicing privileges. Practicing privileges were granted to consultants who

treated patients in the radiology service, that carried out procedures they would normally carry out within their scope of practice within their substantive post in the NHS. The service had processes in place to ensure consultants had professional indemnity insurance, scope of practice, professional registration with the General Medical Council and evidence of revalidation. Radiologists were on duty alongside radiographers throughout the week and to support the radiographers, review scans and report on images. We saw a rota for radiologists was displayed throughout the department, with radiologists having set sessions throughout the week.

Staff told us there was a low rate of sickness and turnover, the service had no current vacancies and no issues in recruiting to vacancies if they become available. Staff told us recruitment for a weekend MRI radiographer will begin shortly to further improve access to the service.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. The manager could adjust staffing levels daily according to the needs of patients, and the number of staff on all shifts in each modality matched the planned numbers. Staffing requirements were reviewed and planned in advance of scheduled patients and to provide a walk in service for x-ray. Staff told us that the team were flexible and multi-modality trained which allowed them to change their shifts to cover staff shortages. Staffing issues were discussed at the daily radiology huddle, as well as sickness and any agency or bank staff on shift. Data provided by the hospital showed between July and September 2019 there were no unfilled shifts in any modality.

Managers limited their use of bank and agency staff and requested staff who were familiar with the service and ensured all new bank and agency staff had a full induction and understood the service. Staff told us the use of agency staff was rare in the radiology department, and data provided by the hospital showed no agency staff had been used between July and September 2019, except for eight hours in theatre x-ray. All new staff, including bank and agency received a local induction to each area on their first shift. The service also typically used the same agency staff to ensure they were familiar with each of the scanning rooms and emergency

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procedures. This meant patients could be assured that staff were familiar with the service provided, the needs of the patients and that staff had completed required training.

Records

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

Patient notes were comprehensive and all staff could access them easily. The service used two electronic record systems. The Radiology Information System (RIS) and the Picture Archiving and Communication System (PACS). The RIS was a password protected record of patient's demographics and could be used to book patients into vacant investigation slots. PACS was the system for storing completed images and the associated reports, which was password protected and accessible to radiology staff for reporting and clinicians who had requested the image. We saw that the service maintained written patient records for admitted patients, as well as storing details of all investigations and their findings electronically.

When patients transferred to a new team, there were no delays in staff accessing their records. The radiology team received patient referrals through a secure email, telephone call from the referring consultant or hospital or via post. Appointments were booked in advance, and patients sent appointment letters, or contacted via phone if short notice. The hospital provided referrers with electronic diagnostic imaging reports which were encrypted. An encrypted disk was provided to patients on request. Staff told us there were no issues with delays in receiving scan results from other hospitals or providers.

Records were stored securely. Throughout the radiology department, care was taken to ensure that computer screens were not accessible or in view of unauthorised persons. Computers were locked when not in use. There was a clear standard operating procedure for staff to follow in the event of IT failure. Computer access was password protected and staff used individual log-ins. Paper documentation such as referral requests were stored securely and destroyed in line with Spire Healthcare policy. Staff received training on information governance as part of their mandatory training

programme. Data provided by the centre showed that as of July 2019, 92% of staff across radiology department had completed their information governance training either face to face or through e-learning.

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. Staff were aware of the hospitals medicines policy, which outlined suitable arrangements for the recording, safe-keeping, handling and disposal of medicines. Staff were aware of how to find the policy. They were able to describe processes for monitoring stock levels of medicines stored in cupboards and ensuring that all stock was within its expiry date.

Patient Group Directions (PGDs) were used by the service. This enabled radiographers to inject contrast within CT and MRI without the requirements for medical staff to complete a prescription for each patient. We saw evidence these were signed and dated, in line with best practice. Patient Group Directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

Allergies were clearly documented on referral forms and safety questionnaires. Allergies were verbally checked during the diagnostic imaging safety checklist.

The Society of Radiographers (SoR) recommended "Pause and Check" system was used to check medications prior to administration. Care was taken to ensure the right patient received the right medicine. Patient's identity was checked, confirmed and then checked against their prescriptions. Patients did not wear identity (ID) bracelets when visiting the department as an outpatient, however, inpatients were expected to wear ID bracelets throughout their admission.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The radiology service had appropriate lockable storage facilities for medicines, including contrast media, such as

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cupboards. Keys to the medicine cupboards were stored in accordance with national guidance and held by senior radiology staff to prevent unauthorised staff from gaining access.

Medicines requiring storage within a designated room were stored at the correct temperatures, in line with the manufacturers' recommendations, to ensure they would be fit for use. Room temperatures were recorded as part of the daily checks by staff. The temperature records showed temperatures had been checked daily and were within the required range. Staff knew what to do if the temperatures were not within the required range.

Contrast media was stored appropriately and was accessible to key members of staff. Contrast media is a substance introduced into a part of the body to improve the visibility of internal structures during radiography. Staff were trained on the safe administration of contrast media including intravenous contrast. We reviewed staff competency files and saw all staff had received this training.

There were no controlled drugs (CDs) kept or administered in the diagnostic imaging service.

Emergency drugs were kept on resuscitation trolleys and ward staff documented daily checks. All emergency drugs were within their expiry date.

For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

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

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic

online system for reporting incidents. Staff throughout the radiology department described the process for reporting incidents and were confident in using the system.

Staff reported all incidents that they should report. Staff told us they were aware of what constituted an incident, and the types of issues they should report and record as incidents. For example, staff said when patient identifiable information did not match preventing them from proceeding with a scan such as MRI, they would raise an incident. Staff told us there was a good reporting culture and they were encouraged to report 'near-miss' situations.

Staff could describe how they would manage and report IR(ME)R incidents. Managers told us that all incidents would be reported following the incident reporting procedure and escalated to the radiation protection advisor and meeting. There was a medical physics expert available for advice when needed.

During the reporting period from April 2018 to March 2019, there were 416 incidents reported within the outpatients and diagnostic imaging services which were grouped together. Of these, 285 were clinical, and 131 were non-clinical incidents.

The service had no serious incidents, however staff were aware of the incident reporting process, and raised them in line with hospital policy.

Between April 2019 and October 2019, the diagnostic imaging service had reported 68 incidents across all imaging modalities. The incidents were categorised into those that resulted in no harm (59), minimal harm (8), moderate harm (1) and major harm (0). The most frequently reported themes for incidents included radiology (19) and documentation/patient information (16). The remaining 33 incidents related to topics including cancellation, security, diagnosis, and health and safety. The one incident that resulted in moderate harm was related to a moderate to severe allergic reaction to the CT contrast, and we saw that it was fully investigated, the patient was reviewed by the RMO and admitted to the ward for observation and care. On discharge they were given an alert card containing information related to their allergy to the contrast given. The service also had a process in place whereby they would call the patient 24 hours post contrast reaction to

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check on their wellbeing, and an alert sent to the patient's GP and referring clinician for future reference. We reviewed the incident reports and found comprehensive investigations were completed, with lessons learned, arrangements for shared learning, recommendations and actions taken to minimise the risk of recurrence. We saw that duty of candour was applied to incidents where appropriate.

There was a positive incident reporting culture in the department; all staff we spoke with had received training and were encouraged to report incidents. Staff knew how to access the system and their responsibilities to report incidents and felt confident to do so. All staff could give examples of when they had or would need to report an incident. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through daily huddles and team meetings.

Managers debriefed and supported staff after any serious incident. Staff told us when they reported an incident, they discussed it with their manager and when feedback was returned they had further discussions about what improvements could be made to prevent it from recurring.

The service had no never events, however managers shared learning with their staff about never events that happened elsewhere if applicable. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. From April 2015, healthcare providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reason able support to the person. Staff said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full

apology. Staff were familiar with the terminology used to describe their responsibilities regarding the duty of candour regulation. Staff described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the patient and their relatives.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed root cause analysis of an incident and found comprehensive investigations were completed, with lessons learned and arrangements for shared learning. We saw evidence of action plans put in place to reduce recurrence. For example, staff told us a theme from incidents was the poor completion of referral forms into the service which led to referrals being rejected, or scans delayed due to inappropriate imaging requests. As such, additional questions were added to the MRI referral form at the request of radiologists. The service held discussions with patients and their families who were invited to discuss the outcome of the investigation.

Staff received feedback from investigation of incidents, both internal and external to the service, and staff met to discuss the feedback and look at improvements to patient care. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through staff team meetings daily huddles, and on staff noticeboards. During team meetings and huddles, improvements were discussed and learning shared.

There was evidence that changes had been made as a result of feedback. Following learning from incidents, additional questions were added at the request of radiologists to MRI referrals.

Are diagnostic imaging services effective?

Not sufficient evidence to rate 

We inspected but did not rate effective.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists, the Society of Radiographers and other national bodies. This included all modalities within the diagnostics service. Staff we spoke with demonstrated a good understanding of the national legislation that affected their practice. For example, in line with NICE guidance, staff ensured all patients who required contrast media received a blood test to check their kidney function before proceeding with the scan.

‘Pause and Check’ posters were displayed in all areas visited, as a ready reminder of the checks that needed to be made when any scan is undertaken. The Society and College of Radiographers (SCoR) produced this resource to reduce the number of radiation incidents occurring within radiology departments. During our inspection we saw staff used ‘Pause and Check’ for all patients undergoing a scan.

Processes were in place to ensure the correct radiation doses were set for adults and children. The service had diagnostic reference levels (DRL) for safe radiation doses available for all the examinations performed and all staff had access to a DRLs which were written in local rules. Radiographers displayed a good understanding of dose reference levels. Local rules were displayed in the control rooms each imaging suite. The team maintained a signature sheet to show that staff had read the local rules, and this was updated annually, in line with good practice and IR(ME)R regulations. Activity for each exposure was optimised so the lowest practicable dose to the patient was given and radiographers recorded the DRL used.

DRL levels were regularly audited and the outcomes were monitored at daily huddles, clinical governance meetings and the annual radiation protection committee meetings. Using outcomes from these audits, staff in the diagnostic imaging service developed local DRLs. For example, staff carried out a pelvis audit in x-ray which demonstrated

doses were high and varied from patient to patient. Results from the audit were shared at a daily huddle, and changes to local rules and DRLs based on results were discussed.

Staff told us they were kept up to date with changes in policies by the radiology manager and hospital director at team meetings and daily huddles. Clinical policies and procedures were available on the intranet and staff were aware of how to access them.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Policies were in place to ensure patients were not discriminated against. We saw no evidence of any discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions. Staff were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients. Staff were aware of how to access policies and procedures. Staff told us that they would escalate any concerns and seek further guidance if necessary.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. While patients attending the department were not routinely provided with food or drinks, as they were only there for a short period, access was provided by a café in the hospital. There were also water coolers and disposable cups available throughout the department. Staff were alert to patient’s hydration needs and we saw staff providing patients with water while they waited if required.

Pain relief

The service managed patients’ pain effectively.

Patients were asked by staff if they were comfortable during their appointment, however no formal pain monitoring was undertaken as patients were generally in the department for short periods. Staff described how they would offer support to patients who reported being in pain by referring them to a consultant.

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Patient outcomes

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

Managers carried out a comprehensive audit programme. Information about the outcomes of patient's care and treatment was routinely collected and monitored. The diagnostics service undertook regular clinical audits and took appropriate action to monitor and review the quality of the service. The diagnostics service had an audit schedule in place to monitor compliance with policies and against guidelines. Audits included World Health Organisation (WHO) checklists, IRMER compliance, radiation personal protective equipment, a peer review programme for reporting of images. Staff confirmed results were shared at relevant meetings such as daily huddles, the radiation protection committee, and the clinical audit and effectiveness committee.

Managers used information from the audits to improve care and treatment, and they shared and made sure staff understood information from the audits. Improvement was checked and monitored. We reviewed audit outcomes for 2019, which demonstrated the intended outcomes for people were being achieved. Most audits completed, demonstrated 100% compliance against set criteria. For example, the WHO checklist audit in July to September 2019, demonstrated 100% compliance respectively.

The quality of diagnostic images was regularly audited by the service and the outcomes were shared with staff. This included peer reviews of radiologists work to improve standards and education. The Royal College of Radiologists recommends that there should be regular discrepancy audits and MDT meetings to discuss cases and discrepancy errors that have been reported for learning and reflective purposes. Discrepancy audits were recorded as a medium risk on the imaging services risk register due to a lack of compliance with this guidance. However, during the inspection staff told us the radiology manager was looking for an external radiologist to complete independent reviews to avoid potential conflict within the team where a discrepancy was identified in the audits being completed by peers. These audits included a 10% sample of MRI images, and a monthly 2% of CT, MRI and plain film x-ray. These audits were implemented in

May 2019, and data provided by the hospital showed in June 2019 there were no discrepancies found. Managers shared audit results and improvements discussed at governance meetings with staff and they were discussed at regular team meetings and daily huddles.

The service did not participate in the Imaging Services Accreditation Scheme (ISAS). Staff told us they intended to gain accreditation and had prepared a range of documentation and evidence to support their application. While there was no timescale to participate, we saw evidence that the service was actively working toward it.

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. Staff confirmed they had been assessed to ensure they were competent in their role. We saw a competency folder in place which demonstrated staff had been appropriately assessed. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisals. Staff were supported to reflect, improve and develop their practice through education by their manager. The service operated a comprehensive mandatory and statutory training programme which ensured relevant knowledge and competence was maintained and updated throughout the lifespan of employment with the organisation.

All radiographers were Health and Care Professions Council (HCPC) registered and met the standards to ensure delivery of safe and effective services to patients. Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements and had a monthly CPD programme established, delivered by in-house external trainers. For example, we attended a planned MRI safety update during our inspection, attended by staff from across the hospital. All radiographers had revalidated their professional registrations in a timely manner.

Managers gave all new staff a full induction tailored to their role before they started work. Staff received a comprehensive induction when they started work at the

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hospital to ensure competence, skills and confidence. The hospital induction programme took place over 10 weeks and included orientation to the radiology department such as a tour and fire evacuation routes, as well as completion of mandatory training and local competencies. Staff said they found the inductions helpful and were very well supported. All bank and agency staff had an induction and were orientated to the clinical areas to ensure that they were familiar with procedures and the environment. Managers generally used bank and agency staff who were familiar with the service whenever possible.

We saw induction checklists completed for all staff working within the diagnostic service, including temporary staff used. We also saw evidence of staff safety checklists being completed to ensure staff were safe to work in the diagnostic service. Radiographers underwent a comprehensive competency sign off before they were able to complete specific clinical tasks and operate scanning equipment. Each radiographer had a competency workbook which was updated and signed off by the radiology manager.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff received an annual appraisal which they told us was constructive and provided a formal opportunity to review their progress and identify further training needs. Data provided by the hospital showed 100% of staff in the diagnostic imaging service had received their appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings for the imaging service were held every month and were chaired by the imaging manager. They had a set agenda and covered topics including regulatory compliance, policy updates including changes to NICE guidance, audits, training and risks. Staff told us they also received updates from the senior management team. Minutes were circulated following the meeting.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their training and development needs were discussed at their annual appraisal, and at their monthly one to ones. Staff were given the opportunity to attend

training courses relevant to their role. Regular team leader forums (every six weeks) provided development for key staff as well as offering opportunities to progress and improve.

Managers made sure staff received any specialist training for their role. Staff showed us competency folders which they had created to ensure that staff had the skills and knowledge for their role. There was a tracker in place to ensure effective oversight of competency completion including review dates. confirmed they had received additional training in for example; sepsis awareness.

Managers identified poor staff performance promptly and supported staff to improve. At the time of our inspection, there were no staff who with performance issues which had been identified.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The diagnostic service worked well with the wider hospital team and held regular and effective multidisciplinary meetings to discuss patients and improve their care. Throughout the inspection, we saw that effective multidisciplinary team (MDT) working practices were established and teams worked well together to improve the efficiency and timeliness of care. Staff were able to access specialist teams and individuals for advice when required.

Patients could see all the health professionals involved in their care at one-stop clinics. The one-stop clinics were led by a multidisciplinary team which included doctors, specialist nurses and radiographers who worked together to ensure patients had their initial consultation, diagnostic tests, investigations and follow-up consultation on the same day. This meant a more efficient service for patients, with fewer appointments needed, prompt diagnosis and in some instances, immediate treatment. Staff in the diagnostic imaging service told us they had a positive working relationship with the outpatient service.

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The service had regular team meetings which were used to share information across all modalities, specific to the service or hospital. We saw that these were well attended, with minutes available to all staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked closely with referring consultants, which ensured a smooth pathway and prompt diagnosis for patients. Staff told us they had good working relationships with consultants. Staff were able to provide examples of how good working relationships with radiologists and consultants improved the outcomes for patients. We saw positive working relationships between radiographers and radiologists. A radiologist we spoke with told us they had good working relationships with radiographers and consultants. We heard positive feedback from staff of all grades about the excellent teamwork.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. (AMSAT). Staff were able to refer patients for mental health assessments and for psychological support where necessary.

Seven-day services

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

The radiology department was not open seven days a week. The department was open Monday to Friday from 8am to 9pm and Saturdays from 8am to 4pm, with radiographers and radiologists available during these opening times. The department was open Sundays from 8am to 4pm for MRI scans only and the service planned to recruit a substantive weekend MRI radiographer to allow provision on a permanent basis. Both modalities were available out of hours for emergency requests. There was an on call radiographer to support the service out of hours. Consultants were on site during core opening times.

Appointments were flexible to meet the needs of patients. Appointments were offered at short notice and on a walk-in basis with an appropriate referral.

Staff could call for support from doctors and other disciplines, including mental health services 24 hours a day, seven days a week. The RMO was always onsite, and the inpatient ward was open 24 hours a day if patients required advice outside of department opening hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support across the radiology department. There were health promotion information and materials, including information leaflets on display in the radiology reception and waiting areas which covered a range of subjects including smoking cessation and mental wellbeing.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. Staff identified patients who may need extra support.

Consent and Mental Capacity Act

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke to had a good understanding of the need to assess patient's capacity to make decisions when necessary.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff had an effective understanding of gaining consent. They were aware of what to do if they had concerns about a patient and their ability to consent. Staff would seek guidance from the referrer, radiologist or consultant before proceeding with a scan. Patients completed a safety questionnaire before their procedure, and by signing the

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form, the patients were giving consent to the scan. Radiographers checked the details of the form before they took patients to the scanning room and would verbally check the patient was still happy to go ahead with the scan.

Staff clearly recorded consent in the patients' records. We reviewed four patient records and saw consent had been documented in all correctly.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients told us they had been given clear information about the benefits and risks of their scan in a way they could understand prior to signing the consent form. Patients said they were given enough time to ask questions if they were not clear about any aspect of their scan.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff were able to explain the best interests' decision-making process, and gave examples of when staff recognised patient's needs for extra support when consenting to treatment, such as when patients had a learning disability or were living with dementia. Staff told us they would involve the patient's relatives and carers to provide further information about the patient's wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient.

Staff made sure patients consented to treatment based on all the information available. Patients told us they had been given clear information about the benefits and risks of their scan in a way they could understand prior to signing the consent form. Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Gillick competence is concerned with determining a child or young person's capacity to consent to medical treatment without the need for parental permission. Staff told us they only see children with a parent present. The children and young people (CYP) lead was readily available for support and attended scan appointments when required.

Staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Data provided by the hospital showed staff were 100% compliant, with the training mandatory on an annual basis.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice (AMSAT). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Medical staff supported patients to make decisions in line with relevant legislation and guidance. Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards which were available on the hospital's intranet.

Are diagnostic imaging services caring?

Good 

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last 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 saw staff being caring and compassionate with patients and their relatives. Patients praised staff for their kindness and understanding of their needs. Staff treated patients with dignity and respect and spoke in a respectful and friendly manner. Staff members spent time with patients and interacted with them during tasks and clinical interventions. The department had a chaperone policy. There were posters available informing patients about the availability of chaperones and staff were readily available to act as chaperones when needed. All patients were offered the choice of having chaperones during their scans.

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Patients said staff treated them well and with kindness. We observed caring interactions with patients throughout the radiology department. Patients told us all staff, including nurses, doctors and receptionists were very pleasant, and treated them with great kindness. Patients were welcomed into the hospital and staff introduced themselves to patients, explained their role, and what would happen during their scan. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.

Staff followed policy to keep patient care and treatment confidential. Patients we spoke to told us their privacy and dignity was always maintained. They told us they were provided with private areas to change their clothes and felt comfortable at all times.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff responded well to people's questions and concerns. Staff quickly recognised when someone might need some extra reassurance or support and provided it tactfully. Staff were aware of how patient's behaviour may be affected by their health and showed compassion and understanding during their interactions.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. Staff had a good awareness of patients with complex needs and those patients who may require additional support should they display difficult behaviours during their visit to the department. Patients told us staff were very helpful, and were able to answer any questions they had, without feeling rushed. There was a range of information available for patients to take away across the department in the form of booklets and leaflets.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us they provided extra time

for patients who were nervous or patients attending for an MRI scan who were claustrophobic (a phobia of enclosed spaces). This procedure can often make patients feel nervous. Staff allowed time for patients to adjust to the scanning room. Patients told us staff were very calm, patient and allowed them as much time as was needed to feel comfortable to undergo a scan.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff said they received difficult conversation training and usually delivered distressing news with a radiologist or doctor present, in a private environment that was supportive, and ensured that patients had enough time to process and ask questions without being disturbed. All patients we spoke to said nursing and medical staff discussed sensitive issues with empathy and compassion.

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 provided emotional support whilst caring for patients and were allowed time to provide any emotional support patients needed. Staff supported patients through their investigations, ensuring they were well informed and knew what to expect. For example, staff told us they updated patients regularly about how long they had been in the Magnetic Resonance Imaging (MRI) scanner and how long they had left.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff involved patients and those close to them in decisions about their care and treatment. Patients we spoke to said they felt involved, and had been given the opportunity to ask questions, and felt comfortable and reassured. All patients told us they were provided with a good, clear explanation and were provided with written

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information about their condition and the type of scan they were due to have. All patients we spoke to could explain what they had been told during their scan and were aware of what the next steps were.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The hospital introduced an electronic survey which was sent to patients who recently visited the radiology department which they could complete online. Staff told us the survey responses were overwhelmingly positive, and patients were happy with the service and care they had received. Patients were also able to leave comments and write reviews of their experience in the radiology department on the Spire website and on the hospital's social media pages

Staff supported patients to make informed decisions about their care. Patients told us they were very satisfied with the care they received and the staff who provided it. They felt involved in their ongoing treatment and staff took the time to explain the procedure and what would happen during their scan. Patients we spoke to said they had plenty of opportunity to ask questions and staff listened to them and were happy to answer any questions they had. They had been kept 'well-informed' of their treatment plan and that they felt able to raise any concerns with radiology staff. Staff checked patient's understanding prior to asking them to make decisions.

The feedback from the Friends and Family Test was positive for all areas. All patients had the opportunity to complete the Friends and Family Test (FFT) and indicate their likelihood to recommend the service. The Friends and Family Test (FFT) is an important feedback tool supporting the fundamental principle that people who use healthcare services should have the opportunity to provide feedback on their experience. While data specific to the radiology department was not provided, across the hospital 98% of patients in June 2019 said they would recommend services provided by Spire Parkway.

Are diagnostic imaging services responsive?

Good 

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last 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.

Managers planned and organised services so they met the changing needs of the local population. The hospital provided a range of diagnostic and imaging services, which included general radiography, computerised tomography (CT), magnetic resonance imaging (MRI), fluoroscopy, mammography, and ultrasound. The department had access to three paediatric radiologists session a week, however staff said they did not see many children.

We saw that the hospital provided 'one-stop' clinics where possible to reduce the number of patient's hospital appointments. For example, patients attending for colposcopy had further investigations and a consultant appointment on the same day preventing patients from attending the hospital on two separate occasions.

Facilities and premises were appropriate for the services being delivered. The radiology department was on the ground floor of the hospital and was accessible to those using mobility aids. The reception area could be accessed via the hospital's main entrance, which was a short distance from the car park with dedicated disabled parking bays. Staff received verbal complaints about parking, however said it varied each day on whether parking was an issue for patients. The service had appropriate facilities to meet the needs of patients waiting for their scans, which included comfortable seating, access to bathrooms, water dispensers and reading material.

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

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Information was provided to patients in accessible formats before appointments. Appointment letters containing information required by the patient such as contact details, information about the procedure including any preparation such as fasting was required. Patients who required additional support, for example patients living with dementia or a learning disability, were able to bring a carer/relative.

The service relieved pressure on other departments when they could treat patients in a day. Patients were able to have diagnostic tests on the same day as their outpatient appointment, in order to reduce visits for the patients and relieve pressure on other services.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Reasonable adjustments were made by staff to ensure patients in these groups could access the care they needed and received scans in a timely and safe way. Patients were able to have early or late bookings to support their individual needs, and staff regularly carried out home visits to patients to provide reassurance and to make their experience tailored for them.

Staff told us they had completed home visits for children and adults who were anxious about attending the department and required additional support. For example, staff would describe the imaging process in detail in a way that the patient could understand. For children, staff were able to re-enact the situations they were likely to face so they were familiar with the process before they arrived.

Staff visited patients homes with the safeguarding lead to carry out best interests meetings, following which patients were either consented or able to consent themselves, and staff planned their visit with the patient

to ensure their needs were met. All staff we spoke to said they take great pride in their work, especially when they are able to accommodate patients with mental health problems, learning disabilities or dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff received training to recognise and care for patients who may require additional support, such as those with dementia or other co-morbidities. The hospital had a dementia lead in post, who supported staff when patients living with dementia or learning disabilities attended the department. Staff told us they used the 'this is me' documents and patient passports when patients attended the department if applicable.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There were hearing loops (a sound system available to assist patient's wearing a hearing aid) available in the radiology department reception area. Information leaflets were available in accessible formats if they were requested. The service provided appropriate translation services, and sign language interpreters, when required. Translation services were available through a private contracted service. This included British Sign Language as well as other spoken languages. The hospital had access to a telephone interpreter if they could not attend the hospital at short notice.

The service had information leaflets available in languages spoken by the patients and local community. The service provided a range of patient information leaflets, and patients were given a wide range of information prior to attending for their scan. We found the information leaflets were all current and relevant. Information was available in accessible formats.

There were procedures in place to make sure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs and aimed to ensure that patients understood the costs involved. Leaflets were available that explained the payment options, and procedures and gave advice of who to contact if there were any queries. The hospital website also clearly described the different payment options available.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The diagnostic service offered access to appointments in a timely manner for all patients, regardless of payment method. Patients were referred to the hospital via a variety of methods including GPs and consultants. Access to radiology appointments was fast and all patients told they were more than satisfied with the amount of time it had taken to obtain an appointment. Patient also told us they were able to book appointments at times that suited them.

Referrals were prioritised by clinical urgency. The service had capacity to accommodate walk in patients for x-ray, as well as urgent referrals.

A process was in place to monitor waiting times from initial referral to receiving an appointment. Following the inspection, the hospital provided us with audit results from July 2019 where 15 MRI and 15 CT referrals were reviewed. The findings showed all patients were contacted within 48 hours of the diagnostic service receiving the referral, and the average waiting time for CT was four days, and MRI was 4.7 days. The audit highlighted that the waiting time for MRI scans had slightly increased and that the need for a permanent seven day working was required. The waiting time for CT had also slightly increased, but this was in line with the increase in CT activity and that the majority of patients require preparation in readiness for their scan. As the service offered a walk-in service for plain film x-rays, staff told us there was no waiting list for patients and as such waiting times were no longer monitored.

An audit of waiting times within the department was also completed. Results from July 2019 where a sample of 50 were reviewed, showed the average waiting time from the point of arrival in the radiology department to receiving their diagnostic investigation was 5.4 minutes. This demonstrated that patients have a minimal waiting in the radiology department.

Staff told us reporting of x-rays were completed same day, and most scans for CT and MRI were reported within four days of patients attending for their scan. Urgent scans were reported within 24 hours. Following our inspection, the hospital provided us with their current waiting as of 25 September which showed there were eight MRI, four CT and one x-ray awaiting reporting, with no scans identified in the last 12 months which had been reported outside of the services performance target.

Managers and staff worked to make sure patients did not stay longer than they needed to. Appointments generally ran to time; reception staff would advise patients of any delays as they signed in. Staff told us they would keep patients informed of any ongoing delays. Three patients we spoken to told us they were seen on time.

Managers worked to keep the number of cancelled appointments to a minimum and made sure they were rearranged as soon as possible and within national targets and guidance. Staff told us cancellations were minimal and were very rarely caused by equipment or staffing issues. If there were issues which prevented patients from being scanned at the hospital, staff would try to book patients into other local Spire locations. During our inspection another Spire hospital experienced equipment technical issues and was unable to use their MRI scanner during the week. Staff at Parkway Hospital were able to accommodate four of their patients during our inspection, without causing disruption to their existing workload, which showed evidence of team work across sites and resilience in local systems.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns, and the service clearly displayed information about how to raise a concern in patient areas. We saw information leaflets and posters through the department informing patients how to make complaints, and those we spoke to said they would raise their concerns with the radiographers during their appointment, or their consultant in an outpatient clinic.

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Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff described their approach to complaints and said they tried to meet all complainants on the day while they were still in the hospital, to try to understand their complaint and resolve as much as possible, before proceeding with a formal complaints process. Following completion of the investigation, they would offer a face-to-face meeting with the complainant to explain and apologise.

We saw the number of complaints received for radiology was low. There had been several complaints related to the booking process for CT (computerised tomography) scans, as patients commented it was not an easy process to follow. They had also received complaints about patients being strapped into the MRI (magnetic resonance imaging) scanner and feeling 'bolted' to the machine. Learning from this complaint led to MRI radiographers providing each patient with more information related to the MRI scanning process and the importance of being completely still during the scan.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of learning from complaints was discussed at team meetings and at daily huddles.

Are diagnostic imaging services well-led?

Good 

We previously inspected outpatients with diagnostic imaging and cannot therefore compare ratings with the last inspection. We rated it as good.

Leadership

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

The diagnostic imaging service had a clear management structure in place with defined lines of responsibility and

accountability. The service was led by the imaging manager who staff told us provided strong leadership and all staff reported they were very approachable. We found staff were enthusiastic and proud to work within the diagnostic service.

Across the service, staff told us they could approach immediate managers and senior managers, including the hospital director with any concerns or queries. Staff throughout the diagnostic service told us they felt supported, respected and valued by their immediate line manager, and the hospital director. Staff said they were visible and approachable.

Staff saw their managers daily and told us they were visible and listened to them. Any changes made were communicated through daily huddles, team meetings and emails.

Staff told us the service was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did. There was a culture of openness and honesty and they felt they could raise concerns without fear of blame.

Staff we spoke with spoke highly of the hospital director, saying that they were always available and approachable.

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. Leaders and staff understood and knew how to apply them and monitor progress.

During our previous inspection in July 2015, we found the vision and values were not visibly displayed across the radiology department. None of the staff we spoke to made any reference to the vision or values or how they used them in their daily work. This suggested the hospital and corporate visions were not well embedded across the service. During this inspection, we found a well developed strategy and vision for the service, which had been developed together with input from staff across the service. The service had a three year vision and strategy for what it wanted to achieve and had developed strategic objectives for 2019 to meet this vision. The vision and strategy were displayed on staff notice boards throughout the radiology department, and staff could explain and understand the vision.

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The radiology service was not aligned with any accreditation scheme; however, staff told us they would soon begin working towards the Imaging Services Accreditation Scheme (ISAS). This is an accreditation scheme assessed by the United Kingdom Accreditation Service (UKAS) on behalf of the Royal College of Radiologists and College of Radiographers. The programme is designed to help diagnostic imaging services ensure that they provide consistently high quality services by competent staff working in safe environments. During our inspection we saw evidence that they service had begun to format documentation in support of the processes in line with the required ISAS standards, and plan for any work required to achieve the ISAS standards.

Culture

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

Managers across the diagnostic service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with felt supported by both the hospital director and the radiology manager.

Staff described the culture at the hospital as being open and honest and felt they were listened to by senior managers.

Staff said there was a high staff retention rate amongst all staff. Staff said they felt valued by managers and colleagues.

All staff we met were welcoming, friendly and helpful. They were very proud of where they worked, enthusiastic about the care and services they provided, and said they were happy working for the service. We observed staff practice and saw that they were polite and professional with all patients and families.

We saw that the culture of all the areas we visited during our inspection centred on the needs and experiences of the patients. For example, if a mistake happened this was handled in a sensitive and open way. Staff felt empowered to make decisions and to challenge if required to ensure patient care constantly improved.

Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.

The culture across the diagnostic imaging service was positive, with all staff stating how friendly and approachable everyone in the team was. All staff we spoke with were positive about working at the hospital and said it was a 'pleasant place to work' and that they felt 'safe' working there. This was evidenced in low sickness rates.

For our detailed findings on culture please see the Well Led section in the surgery report.

Governance

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

The diagnostic imaging service had governance systems that ensured there were structures and processes of accountability in all areas to support the delivery of good quality services. The radiology manager attended a heads of department meeting and clinical governance meeting which discussed complaints, incidents, audits, risk and shared information. This information fed into the senior management team meetings and the medical advisory committee (MAC).

The radiology manager attended a yearly radiation protection committee. There was an agenda and minutes for the meetings showing actions to be completed, timescales and the responsible person. For example, radiation protection training compliance, audits, local rules and risk assessments were discussed. The committee had oversight of all risks and requirements of the radiation regulations.

All staff from the imaging service attended meetings through which governance issues were addressed. The meetings included monthly team meetings, which were chaired by the radiology manager. The team meetings had a set agenda and covered topics including regulatory

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compliance, policy updates including changes to NICE guidance, audits, training and risks. Staff told us they also received updates from the senior management team. Minutes were circulated following the meeting.

Governance processes were effective to ensure all radiology staff received an appraisal. Clinical staff members were clear on their objectives and understood how they contributed to the service's success. The radiology manager identified training needs of staff through appraisal and supported completion of specialist training to support patient care.

Documentation formats used across the service such as national dose levels, imaging suite cleaning schedules, pregnancy flow charts, pause and check posters, protocols and local rules had been standardised. This meant staff new to the service and new to working in a modality, could go into any of the imaging suites and be able to start scanning in a short period of time, with details of familiar governance documents and processes easily accessible.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had arrangements in place for identifying, recording and managing risks, and maintained a departmental risk register which was reviewed at team and clinical governance meetings.

We saw that all risks were reviewed regularly and updated when any actions were taken to mitigate risk or harm. Each risk had a review date and a nominated manager who was responsible for tracking the risk identified. We saw evidence that reviews had been undertaken, what mitigation actions had been completed, and if the risk had reduced/increased. The main risks in relation to the radiology service were compliance with the Royal College of Radiologists guidance on discrepancy audits, reaction to contrast media, and unintended radiation exposure. We noted controls were in place to mitigate each risk and were constantly reviewed and updated.

Local risk assessments for all modalities and imaging suites were in place and were overseen by the modality leads and the imaging manager. Risks regarding radiation were monitored through the local radiation protection committee.

Managing information

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

Staff were able to access patient electronic records appropriate to the needs of the investigation being completed. Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Electronic patient records were kept secure to prevent unauthorised access to data, however, authorised staff demonstrated they could be easily accessed when required. The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within the regulations.

During the inspection we saw appropriate use of computers with no screens detailing patient information left unattended. There were sufficient computers available to enable staff to access the system when they needed to. Computers were available in all the areas we visited. All staff had secure, personal login details and had access to email and all hospital information technology systems. Data provided by the hospital following our inspection showed that staff were 92% compliant for information governance, which was above the hospital target of 75% for this point in the training year at the time of our inspection.

The service had clear performance measures, which were reported and monitored. These included, key performance indicators, referral to treatment times, treatment to reporting times, and friends and family test results. The data from these was used to drive forward changes in practice.

Policies were stored on the hospital's intranet and were easily accessible. Staff we spoke to could locate and

Diagnostic imaging

access relevant policies and key records easily. All staff had access to the hospital's intranet to gain information on policies and national guidance, and to access online e-learning training.

For our detailed findings on managing information please see the Well Led section in the surgery report.

Engagement

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

The diagnostic imaging service sought feedback from the relatives and carers of patient who had attended the department to help share and improve the service. Patients and visitors were encouraged to give feedback and were supported to do so. The hospital had introduced an electronic survey which was sent to patients who recently visited the radiology department which they could complete online. The department also undertook a monthly local paper based survey, to gather more specific information to improve the service. Staff told us the survey responses were overwhelmingly positive, and patients were happy with the service and care they had received. Patients were also able to leave comments and write reviews of their experience in the radiology department on the Spire website and on the hospital's social media pages

All patients also had the opportunity to complete the Friends and Family Test (FFT) and indicate their likelihood to recommend the service. The Friends and Family Test (FFT) is an important feedback tool supporting the fundamental principle that people who use healthcare services should have the opportunity to provide feedback on their experience. While data specific to the radiology department was not provided, across the hospital 98% of patients in June 2019 said they would recommend services provided by Spire Parkway. Staff told us that patient feedback was discussed and shared at daily huddles and team meetings.

Radiology staff used daily huddles as key ways of sharing important messages and regular meetings were held for staff to learn from each other and enable them to cascade the information.

During our inspection, we saw staff were engaged in the service and empowered to help improve services. Staff told us that local and departmental managers were approachable and that they felt comfortable to raise any concerns with them. Information was shared with staff in a variety of ways, such as face-to-face, email, and noticeboards. Staff participated in the Spire scheme 'Spire for You' awards to promote top performing team members.

For our detailed findings on Engagement please see the Well Led section in the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Staff within radiology confirmed they were continuously striving to implement changes and improvements for the benefit of the service. They had regular meetings where learning was discussed in a variety of forums. For example, radiology team meetings and governance meetings.

The service planned to implement an imaging pathway demonstration in the form of video called 'little journey'. It had previously been implemented at some of the larger Spire Healthcare hospitals, and was a video aimed at showing children and young people the pathway from preassessment, to the ward, to theatre and finally recovery. There were plans to also include diagnostic imaging to help reduce anxiety in children as they would already been familiar with the department prior to arriving for their scan.

During our last inspection, we found incident reporting was not well embedded, the storage of medicines needed improvement, and not all staff were aware of the hospital's vision and strategy. During this inspection, we found incident reporting was embedded, staff recognised and reported incidents, lessons were learned and when things went wrong staff apologised and gave suitable support. The service used systems and processes to safely prescribe, administer, record and store medicines, and there was a clear strategy and vision, which all staff were able to share and had been included in its development.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had a multi faith resource box. This included a prayer mat, various religious texts and scriptures. There was a specific room that could be used as a 'quiet room' for patients and relatives to use when needed.
- Radiology staff had completed home visits for patients with additional needs to describe the process to the patients and their families, so they were fully informed, prepared and aware of the procedure to be undertaken.
- A broad range of age appropriate information had been developed for CYP and their families. This included a range of activities, the use of pictorial cards to enhance understanding, information about bullying, safeguarding and supporting CYP with learning disabilities.
- Pharmacy staff had developed personalised leaflets for patients regarding their medicines following joint surgery and for oncology patients.
- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets those needs, which was accessible and promoted equality.
- Pharmacy staff had robust systems in place to safely manage and comply with medicines in the oncology service which was in line with national best practice.
- The hospital had a comprehensive audit and risk management structure which ensured the service had a transparent approach to the management of risk and the assurance of safety.
- The hospital had gained and held national accreditations such as: ISO accreditation for pathology (ISO certification is a seal of approval from an external body whereby a company complies to one of the internationally recognised ISO management systems), British United Provident Association (BUPA) accreditation for breast care, bowel care, prostate care, and the cancer survivorship programme. The specialist care centre (oncology unit) had been awarded a Macmillan Mark of Quality Environment (MQEM) for achievements in quality for cancer care environment.
- The oncology service was awarded an Exemplar award by the provider's group clinical director and had been recognised for excellent care and service for cancer patients in 2018.
- "Spire elephant teddies were given to children who were distressed, the service also gave out bravery awards upon discharge to award the child for their bravery"
- The hospital hold open health information session for patients to attend and ask questions. At a cancer prostate open day there was over 700 attendees, blood tests were undertaken to help with early diagnosis.

Areas for improvement

Action the provider **SHOULD** take to improve Children and young people:

- The service should consider undertaking face to face pre-operative assessment appointments for all children and young people

Medical care:

- The service should ensure all records are timed by consultants (Regulation 17).
- Manager should consider a review of the culture within the oncology service to ensure staff are updated on progress of vacancies and feel supported.