Spire Washington Hospital

Quality Report

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

Ratings

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

Overall summary

Spire Washington Hospital is operated by Spire Healthcare Limited. The hospital had 47 beds, however the hospital provided information stating there were currently 36 beds operational.

The hospital provides a range of inpatient and outpatient elective services. We inspected surgery, termination of pregnancy, outpatients and diagnostic imaging.

We carried out the unannounced visit to the hospital on 4 and 5 December 2019 and inspected the diagnostic imaging service on the 7 February 2020.

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.

Summary of findings

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 level.

Services we rate

Our rating of this hospital stayed the same. We rated it as **Good** overall.

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- 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. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- Staff identified and acted upon patients at risk of deterioration. The service had enough staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels.
- The service used systems and processes to safely prescribe, administer, record and store medicines. 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.
- The service provided care and treatment based on national guidance and evidence-based practice. 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- 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 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.
- 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.
- 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.
- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a 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.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

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

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- 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.
- Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services. All staff were committed to continually learning and improving services.

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

- Staff did not always keep detailed records of patients' care and treatment in the outpatient department.
- We observed some inconsistencies in executing the WHO checklist which was not implemented consistently across each operating theatre.
- Recruitment and retention of orthopaedic scrub staff for theatres required some development to alleviate shortages.
- Some items of equipment were overdue for service which did not comply with documentation.
- Staff used personal protective equipment with one exception we observed following which immediate action was taken to remedy practice.
- Some key positions were filled on an interim basis and the hospital identified recruitment to key leadership roles in clinical areas as an area for development.
- Consultation appointments were available on only one weekday in the termination of pregnancy service.

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.

Ann Ford

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	**Summary of service** 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. We rated this service as good because it was safe, effective, caring, responsive and well-led. The service used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Detailed records of patients' care and treatment were clear, up-to-date and easily available to all staff providing care. The service had systems in place to identify and manage adults and children at risk of abuse. Systems were in place for reporting, monitoring and learning from incidents. The service contributed to the NHS Safety Thermometer to support monitoring of patient harm incidents and promote harm-free care. The hospital consistently achieved positive patient outcomes including low rates of surgical site infection and positive patient reported outcome measure results. The hospital held a number of national accreditations which demonstrated the hospital met national quality markers. Staff supported patients to make informed decisions about their care and treatment and followed national guidance to gain patients' consent. The hospital promoted privacy and dignity for patients and the provider's value statement was 'Caring is our passion'. Staff were compassionate, 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. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Summary of findings

Special arrangements were made for bariatric patients requiring surgery including holding a multidisciplinary meeting prior to surgery.
The service supported patients living with dementia by making suitable arrangements for their stay in hospital.
Patients were not discharged on the day of their surgery if they lived alone and their circumstances were checked at the pre-operative stage so that overnight accommodation was pre-arranged.
The hospital had a stable leadership structure with an experienced hospital director and registered manager and a leadership team of 12 senior managers and managers. Consultant staff we spoke with told us their engagement with the hospital leadership team was positive.
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.
Staff were consistently positive about the culture they experienced in the hospital. Staff felt well supported and morale was high. A robust procedure was in place for challenging consultant behaviours and performance. Any staff issues were dealt with supportively.
The service had in place clear and well-established governance structures and leaders operated effective governance processes. An established clinical governance team was in place with robust arrangements for clinical governance. The service managed risks proactively and used systems to manage performance effectively.

Outpatients

Good

We rated this service as good because it was safe, caring, responsive and well led.
We do not rate effective for outpatients.
The service provided mandatory training in key skills to all staff and made sure everyone completed it.
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. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Summary of findings

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.
Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Diagnostic imaging

Good 

We rated this service as good because it was safe, caring, responsive and well led.
We do not rate effective for diagnostic imaging.
The service provided mandatory training in key skills to all staff and made sure everyone completed it.
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. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
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.
Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Termination of pregnancy

Good 

Spire Washington provides medical termination of pregnancy up to 16 weeks gestation and surgical termination of pregnancy up to 19 weeks gestation.
The service provides a vasectomy service.
We rated this service as good because it was safe, effective, responsive and well led.
We rated safe as good, because the service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
The service controlled infection-risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
Training was up-to-date. Staff were aware of their responsibilities is respect of safeguarding. Staff complied with best practice regarding cleanliness and infection control, and the environment was

Summary of findings

appropriate for the service. Risks were assessed and managed appropriately. Nursing and medical staff numbers were sufficient and appropriate to meet the needs of patients in their care. Medicines were stored and prescribed safely. Medical records were comprehensive and clear. There was a process for reporting incidents, staff understood when and how to use it, and there was a process for cascading lessons learned and actions to be taken to front-line staff.

We rated effective as good, because 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.

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Patient outcomes were monitored. Pain relief was prescribed pre and post-procedure, and women's pain levels were assessed following both medical and surgical terminations. Staff were competent in general nursing practice, and additional, informal training in caring for women undergoing termination of pregnancy was provided by appropriate consultant staff. Informed consent was obtained in all cases, and staff understood their responsibilities under the Mental Capacity Act 2005

We had insufficient evidence to rate 'caring' within this service.

It was evident that staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their procedure. They provided emotional support to patients, families and carers.

There were no women attending clinics or theatres for this service during our inspection. We were therefore unable to observe the way patients were treated by staff. However, staff described to us how they treated women with compassion, kindness, dignity, and respect. They told us how they explained the different

Summary of findings

methods of termination and options available to women attending the service. Should a woman need time to make a decision, staff told us how they would support her.
Post-termination counselling was offered to all women using the service.
We rated responsive as good, because the service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. Women did not have to wait too long for treatment.
The service was responsive to the needs of women. Pre and post-procedure checks and tests were carried out at the hospital, and waiting times were consistently within guidelines set by the Department of Health and Social Care. Interpreting and counselling services were available to all women using the service, and information and advice were available to women at all stages of their episode of care. Foetal remains were disposed of sensitively, and choice was available. There were appropriate systems for managing complaints should they arise.
Leaders ran services well, using reliable information systems, and supported staff to develop their skills. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.
There was strong leadership of the service. Quality care and patient experience were regarded as the responsibilities of all staff members, and staff felt proud of the service they provided. Clinical governance and risks were managed well. Staff felt supported to carry out their roles and were confident to raise concerns with managers.

Summary of findings

Contents

Good

Spire Washington Hospital

Services we looked at

Surgery; Outpatients; Diagnostic imaging; Termination of pregnancy;

Summary of this inspection

Background to Spire Washington Hospital

Spire Washington Hospital is operated by Spire Healthcare Limited. The hospital/service opened in 1988. It is a private hospital in Washington, Tyne and Wear. The hospital was located two miles from Chester-Le-Street and Washington, and 11 miles south of Newcastle upon Tyne. The hospital primarily serves the communities of Sunderland, Durham and Gateshead. It also accepts patient referrals from outside this area. It was registered as an acute hospital with 47 beds.

The Hospital Director has been the CQC registered manager since 25 July 2013. The hospital was previously inspected on the 5th, 6th and 18th August 2015 and received an overall rating of good. There was no enforcement associated with the previous inspection.

The service was inspected on the 4th and 5th of December 2019 and diagnostic imaging was inspected on the 7th February 2020.

The hospital had not taken part in any special reviews or investigations by the CQC during 2019/2020.

The inspection team inspected the following four core services:

- Surgery
- Termination of Pregnancy
- Outpatients
- Diagnostic Imaging

Our inspection team

The team that inspected the service comprised CQC inspectors and specialist advisors with expertise in surgery, termination of pregnancy, outpatients and diagnostic imaging. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Spire Washington Hospital

The hospital has two wards and is registered to provide the following regulated activities:

- Diagnostic and Screening Procedures
- Surgical Procedures
- Treatment of disease, disorder or injury
- Services in slimming clinics
- Termination of pregnancies
- Family planning

During the inspection, we visited surgery, outpatients, the termination of pregnancy service and the diagnostic imaging department. We spoke with 40 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 19 patients and one relative. During our inspection, we reviewed 40 sets of patient records.

The two wards were the Lambton ward and Sunniside ward.

The hospital provides a range of inpatient and outpatient elective services including orthopaedics, general surgery, oncology, cardiology, endoscopy, gynaecology, urology, termination of pregnancy services, outpatient services for children and young people, outpatients and diagnostic imaging. We inspected surgery, termination of pregnancy, outpatients and diagnostic imaging.

There are three operating theatres with laminar flow, and an endoscopy suite providing day case care. There was an extended recovery where level 1 was provided and the

Summary of this inspection

hospital had on site pathology and pharmacy services. There was a diagnostic imaging department equipped with static MRI and CT and the service offered ultrasound and mammography services.

In the previous 12 months to the inspection there were 44,171 outpatient appointments of which 0.5% of the total appointments were for patients under the age of 18.

Diagnostic imaging facilities included a CT scanner, mammography, an MRI scanner, a ultrasound scanner, fluoroscopy services and x-ray. Diagnostic imaging provided services to adults and children and had a waiting room for patients and visitors to wait.

The diagnostic imaging department completed 3794 scans between February 2019 and January 2020. Of these, the department saw 32 children between the age of 16 and 18. The percentage of patients scanned between the age of 16 and 18 was 0.8%.

Procedures included approximately 257 CT examinations, 2585 MRI examinations, 347 plain film x-rays, 532 ultrasound scans and 73 fluoroscopy's.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital/service has been inspected once, and the most recent inspection took place in August 2015, which found that the hospital/service 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 7,904 inpatient and day case episodes of care recorded at The Hospital; of these 64% were NHS-funded and 36% privately funded.
- 23% of all NHS-funded patients and 30% of all privately funded patients stayed overnight at the hospital during the same reporting period.
- There were 37,499 outpatient total attendances in the reporting period; of these 19,239 were privately funded and 18,260 were NHS-funded.

169 doctors worked at the hospital under practising privileges. Two regular resident medical officer (RMO) worked on a seven-day rota. Spire Washington employed 30.6 whole time equivalent registered nurses, 23.7 whole time equivalent care assistants 113 other whole time equivalent hospital staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No Never events between July 2018 and June 2019.
- Clinical incidents 390 no harm, 65 low harm, 45 moderate harm, two severe harm, Zero deaths between July 2018 and June 2019.
- Seven serious injuries between July 2018 and June 2019.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) between July 2018 and June 2019.
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA) between July 2018 and June 2019.
- No incidences of hospital acquired Clostridium difficile (c.diff) between July 2018 and June 2019.
- No incidences of hospital acquired E-Coli between July 2018 and June 2019.

There had been 63 complaints between August 2018 and July 2019.

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department
- Joint Advisory Group on GI endoscopy (JAGS) accreditation
- UKAS – Pathology
- BUPA accredited bowel and breast services

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry

Summary of this inspection

- 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?

Good

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

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service controlled infection-risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff complied with best practice regarding cleanliness and infection control, and the environment was appropriate for the service. Risks were assessed and managed appropriately.
- The service used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.
- Detailed records of patients' care and treatment were clear, up-to-date and easily available to all staff providing care. The service had systems in place to identify and manage adults and children at risk of abuse.
- Systems were in place for reporting, monitoring and learning from incidents. The service contributed to the NHS Safety Thermometer to support monitoring of patient harm incidents and promote harm-free care.
- The service had sufficient medical and nursing staff to keep patients safe.
- The design of the operating theatres and the maintenance of equipment was fit for purpose and in line with national guidance. The theatre department was very clean and organised. Equipment available within theatres was appropriate.
- Medicines were stored and managed safely and prescribing documents were prepared in line with the provider's policy.
- The service managed safety incidents well and learned lessons from them.

However, we found the following areas that the service provider needed to improve:

- We observed some inconsistencies in executing the WHO checklist which was not implemented consistently across each operating theatre.
- Recruitment and retention of orthopaedic scrub staff for theatres required some development to alleviate shortages.
- Some items of equipment were overdue for service which did not comply with documentation.

Summary of this inspection

- Staff used personal protective equipment with one exception we observed following which immediate action was taken to remedy practice.
- Staff did not always keep detailed records of patients' care and treatment in the outpatient department.

Are services effective?

Good

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

- The hospital consistently achieved positive patient outcomes including low rates of surgical site infection and positive patient reported outcome measure results. The hospital held a number of national accreditations which demonstrated the hospital met national quality markers.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Pain relief was prescribed pre and post-procedure, and women's pain levels were assessed following both medical and surgical terminations. Staff were competent in general nursing practice, and additional, informal training in caring for women undergoing termination of pregnancy was provided by appropriate consultant staff. Informed consent was obtained in all cases, and staff understood their responsibilities under the Mental Capacity Act 2005.
- Staff supported patients to make informed decisions about their care and treatment and followed national guidance to gain patients' consent.
- Staff followed up-to-date policies to plan and deliver high quality care and treatment according to best practice and national guidance. Care pathways were used for all patients undergoing surgical procedures.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. The patient's pain score was assessed following guidelines.
- Adequate nutrition and hydration standards were maintained in the theatres and ward areas. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- The hospital held effective multidisciplinary meetings to support effective care for patients and staff worked across health care disciplines and with other agencies when required.
- The service helped to promote healthy lifestyles for patients. Staff assessed each patient's health when admitted and provided support for individual needs to promote healthy living.

Summary of this inspection

- Key services were available seven days a week to support timely patient care.
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers supported staff, including consultant staff, with their development through six monthly or annual appraisals of their work performance.
- A clinical audit programme was in place which supported the hospital's management of its policies.

Are services caring?

Good

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

- The hospital promoted privacy and dignity for patients and the provider's value statement was 'Caring is our passion'.
- Staff were compassionate, 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.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
- Staff talked with patients, families and carers in a way they could understand, using communication aids where needed. Staff gave informative explanations to the patient and continued to keep them informed.
- Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Each patient we spoke with (with one exception) was very positive about their experience of the hospital and their care and treatment.
- There were no women attending clinics or theatres for this service during our inspection. We were therefore unable to observe the way patients were treated by staff. However, staff described to us how they treated women with compassion, kindness, dignity, and respect. They told us how they explained the different methods of termination and options available to women attending the service. Should a woman need time to make a decision, staff told us how they would support her.
- Post-termination counselling was offered to all women using the service.

However, we found the following area that the service provider needed to improve:

- One patient had been disturbed by the noise of staff in the theatre area.

Summary of this inspection

Are services responsive?

Good

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

- 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 including primary healthcare and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Special arrangements were made for bariatric patients requiring surgery including holding a multidisciplinary meeting prior to surgery.
- The service supported patients living with dementia by making suitable arrangements for their stay in hospital.
- Patients were not discharged on the day of their surgery if they lived alone and their circumstances were checked at the pre-operative stage so that overnight accommodation was pre-arranged.
- 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.
- One-stop clinics were used to reduce the need for patients to attend on several occasions.
- The service worked to ensure patients accessed services they needed promptly. Managers and staff worked to ensure patients did not stay in hospital longer than necessary and to keep the number of cancelled operations to a minimum.
- Discharge planning started as early as possible. Discharge planning was discussed at the patient's pre-assessment meeting. Patients requiring assistance from other services at discharge were identified at pre-assessment.
- The service was responsive to the needs of women. Pre and post-procedure checks and tests were carried out at the hospital, and waiting times were consistently within guidelines set by the Department of Health and Social Care. Interpreting and counselling services were available to all women using the service, and information and advice were available to women at all stages of their episode of care. Foetal remains were disposed of sensitively, and choice was available.
- 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.

However:

Summary of this inspection

- Consultation appointments were available on only one weekday.

Are services well-led?

Good

Our rating of well-led stayed the same. We rated it as **Good** because:

- The hospital had a stable leadership structure with an experienced hospital director and registered manager and a leadership team of 12 senior managers and managers. Consultant staff we spoke with told us their engagement with the hospital leadership team was positive.
- Leaders ran services well, using reliable information systems, and supported staff to develop their skills. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.
- There was strong leadership of the services. Quality care and patient experience were regarded as the responsibilities of all staff members, and staff felt proud of the service they provided. Clinical governance and risks were managed well. Staff felt supported to carry out their roles and were confident to raise concerns with managers.
- 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.
- Staff were consistently positive about the culture they experienced in the hospital. Staff felt well supported and morale was high. A robust procedure was in place for challenging consultant behaviours and performance. Any staff issues were dealt with supportively.
- The service had in place clear and well-established governance structures and leaders operated effective governance processes. An established clinical governance team was in place with robust arrangements for clinical governance. The service managed risks proactively and used systems to manage performance effectively.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- The hospital could demonstrate high levels of patient and staff satisfaction. Leaders and staff actively and openly engaged with

Summary of this inspection

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

- The hospital was committed to continually learning and improving services. It's staff had an understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However, we found the following area that the service provider needed to improve:

- Some key positions were filled on an interim basis and the hospital identified recruitment to key leadership roles in clinical areas as an area for development.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Termination of pregnancy	Good	Good	Not rated	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

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.

Staff received and kept up to date with their mandatory training. The hospital used a system to ensure staff received annual mandatory training, comprised of e-learning and face-to- face training. The hospital mandatory training system provided reminders to staff to complete the required mandatory training. The training system allowed staff to see what training they were required to complete and allowed managers to view overall compliance, for their area.

Each member of staff we spoke with told us they had completed their mandatory training including resuscitation training, or an arrangement was in place for them to attend training. Our review of mandatory training information confirmed this. 100% of contracted staff had received mandatory training against the hospital standard of 95% compliance. Bank staff were awarded similar mandatory training to permanent staff but some bank staff were due to complete their mandatory training which meant 90% of theatre staff overall had completed their mandatory training at inspection. The deadline for outstanding staff was March 2020.

The clinical governance lead provided oversight of mandatory training compliance for all staff. The hospital monitored mandatory training compliance daily and mandatory training compliance figures were reported to the clinical governance meeting monthly. Results of audit about staff training compliance were displayed in the seminar room.

Resident medical officers (RMOs) were employed through a national agency and completed mandatory training with the agency. The hospital received confirmation of the training and kept a record of attendance.

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 service had systems in place for the identification and management of adults and children at risk of abuse. The hospital safeguarding policies for adults and children were accessible to staff and detailed the different types of abuse and issues which staff should report. A safeguarding lead was in place for the hospital.

Staff we spoke with were aware of what concerns could potentially be a safeguarding concern and knew how to raise them. Staff we spoke with told us the safeguarding lead was accessible and supportive when staff needed advice about safeguarding concerns.

The safeguarding lead and some senior managers had completed safeguarding level four training including the hospital director and director of clinical services. 100% of contracted staff had received mandatory safeguarding training against the hospital standard of 95% compliance. Bank staff were awarded similar mandatory training to permanent staff but some bank staff were due to complete their mandatory training which meant 79% of theatre staff

overall had completed their mandatory training at inspection. The deadline for remaining training to be completed was March 2020. Staff we spoke with confirmed they had completed adult and children's safeguarding training.

Female genital mutilation (FGM) was included in the hospital's safeguarding training. Staff were aware of FGM and understood their responsibilities to report any instances.

We spoke with the safeguarding lead who described the steps the hospital took when a safeguarding concern arose. A safeguarding concern had occurred during our inspection and appropriate actions had been put in place. The registered manager also described the steps taken following a recent safeguarding concern which led to the member of staff involved in raising the alert receiving an internal award. We found evidence of learning from the investigation had been shared with external organisations with an interest in the results of the investigation.

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.

The hospital infection, prevention and control policy was supported by an annual plan for infection control which guided staff about cleaning, decontamination and personal protective clothing and linked to related policies and procedures.

An infection prevention and control lead for the hospital was in place and an infection prevention and control committee was responsible for ensuring that the service was delivered in accordance with infection prevention and control requirements.

We observed all areas of the hospital were clean and had suitable furnishings which were well-maintained. The theatre department was very clean and organised.

We observed processes for segregation of waste including clinical waste. We observed within the operating theatre waste disposal procedures were followed. Sharps disposal boxes were provided within the theatres. Also, within the operating theatres cleanliness was maintained and laminar flow theatres were functioning appropriately.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We inspected reusable equipment stored in the department and all items were visibly clean and ready for use. Staff used a specific label to identify the equipment was clean and ready for use.

Each member of staff completed infection prevention and control training as part of their mandatory training programme. Training data provided by the hospital showed 100% compliance.

Staff we spoke with including healthcare assistants and operation practitioners confirmed they followed infection control policy and guidance strictly which confirmed our observation in theatres and wards.

Water flushing records were maintained which showed compliance with water safety plans, supported by a separate safety meeting for water matters.

Alcohol gel was provided at several areas in the corridor and while entering into operating theatre and also in the recovery area. We observed staff cleaning their hands between patient contact and staff were compliant with 'bare below the elbows' policy. Staff used personal protective equipment with one exception we observed following which immediate action was taken to remedy practice.

The hospital audited hand hygiene compliance using observational hand hygiene audits, results we reviewed showed a very high level of compliance. The results of the quarterly audits were displayed in the department and shared in monthly clinical governance and monthly theatre meetings.

Staff used records to identify how well the service prevented infections. The hospital screened surgical patients for methicillin-resistant staphylococcus aureus (MRSA) and some patients for methicillin-sensitive staphylococcus aureus (MSSA) following practice guidance. Infection prevention and control was included in the health and safety meeting agenda and shared with regional health and safety leads.

Environment and equipment

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

The design of the operating theatres and the maintenance of equipment we found was fit for purpose and in line with national guidance. The main hospital ward consisted of single use rooms with suction equipment, piped oxygen and emergency call facilities. Within the theatre area four bays were fitted with alarms, suction and monitors; a fifth bay was used for spare equipment. The service had suitable facilities to meet the needs of patients' families.

The hospital had access to endoscopy and radiology services on site although no major endoscopic therapeutic interventions were undertaken at this site. A small blood storage facility in the corridor of main theatres we found was locked and secured.

Equipment available within theatres was appropriate. Separate bins were used for domestic, contaminated and sharp disposal. A separate corridor was used for carrying waste. Anaesthetic machines and cardiac arrest trolleys were regularly checked with the time of next inspection shown.

Resuscitation equipment was regularly checked and tested consistently and in line with hospital policy. We observed clear signage for the location of emergency equipment. Equipment we reviewed was clean, tidy, ready for use and staff had checked the equipment was in order. Trolleys we inspected were locked, appropriately stocked and equipment was in date.

We reviewed the equipment storage areas including the sterile equipment storage facility (instrument trays). Separate designated areas were used for storing instrument trays. Staff carried out daily safety checks of specialist equipment. Electrical equipment portable appliance testing had been undertaken and labels were in date.

Sufficient suitable equipment was available to support the safe care of patients. Staff we spoke with told us adequate stocks of equipment were available and we saw evidence of stock rotation and equipment replacement. A hospital system alerted essential maintenance when it was due and on-site engineers maintained equipment which provided assurance equipment was fit for use. However, we found an item of equipment was overdue for service which did not comply with documentation. The hospital took immediate action to remedy this.

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.

The hospital used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed risk assessments for each patient on arrival and updated them when necessary and used recognised tools. Staff were aware what action to take to deal with any specific risk issues and took appropriate action.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

A system of WHO checklist was in place and completed for every procedure. However, we observed some inconsistencies in executing the checklist. The WHO checklist was not implemented consistently across each operating theatre. Staff identified to us the application of the WHO process in the hospital was being reviewed to achieve consistency and ensure the safety of patients. This confirmed our observation of the use of the surgical checklist.

Patient safety briefings were carried out pre-operatively. Briefings included introductions from the clinical team, the order of the list, additional equipment anticipated and the addition of emergency patients. We observed the brief completed with the whole surgical team present. Two briefings were held daily to support the morning and afternoon theatre lists. We observed a stop before you cement safety process was followed and we observed the daily cardiac arrest huddle documentation identification by the crash team. We also spoke with staff about the relevance of NHS England's Local Safety Standards for Invasive Procedures to promote safe practice. A surgical safety guardian was in role and we found evidence surgical safety was assured with processes compliant with the National Safety Standards for Invasive Procedures (NatSSIPs).

We observed the hospital used the national early warning score tool (NEWS2). Staff received training in completing the early warning score and the scores were audited each month and submitted to the clinical governance lead for review.

An escalation policy was in place in the event of a deteriorating patient or a seriously ill patient. Nursing staff we spoke with could describe the deteriorating patient protocol and were able to state when they would escalate to medical staff. In case of the particular surgeon not being available, contact details were held for other surgeons within the same speciality who provide cross cover. An escalation policy operated for patients with confirmed or presumed evidence of sepsis.

No clinical care outreach team or HDU facility was available within the hospital however the surgeon responsible for the patient was contactable when necessary (including out of hours).

To support a patient's discharge, the hospital provided leaflets with contact details of the hospital and measures to be taken at home and if the patient required emergency assistance following their surgical procedure. The hospital operated an on-call service for unplanned returns to theatre. A team was available and would attend within 30 minutes. The hospital had an agreement with an NHS ambulance provider to transfer patients in the event of an emergency or if a deteriorating patient required an increased level of care. We found unplanned returns to theatre were relatively infrequent, with nine in the previous 12 months.

Staff we spoke with told us they had received sepsis training. Staff could describe the signs of sepsis and were aware of actions required for escalation and treatment. We reviewed risk assessments including pressure damage acquisition, malnutrition, falls, bed rails, moving and handling and we found these were completed appropriately.

Reception staff carried out a daily crash call test between 8am and 9am for staff to respond to reception. Reception staff recorded who had not responded. We reviewed the log kept at reception which provided assurance a safe and robust mechanism to ensure the crash bleep was covered and other issues were addressed.

Nursing and support staffing

The service had enough nursing 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 staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had in place sufficient nursing staff of all grades to keep patients safe. Managers we spoke with told us they had no staffing concerns. Managers calculated and reviewed the numbers and grades of nurses and healthcare assistants needed for each shift, following national guidance.

The duty rota was planned in advance with patient dependency calculated according to the organisation's safe staffing policy which took account of actual patient numbers and the dependency of patients. The staffing tool calculated a safe number of staff and was used on a shift by shift basis to provide assurance staffing levels were safe. The acuity score for each patient was reviewed three times in the day to determine actual patient needs.

We observed the hospital including the theatre department was adequately staffed. The ratio of nursing staff in the theatre department and in the ward areas was appropriate. The hospital operated within Association for Perioperative Practice guidelines.

We found evidence of effective recruitment and retention of staff. The hospital had very low vacancy rates at our inspection and expected to be fully established by January 2020. Staff turnover rates and sickness rates were generally very low. Bank and agency staff were used infrequently but received a full induction when they were. There had been no use of agency staff in the three months prior to our inspection.

Staff worked flexible shifts depending on the service need and their own circumstances. Ahead of the inspection the full-time equivalent staff numbers for the theatre departments were: registered nursing staff: 12 FTE; operating department practitioners and health care assistants: 13.6 FTE.

Staff allocations to theatre lists were pre planned and allocations were the responsibility of the theatre manager. We reviewed the rota and allocation of theatre staff to each theatre.

We observed the daily hospital safety meeting in which staffing was reviewed in detail to provide assurance that the department was operating safely. All departments were fully staffed. The meeting was minuted and sent to heads of department to share with staff.

We observed staff handover between patients followed robust procedures which assured patient safety. An adequate hand over between teams took place at shift change, when patient care was transferred from theatres to recovery and recovery to wards. We followed two cases from ward to operating theatres and from operating theatre to ward. The hand over between the teams at every stage was adequate and detailed.

The hospital identified ahead of the inspection that recruitment and retention of orthopaedic scrub staff for theatres required development. Staff we spoke with explained there had been some sickness and vacancies with scrub nurses which required bank and agency staff to be used as a contingency. At the time of our inspection these posts had been filled and staff were being inducted to the team.

Medical staffing

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

The service had enough medical staff to keep patients safe. The hospital accessed locum doctors when the service needed additional medical staff but we found this was infrequent. Managers made sure locums had a full induction to the service before they started work.

Each patient was admitted under the care of a named consultant. Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care.

The hospital required the consultant to review patients every day, including at weekends and to be accessible out of hours. Consultants nominated a colleague to provide cover when they were not available. We observed the list of consultant cover arrangements.

Medical staff with practising privileges were required to provide cross cover arrangements in the event they are unable to be contacted. The cross-cover information was stored in the doctor's profile and reviewed biennially. When a surgeon was on annual leave and had recently undertaken a theatre list, they were required to inform the hospital of the cover arrangements in the event a patient needed to be readmitted. Consultants were required to remain on call so long as they had a patient in the hospital. A hospital contact list was maintained for doctors with practising privileges for staff use. Nursing staff contacted the member of medical staff directly if they were required out of hours. It was the consultant surgeon's responsibility to arrange alternative anaesthetic cover if their regular anaesthetist was not available.

Two resident medical officers in the hospital provide a 24-hour on call on a weekly basis. A resident medical officer was on duty 24 hours a day, seven days a week to respond to any concerns arising as to a patient's clinical condition. The resident medical officer attended a scheduled daily meeting to discuss any patients with concerns.

Records

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

Paper records were available for each patient that attended the hospital. We observed patient records held the patient's individual plan of care. Patient notes were comprehensive and all staff could access them easily. When patients transferred to another department there were no delays in staff accessing their records.

Records were stored securely. Medical records were stored in locked cupboards in the ward areas with keys secured in digital key enabled boxes. A white dashboard in the ward area identified patients' details and location with room numbers and the members of staff who were assigned to the care of the patient.

We reviewed patient documentation in the theatre department for a selection of records. We reviewed three medical records in the theatre and ward areas. Patient identifiers were present on each page of the case notes. Nursing records showed the same attention to detail. Checklists were completed in each set of case notes, particularly in the assessment of falls, alcohol consumption history, moving and handling, pressure damage, MUST score and VTE prophylaxis. All entries were dated, timed

and signed. All details were legible although blue ink had been used on some occasions. Clinic letters were clearly documented with a care plan and actions. Patients were reviewed appropriately.

Verification forms for surgical site marking were completed accurately. The surgical first assistant log book in the theatre department was kept up to date and documented clearly. Theatre documentation was completed at the correct times and found to be accurate. Traceability was recorded appropriately and National Joint Registry forms were completed as required. The theatre register was completed. All procedures were recorded in the register of the respective theatre. After each procedure accountable instruments were cross-checked by other team members including the swabs.

The hospital audited ten sets of randomly selected patient notes each month and the audit showed a 96% level of compliance against the hospital's standard.

Medicines

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

The hospital informed us ahead of the inspection the pharmacy department was under review to extend the facility.

The hospital stored and managed medicines and prescribing documents in line with the provider's policy. Medicine stocks were managed safely in theatre and ward areas. We checked a selection of medicines including controlled drugs and medical gas cylinders and found these were consistently in date. We observed safe practice in the preparation of medicines for surgery.

Medicines including controlled drugs and fridge items were stored securely and monitored in line with the hospital medicine policy. Records we checked were correct and audits were undertaken regularly.

We observed medicines were handled safely in the anaesthetic, theatre and ward areas. Staff followed current national practice to check patients had the correct medicines. Medicines were prescribed in appropriate doses and administered according to guidelines. Patient allergies were documented appropriately and highlighted with distinctive red labels. Nursing staff in the ward areas followed appropriate guidelines and standards of administration for controlled drugs. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Decision making processes were in place to ensure patient's behaviour was not controlled by excessive and inappropriate use of medicines.

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.

The hospital had systems in place for reporting, monitoring and learning from incidents. The hospital had an incident management policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents.

Hospital staff knew the type of incidents they needed to report and were familiar with how to do this. Staff reported all incidents that they should report including reporting serious incidents clearly and in line with hospital policy. Incidents reports were sent to line managers and reported incidents were reviewed in the daily safety meeting where immediate learning was shared.

Staff understood the duty of candour and were open and transparent. Patients and families were given a full explanation if and when things went wrong.

The hospital had no never events in the reporting period. The hospital reported two severe clinical incidents in the reporting period. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with told us if a serious incident occurred they would be

involved in the root cause analysis process. Staff met to discuss the feedback and look at improvements to patient care, lessons learned and recommendations to prevent reoccurrence of the incident.

We reviewed two completed incident investigation reports. The reports included: action already taken – high priority actions, medical governance arrangements, patient support and involvement, staff support and involvement, lessons learnt, recommendations and shared learning. Monthly safety bulletins shared with staff included key learning. The hospital also held an incident review working group, linking with the investigation of incidents.

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 hospital contributed information to the NHS Safety Thermometer to support monitoring of patient harm incidents and harm-free care. The submission of safety thermometer information was monitored by the hospital's director of clinical services.

The incidents of patient falls in the hospital had reduced and incidents that had occurred were categorised as of no harm. Falls management and VTE working groups met regularly. The hospital contributed to the provider level falls scrutiny panel. A revised falls policy for the provider was due to be published in February 2020.

The hospital's director of clinical services had led the review of the provider's national falls policy based on NICE and NHS improvement guidelines. This included an impact assessment for reducing the financial burden from falls and reduced falls decreasing the length of stay and morbidity. The director of clinical services was also assisting in national scrutiny panels for falls within the provider, recommending best practice principles which had shown a reduction of falls at other hospitals where a higher rate of falls had been identified.

Are surgery services effective?

Good

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 and treatment according to best practice and national guidance including the National Institute of Health and Care Excellence, the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Surgeons. We reviewed a selection of policies accessed through the hospital intranet and saw evidence clinical policies were updated in 2019. A folder of updated policies was available in the staff area and we saw evidence staff read and signed to confirm they had read the updated policies.

Care pathways were used for all patients undergoing surgical procedures. The hospital used evidence-based care pathways as commissioned and developed by the provider. Care pathways were based on clinical guidelines from recognised bodies and covered a range of procedures. Care pathways were accessed through the provider intranet. Pathways were updated in line with changes to national guidelines.

A clinical audit programme was in place which supported the hospital's management of its policies. The hospital completed national and local audits. Outcomes of audit were discussed at governance meetings. The hospital participated in the national PLACE audit.

The hospital informed us ahead of the inspection it used a range of guidance and supporting tools to monitor and benchmark performance against standards and other hospitals and providers. This included the national clinical scorecard and national audit programmes for effective management of cancer patients. The hospital could demonstrate effective patient outcomes for a number of measures including surgical site infections, venous thromboembolism, pressure ulcers and returns to theatre.

The hospital undertook daily audits linked with clinical scorecards which also informed its departmental audit

action plan. We reviewed the completion of checklists which supported each aspect of care including assessment of the patient's preoperative mental health, alcohol history, and social needs.

We observed surgical procedures were performed as per the respective specialities' professional body guidelines. Surgical venous thromboembolism pathways and venous thromboembolism assessments were competed in each set of patient case notes we reviewed and were well documented. Audits were undertaken for morbidity and mortality, surgical site infection, and venous thromboembolism. We observed audit results were displayed as posters in the hospital seminar room.

Patient reported outcome measures data was collated. The hospital held a number of national accreditations which demonstrated the hospital met national quality markers.

Nutrition and hydration

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

Pre-admission information for patients provided them with clear instructions on fasting times for food and fluid prior to surgery. We observed the guidelines of starvation for patients prior to an operation were followed.

We observed adequate nutrition and hydration standards were maintained in the theatres and ward areas. As part of routine practice, patients were given medications appropriate to their condition and treatment both during and after a surgical procedure.

Patients were asked for feedback on the quality of food, with latest results (June 2019) showing 84% positive feedback from patients; 12% above the provider's average.

The service tailored its menus for patients to meet their needs for example for dietary requirements, to accommodate any allergies or to ensure patients had something they liked when they were not feeling well with bespoke meals cooked to order to reflect the patient's preferences.

We spoke with four patients about how the hospital was meeting their nutrition and hydration needs and they confirmed they had enjoyed the food provided and their nutrition, hydration and fasting needs had been adequately met by the hospital. Staff had communicated clearly about the fasting requirements related to their surgery. The service made adjustments for patients' religious, cultural and other needs.

Prior to the inspection the hospital identified compliance with patient fasting times and ensuring patient hydration as an area for further improvement in its practice. Hydration champions were nominated for wards and theatres to help ensure patients were hydrated. The hospital informed us it was working to achieve King's Fund VTE exemplar status and had reviewed its documentation to help ensure patients were encouraged to remain hydrated. The hydration needs of two or three patients in each of the morning and evening sessions was reviewed in more detail to support this. A hydration committee had been established to monitor and support practice.

Hydration scores were audited quarterly and hydration was included on the hospital's risk register. We observed catering, patient allergies and other patient requirements were included in the agenda for the daily 'dash' meeting.

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.

The patient's pain score was assessed following guidelines. A pain assessment was performed at pre-assessment. During the patient's admission pain scores were regularly checked following their surgery and appropriate pain relief provided. Pain was assessed and recorded with observations on the patient's early warning score (NEWS2) chart.

Prior to the inspection the hospital identified managing patient's pain with more consistency as an area for further improvement in its practice. Pain management for clinical staff was included in annual mandatory training and the hospital pharmacist was involved in staff education. A medicines management committee was in place chaired by a representative of the pharmacy department to help ensure consistency of practice.

The patient satisfaction survey asked the patient how well their pain was managed throughout their stay in hospital. The latest 2019 data showed 88% of patients responded 'a great deal' to pain being managed (where the patient had pain to manage).

We spoke with six patients about how the hospital was managing their needs for pain relief and they spoke positively as to how the hospital had undertaken this aspect of their care and treatment. One of these patients had not required pain relief although they confirmed it was offered. Our review of the patient's records confirmed all patients were given effective pain relief.

Pain audits were undertaken quarterly, including pain scores and the most recent 2019 results showed 97% compliance.

Patient outcomes

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

A range of national scorecards and dashboards were used to monitor patient outcomes including specific service dashboards. The hospital consistently achieved positive patient outcomes including low rates of surgical site infection and positive patient reported outcome measure results.

The hospital participated in national audits including patient reported outcome measures for hip and knee replacement; the national joint registry data quality; national blood transfusion audits; surveillance for surgical site infections; national spinal registry; national confidential enquiry into patient outcome and death audits; patient led assessment of the care environment audits; friends and family patient satisfaction surveys and the provider's national audit programme, dashboards and clinical scorecards.

Patient outcomes were measured and reported using the provider's clinical scorecard and were compared with other hospitals to identify outliers and trends. Data had been collected over an extended period so longer-term results could be compared. Patient outcomes were analysed for returns to theatre, readmissions, transfers, surgical site infections, venous thromboembolism, falls and pressure ulcers. The hospital prepared an action plan to address any concerns and could demonstrate improvement over time with several scorecard measures. The provider's national clinical scorecard was used to compare the hospital with the provider's other hospitals for key performance indicators.

The hospital contributed data to the Private Healthcare Information Network to collate outcome data across the independent sector that was comparable with the NHS. Data was submitted in accordance with legal requirements regulated by the Competition Markets Authority. The theatre team undertook a 'project of the week' to inform a scorecard for the hospital. The hospital's performance was reviewed at the clinical audit and effectiveness committee, the clinical governance committee and the medical advisory committee. Red and amber results were added to the hospital's local risk register and an action plan for improvement was prepared and monitored. For example, temperature control achieved 83% compared with a 95% standard.

The hospital reported 20 cases of unplanned readmissions within 28 days of discharge and nine unplanned returns to operating theatre in the reporting period which was similar to expected compared with other independent hospitals.

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. New staff received a full induction tailored to their role before they started work and were paired with another member of staff as a buddy after they commenced in their role.

Managers supported staff, including consultant staff, with their development through six monthly or annual appraisals of their work performance. We saw evidence 100% of staff had received their appraisal in the January to December 2019 period. Staff described the appraisal process as a valuable experience and felt their learning needs were addressed.

The hospital used the provider's nationally adopted programme of clinical competencies to support staff training. Managers identified training needs of staff and supported them with the opportunity to develop their skills

and knowledge. Managers ensured staff received specialist training for their role. Staff we spoke with told us they were supported to attend courses to further their development. Preceptorships were available to support staff learning and development.

Managers identified poor staff performance and supported staff to improve. There were systems in place to review and withdraw the practising privileges of consultants. Any concerns about a consultant's practice were discussed with the hospital director and the chair of the medical advisory committee. Practising privileges were withdrawn in line with the hospital's policy in circumstances where standards of practice or professional behaviour were in breach of contract.

A resident medical officer was employed through a national agency. The agency was responsible for their ongoing training and provided continuing professional education sessions throughout the year. The chair of the medical advisory committee was available to support medical staff with appropriate clinical supervision.

Multidisciplinary working

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

The hospital held effective multidisciplinary meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients.

The hospital held several daily multidisciplinary team 'huddles' to support effective communication. We observed the multidisciplinary briefing held in the hospital daily. The briefing was attended by all departments and the resident medical officer to ensure teams were updated with key information. Any non-compliance was escalated from the previous day and a set template was used and shared with staff by email. Staff raised any safety concerns at this meeting and daily safety checks were updated to reflect information shared. Patients did not proceed to theatre who were not multidisciplinary team compliant unless there was a strong clinical reason, then a 'mini-MDT' was held.

Other multidisciplinary meetings held daily included clinical departmental meetings and clinical resuscitation 'huddles' with consultants, specialist nursing staff and radiologists to support patients with specific pathways or with complex needs. We observed effective multidisciplinary communication in the theatre area when cement was in use which supported safe practice. Key information was fed into the main daily multidisciplinary meeting. When the patient was discharged, the discharge letter and enclosures was shared with the patient's GP.

The hospital had established effective working relations with local NHS hospitals to provide services through inter-provider transfer, and with the ambulance service for emergency transfers. A multidisciplinary team meeting was held prior to the treatment of patients receiving treatment for cancer.

A biennial multidisciplinary team meeting for consultant staff was held which was chaired by the lead for clinical governance.

Pathways for all patients having cancer treatment were discussed and agreed by a multidisciplinary team. Compliance with this requirement was supported by a monthly audit.

Seven-day services

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

The hospital theatres operated Monday to Friday from 8am to 9pm and 8am to 1pm Saturday. Hospital wards were open seven days and consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. A resident medical officer based in the hospital was available 24 hours a day with immediate telephone access to on-call consultants.

The hospital radiology and physiotherapy services operated Monday to Friday from 8am until 9pm and from 8am and 8am until 6pm on Saturdays. Outside of these hours on-call arrangements were in place.

The hospital pharmacy was open Monday to Friday from 8:30am until 4:30pm and Saturdays from 8:30am to 12 midday. Pharmacy staff were available in the hospital and for out of hours, on-call arrangements were in place.

Health promotion

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

Good

Surgery

The hospital had available information for patients which promoted healthy lifestyles and support. Staff assessed each patient's health when admitted and provided support for individual needs to promote healthy living.

Commissioning for Quality and Innovation (CQUIN) is a framework within the NHS that supports improvements in the quality of services and the creation of new, improved patterns of care. A health promotion CQUIN was in place to monitor smoking and alcohol consumption with training provided to staff receiving patients as they arrived at the hospital to provide relevant advice. Advice was given to patients at the pre-op stage of their pathway of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The hospital had in place policies for consent, the Mental Capacity Act and Deprivation of Liberty safeguards. The hospital gained consent from patients for their care and treatment in line with legislation and guidance. Patients consented to treatment at their outpatient consultation and this was recorded.

Staff recorded consent in the patients' records. Our review of patient records for 10 patients who were undergoing surgery confirmed each patient was seen by an anaesthetist preoperatively as part of pre-op assessment. A separate consent form was completed with the anaesthetist which was separate to the surgical consent form. Our review of records confirmed consent forms for surgery and anaesthetic were accurate and legible although in one instance the consent form although signed was undated.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff ensured patients consented to treatment based on all the information available.

The Mental Capacity Act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests.

Staff completed training in consent, the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their mandatory training. The hospital monitored the use of Deprivation of Liberty Safeguards and ensured staff knew how to complete them. Staff could describe and knew how to access policy and to obtain appropriate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are surgery services caring?

Good

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

Compassionate care

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

The hospital promoted privacy and dignity for patients and the provider's value statement was 'Caring is our passion'. The hospital had in place a privacy and dignity policy. Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We observed staff interactions with patients in the theatre and ward areas. Staff were compassionate, 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 caring for patients and found that they were compassionate and reassuring.

In the theatre area we observed as the team brief took place ahead of surgery. All checks supporting compassionate care were discussed and in place, including

the patient's dignity. Excellent patient care was demonstrated throughout the anaesthetic process. We observed excellent patient care was provided during and following surgery.

We spoke with 10 patients and several relatives and carers on the surgical wards. Each patient we spoke with was very positive about their experience of the hospital and their care and treatment. Patients told us staff treated them well and with kindness. Patients felt the entire pathway of admission to discharge process was very well informed and they had been looked after well by the theatre team and ward staff. Staff were very compassionate and in providing care they were considerate and interacted well. Patients also felt their privacy and dignity was well respected in the theatres and in the wards.

The hospital's patient satisfaction survey results were consistently positive. Patients were asked for feedback and the most recent 2019 patient satisfaction scores indicated 93% of patients were satisfied with the privacy given, 73% stated their worries and fears were dealt with appropriately, 92% informed the hospital their respect and dignity was maintained and 76% stated they were provided excellent care from nurses.

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.

Most patients we spoke with told us they had not needed emotional support but they were confident in would be available if they required. One patient spoke positively about how staff had supported them in controlling their anxiety and how well they were looked after. For another patient, family members expressed the view they were emotionally supported when it was needed. However, one patient had been disturbed by the noise of staff in the theatre area.

The hospital had a designated quiet room in the reception area and patients were provided access to facilities for people of different faiths if they wished. A space for prayer was also accommodated if this was required.

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.

The hospital ensured 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 needed.

We observed during staff interaction with patients in theatre that staff gave informative explanations to the patient and continued to keep them informed. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.

Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions. Patients said medical nursing and other staff took time to explain their care and the risks and benefits of treatment.

Patients we spoke with said that they were aware of their plans of care and they had been given the time for questions and felt listened to. Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge and were being supported with these arrangements, for example, patients had already been supplied with equipment for their discharge.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

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

The hospital met quarterly with local healthcare commissioners as well as commissioners from the wider area to review quality and plan delivery arrangements which met the needs of the local community. Meetings were recorded and an action log prepared and monitored.

Good

Surgery

The hospital provided information for local GPs by holding training courses and education lunch and learning and evening sessions for GPs. The service engaged with local counsellors and the local residents association as to local community events and regularly held events to engage with the local community.

No high dependency or intensive care unit facility was provided at the hospital. The hospital had closed its high dependency unit after arranging for suitable facilities to be available with local NHS hospitals. Patients were transported to an NHS hospital following surgery if their clinical condition indicated. Patients with the long-term comorbidities were referred to NHS hospitals.

To support effective planning of admissions pre-operative assessment appointments were provided during days and evenings where clinically appropriate. The hospital offered a choice of consultants in most specialties and flexibility of appointment times. Patients were offered a choice of consultant and appointment times to suit them. Evening appointments and weekend clinics were available. Open visiting times were encouraged and relatives could stay overnight in the hospital where appropriate.

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.

The hospital supported patients living with dementia and the lead for clinical governance acted as dementia champion. A dementia strategy statement was in place. Alzheimer's Society passports were used to support the patient's needs.

Rooms in the hospital could be adapted to meet the needs of patients with dementia; for example, furniture was rearranged to reflect the arrangement in the patient's home. One to one nursing was put in place where required. Single room facilities were provided for relatives to stay overnight. Dementia friends' sessions were held as part of mandatory training and staff received training in dementia awareness twice yearly. A dementia awareness facilities were provided in the ward area.

The hospital supported patients with learning disabilities although few patients needing this support visited the hospital. The patient was accommodated using their own soft furnishing in the hospital room to provide familiarity with their surroundings. Hospital passports were used to support patients.

Hospital policy supported meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop system was in place in the hospital. Partially sighted patients were escorted to familiarise with their room and provided with an 'obstructions menu.' The patient's bedroom was arranged as near as possible to their home environment and family members were allowed unlimited visiting.

The hospital had a contract in place for information to be available in different formats to ensure patients of different abilities could access clinical information. The hospital provided access to translation services for patients where English was not a first language. One-stop clinics were used to reduce the need for patients to attend on several occasions.

Specialised equipment for bariatric patients was available. We checked and equipment was in place to carry out bariatric procedures. A specialist bariatric dietician was available to provide support following the British Obesity and Metabolic Surgery Society national guidelines. For each bariatric patient, a bariatric multidisciplinary meeting was held prior to surgery. Wards and departments were accessible for patients with limited mobility and people who used a wheelchair.

Patients were not discharged on the day of their surgery if they lived alone and their circumstances were checked at the pre-operative stage so that overnight accommodation was pre-arranged. Patients were discharged with an accompanying district nurse letter.

Access and flow

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

The hospital monitored waiting times to ensure patients accessed services when needed and received treatment within agreed timeframes and national standards. Managers and staff worked to ensure patients did not stay in hospital longer than necessary.

Good

Surgery

Managers worked to keep the number of cancelled operations to a minimum. The hospital had eight cancelled procedures for a non-clinical reason in the previous 12 months. Of these cancelled procedures, each patient was offered another appointment within 28 days of the cancelled appointment where clinically possible.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was discussed at the patient's pre-assessment meeting. Patients requiring assistance from other services at discharge were identified at pre-assessment.

In the previous 12 months there were six unplanned transfers of inpatients to other hospitals, 20 unplanned readmissions within 28 days of discharge and nine unplanned returns to theatre.

The hospital planned staggered admission times to ensure there was minimal waiting to go to theatre on arrival and to optimise patients being appropriately hydrated for surgery. Discharges were planned for before 11am wherever possible. If a patient's planned admission to theatre was delayed, the patient would be informed by reception or outpatient nursing staff. The patient was only sent for from their room when theatre was ready to receive them. Performance information reflected this and was confirmed by our observation of patient flow in the hospital.

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.

Staff understood the hospital's complaint policy and could assist patients in applying it. Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with told us they were satisfied with the service in the hospital although they had received information about how to complain if they required to use it.

Information about how to raise a complaint was available in patient areas. Complaints could be raised with the hospital informally through the hospital's website, through patient feedback forms, patient forums, social media, and in person to a member of staff as well as in writing and by email. 'Please talk to us leaflets' explaining the complaints process were available in the hospital.

The hospital investigated complaints and identified themes. The hospital acknowledged 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. Complainants were offered the opportunity to have a face to face meeting with the registered manager.

Complaints and concerns were discussed daily at the multidisciplinary team huddle and the weekly clinical governance brief. They were also discussed monthly at the hospital leadership team meeting and quarterly at the clinical governance committee and medical advisory committee. The registered manager and clinical governance lead held a monthly complaints meeting to discuss learning outcomes and trends which were shared with staff through a lessons learned bulletin, patient experience meetings, clinical governance briefs, a monthly safety bulletin and departmental monthly meetings.

The hospital complaint policy required complaints to be acknowledged within two days of receipt. The hospital aimed to close all complaints within 20 working days and compliance was monitored by the provider against a standard of 75%. The latest data for 2019 showed the hospital exceeded this standard with 82% of complaints responded to within the policy guidelines.

Learning from the investigation of complaints was shared through management forums and meetings. A 'you said, we did' format displayed learning for patients and staff in the hospital. A lessons learnt bulletin was emailed to staff.

In the year to July 2019, the hospital received 63 complaints. Two of these were related directly to surgery.

As part of our inspection we reviewed four complaints files. Each file showed good risk assessment and investigations. The files showed that the investigator kept the complainant up to date on progress and that outcomes were shared.

Are surgery services well-led?

Good

Our rating of well-led went down. We rated it as **good.**

Leadership

Good

Surgery

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

The hospital had a stable leadership structure with an experienced hospital director and registered manager and a leadership team of 12 heads of department.

Staff spoke positively about the support they received from the leadership team. Staff were well supported at all levels, including more junior members of staff. Consultant staff we spoke with told us their engagement with the hospital leadership team was positive. Staff told us that management were accessible and looked after them well. Staff felt they could approach managers with any concerns and managers listened.

Some of the management team told us that they were well supported by the hospital director and that they had been given opportunities to develop above and beyond what they had expected.

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 service had in place a hospital strategy and an annual business plan. The hospital strategy was developed following a series of meetings in which the hospital director consulted with staff about the proposed strategy and vision for the hospital for 2019.

The overall strategy for the hospital was underpinned by clinical strategies and a hospital wide "Strategy on a page." The 'Strategy on a page' was prepared to show how each department interlinked to deliver the hospital strategy.

The hospital followed the provider's corporate vision, mission and values. The provider's strategic vision was of growth through investment in clinical quality implemented in each hospital. The vision was to be recognised as a world class healthcare business; its mission was to bring together the best people who were dedicated to developing excellent clinical environments and delivering the highest quality patient care; and its values included driving clinical excellence, doing the right thing, caring is our passion, keeping it simple, delivering on our promises and succeeding and celebrating together.

We observed the provider's vision mission and values displayed in the hospital. Staff appraisal objectives linked personal objectives to the hospital strategy and corporate values.

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 spoke with were consistently positive about the culture they experienced in the hospital. Staff felt well supported and morale was high. Some staff described the hospital as a family with everyone working well as a team. Other staff described the culture as professional, open, friendly, welcoming and with a keenness to improve and succeed.

A freedom to speak up guardian and ambassadors were in role and endorsed the whistleblowing process. Staff were encouraged to, and confident to raise issues.

The hospital had a track record of identifying and developing talented staff from within the hospital and staff were proud to work for the organisation. The hospital had an established system to recognise and reward staff for effort, achievement and innovation which included the provider's staff awards programme.

A robust procedure was in place for challenging consultant behaviours and performance. Any staff issues were dealt with supportively.

Governance

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

Good

Surgery

The hospital had in place clear and well-established governance structures. An annual governance plan was in place. The governance framework was supported by a network of meetings and working parties that provided oversight of the clinical and non-clinical services in the hospital. An established board to ward system of governance provided for correctional action to be taken promptly. The hospital informed us a deputy head of governance was being appointed during 2020.

A governance meeting was held weekly at which the theatre department was represented. The senior management team met weekly and escalated issues to the leadership team. Minutes from governance meetings were shared with frontline clinical and non-clinical teams.

The senior leadership team met weekly and this included a weekly clinical governance briefing. The hospital leadership team met monthly and departmental and staff meetings were held monthly. The theatre department met monthly and was also represented at monthly governance meetings attended by the registered manager and a consultant representative as governance lead. A health and safety meeting and team leaders meeting were held monthly.

Robust arrangements for clinical governance and an established clinical governance team were in place. The daily multidisciplinary team 'huddle' (duration observed was 15 minutes) was attended by a representative of clinical governance. The director of clinical services held governance briefs weekly attended by the hospital director and clinical heads of department. Specific hospital committees fed into the overarching clinical governance forums.

A revised medical governance policy was introduced during 2019 and included a consultant handbook, which contained information on practicing privileges. The medical advisory committee met quarterly. The clinical governance meeting also met quarterly and included a representative of the medical advisory committee. The chair of the medical advisory committee also chaired any meeting about consultant concerns. The hospital met quarterly with commissioners to discuss governance and clinical quality.

Governance committee meetings were held quarterly and were informed by a quarterly governance and quality report. An established audit programme supported the governance arrangements.

Arrangements were in place to recruit new consultants with practicing privileges and to monitor their performance. When a new consultant approached the hospital to work under practicing privileges, this was discussed with the theatre manager, director of clinical services and business development lead. The service were proactive in obtaining information about the consultant's performance prior to interview stage. Any consultant would then have to provide their responsible officer's reference and application which could be reviewed by the team prior to interview. This would ensure that the consultants had the appropriate specialty qualifications and experience, disclosure and barring (DBS) clearance and cover some occupational health information. This would be reviewed also at the medical advisory committee.

We were told by the leadership team that they worked proactively with the consultant's responsible officers to keep up to date information on the performance of consultants. Each consultant had a biennial review. We were also given an example of where a consultant had retired from the NHS so had more frequent annual reviews supported by an annual whole practice appraisal and five yearly GMC revalidation.

We reviewed the personnel files of three consultants with practicing privileges. All the files showed that adequate checks for employment were in place and there was evidence of ongoing supervision and annual appraisal information from the responsible officer.

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.

A risk management policy and significant risk register for the hospital were in place which highlighted current risks and documented mitigating actions to reduce the risks. A risk champion was appointed to role to support the monitoring of the hospital wide risk register.

The risk register and escalation position was reviewed and updated weekly. The risk register was regularly reviewed by the senior management team with departmental leads and reviewed at monthly health and safety meetings. Risk was also a monthly agenda item at departmental meetings.

Red and amber rated risks were added to the hospital risk register and an action plan for improvement prepared. At inspection the risk register included 101 risks which changed weekly. The top six risks for the hospital and the top three risks for each department were reviewed monthly. Staff were familiar with the hospital's risks. An example was the shortage of providers for advanced life support training which was included in the risk register as there were insufficient providers in theatre. The risk was mitigated through a training course held in October 2019.

The hospital audited a range of performance indicators on its published clinical scorecard which reflected provider-wide scorecards and dashboards for benchmarking results. Key performance indicators were reported each quarter. Results were benchmarked nationally and performance against standards rated. Performance reports were prepared and used to support improvements.

Staff were encouraged to record incidents involving the conduct and behaviour of the team including consultants and other staff with practicing privileges.

We reviewed two serious incident reports and found that all the relevant information for recording and investigating were present. Investigations were credible and there was evidence of sharing of learning from the outcomes. In both cases patients and families were involved in the investigation and informed of the outcomes. The provider also exercised the duty of candour appropriately in both cases.

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.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. We observed staff accessed the clinical intranet to review clinical policies.

The hospital used a range of digital health facilities to facilitate the patient pathway. Staff completed information governance training annually to support keeping information secure and protecting confidentiality. IT policies governed practice and processes within the provider.

Engagement

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

The hospital could demonstrate high levels of patient satisfaction. The hospital encouraged patient feedback through various means including satisfaction surveys, "please talk to us "cards, patient forums and patients were involved through the complaints process in improving hospital services. NHS choices provided an independent means for patients to leave feedback. Feedback was used to improve hospital services. You said, we did displays in the hospital reflected learning from feedback and complaints and changes made in response.

All patients admitted to hospital were requested to complete an online survey. Results were collated and reported by an external provider. New questionnaires have been introduced to the hospital to help ensure service level feedback was specific and to supplement low response rates to external online surveys including the friends and family test.

Patient satisfaction surveys were emailed to each patient after their stay and results were collated and reviewed monthly. The results of the most recent patient satisfaction survey (November 2019) indicated 96% of patients were always provided with enough privacy, 70% stated they always found someone on the hospital staff to talk to about their worries and fears, 96% said their respect and dignity was always maintained and 99% stated they were provided with excellent care from nurses.

Patients were represented on NHS England's annual patient led assessments of the care environment (PLACE).

Good

Surgery

The hospital recently established a patient experience meeting which was used to discuss learnings from complaints, adverse events and to provide a further opportunity for patient feedback.

The hospital communicated with staff through a staff newsletter, consultant newsletter, and staff communication boards. The hospital held engagement meetings for staff including forums and working groups. Hospital and clinical strategies were developed with staff involvement.

The hospital recognised its staff by highlighting things that it did well. Plaudits and compliments were shared widely through the daily huddles, staff recognition boards and 'Thank you Thursdays.' Director-led staff forums were held monthly. The provider's 'Inspiring People' award scheme recognised staff achievement.

Learning, continuous improvement and innovation

The hospital was committed to continually learning and improving services. It's staff had an understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The hospital provided information for local GPs by holding training courses and education lunch and learning and evening sessions for GPs. The hospital offered a varied GP education programme responsive to current 'hot topics.'

The King's Thrombosis Centre was identified as the first NHS VTE Exemplar Centre by the Department of Health and aimed to provide leadership in sharing best practice. The hospital informed us it was working to achieve Kings College VTE exemplar status.

The hospital had an established system to recognise and reward staff for effort, achievement and innovation which included the provider's staff awards programme.

Some of the management team told us that they were well supported by the hospital director and that they had been given opportunities to develop above and beyond what they had expected.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

We previously inspected outpatients with diagnostic imaging, so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Mandatory training

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

The hospital set a target of 95% for mandatory training for staff.

Staff received and kept up to date with their mandatory training. Mandatory training was provided as a mixture of e-learning and face to face training depending on the training course. Where staff were not up to date with training, leaders told us they were booked on to complete the training.

The department management maintained oversight of mandatory training compliance and leaders had access to electronic systems which enabled them to monitor training compliance levels across the services. During the inspection, we were told mandatory training compliance was at 93% against the 95% target and this was not 100% because a staff member had recently started at the hospital and was working through the training modules.

The mandatory training included training modules such as safeguarding, information governance and infection control amongst other modules. The information provided by the service showed the compliance for outpatient's administrative staff with mandatory training was 100% across the various modules. Compliance for outpatient's staff ranged between 86% and 100% for mandatory training, however this was from September 2019 and during the inspection mandatory training compliance had improved.

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 up to date safeguarding policies in place which staff could access. The department did not see many children as they were part of a hub and spoke model for children's outpatients with another Spire hospital. Where children did attend for outpatient appointments, it was mainly for ear, nose and throat, dermatology, orthopaedic and general surgery consultations or there was child psychology clinics around once a month.

Staff described the 'was not brought' policy regarding children not being brought to their appointment. The safeguarding policy for children and young people had a section for 'was not brought' for further guidance.

Staff had awareness of safeguarding including female genital mutilation (FGM) and there was an information folder in the outpatient managers office for FGM which included a flow chart with what to do if there were concerns.

The hospital had safeguarding leads in place and these were the clinical governance lead and there was a lead physiotherapist for children and young persons in outpatients. These staff were available for support and advice and we were told these staff, along with the

hospital director, director of clinical services and outpatients sister, were trained to level four safeguarding. The level four safeguarding training was provided at another Spire site.

Staff we spoke with could describe the action they would take if they had safeguarding concerns for adults or children across outpatients. Safeguarding posters were on display in the department.

The hospital provided information on safeguarding levels and training across the hospital. This showed the hospital had a requirement for consultants who provided care and treatment to children to be level three safeguarding trained along with registered nursing staff and allied health professionals involved in the care of children. Some reception staff and ward administrators were also required to be trained to level three children safeguarding. All other staff were trained to level two safeguarding children and adults.

We requested compliance levels for safeguarding adults and children split by the safeguarding level. The hospital provided information on safeguarding training compliance as at 17 December 2019 which showed for outpatients, compliance with safeguarding adults level two was 91%.

Compliance with safeguarding children level two was 91% and safeguarding children level three was 100%. The date for remaining staff to complete the training was March 2020. The information showed compliance in physiotherapy for safeguarding adults' level two was 100%, compliance with safeguarding children level two was 100% and safeguarding children level three was 100%. This showed that one staff member was trained to level four training and compliance was 100%.

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.

Areas visited were visibly clean and tidy. During the inspection we saw staff adhering to 'bare arms below the elbow' and also saw posters on display regarding this in some clinic rooms. Hand sanitiser was available and there were washing sinks available in the areas visited. Personal protective equipment was available in the department, for example gloves and aprons. Hand wash was available in the areas visited.

Consulting and treatment rooms had paper on each of the trolley beds and we were told this was replaced after each patient. There were fabric curtains in some of the treatment rooms and the changing dates on these were generally completed as required and in date, except for one. We highlighted the point about dates on equipment and consumables during the inspection and the leaders told us they would address it.

The clinical governance lead for the services was also the infection prevention lead and staff could contact the infection prevention lead for advice and support as required.

Information provided by the hospital highlighted there had been no infections in outpatients and staff told us if there was an infection, a root cause analysis would be completed along with an incident form. Staff told us patients with a communicable disease would be allocated to the end of a clinic list and there would be a deep clean afterwards as required.

There was daily cleaning in the outpatient department and waste disposal available for various types of waste across the outpatient services. At the previous inspection, there were concerns regarding cleaning logs. At this inspection we found these to be present outside the consulting and treatment room doors and the December 2019 cleaning logs were completed as required. We saw some of the previous three months cleaning logs and found these to be generally completed as required with one day not documented in one of the previous three months. The department managers had recently revised the cleaning logs, and these included the daily, weekly and monthly cleaning schedule.

The ear, nose and throat outpatient clinics used endoscopes for procedures. Staff told us there was a system for cleaning these which used specific cleaning wipes and the endoscopes were then sent to the internal sterile services department for cleaning. Leaders told us there was a green bag and red bag system used to indicate which endoscope was clean.

The hospital completed environment audits to enable leaders to monitor the environment as required. This

audit also considered the oncology area. In July 2019, the score for oncology was 100%. The cleaning checklist in the children's outpatient waiting area was completed as required.

Staff had access to an infection prevention and control policy which had a review date of February 2022. There was also a management of MRSA document which had a review date of April 2020. The meeting minutes from July 2019 for the infection prevention committee included agenda items such as antimicrobial stewardship and management of risks.

The departments completed hand hygiene audits on the environment, observation and technique. The quarter three 2019 hand hygiene environment audits showed positive answers to all, but one question and the September 2019 hand hygiene technique audit had all questions answered positively. The service provided an observational hand hygiene audit compliance report which showed 100% compliance across four sessions.

Environment and equipment

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

The outpatient department was located along a corridor which had consulting and treatment rooms along with a reception area where reception staff could book and organise appointments for patients as they were leaving the department. Patients checked in at the main hospital reception and would then be called for their appointment as required. Toilets were available in the outpatient department.

The corridor next to the outpatient department was where the physiotherapy team were based and there was a phlebotomy room on the corridor for outpatient use. The physiotherapy department had a waiting room which highlighted the patient outcome information, had a number of patient information leaflets and a folder with children's packs for when children attended the department.

There was seating available in the waiting rooms for patients waiting for appointments. There was also a quiet room available for patient and visitor use in the outpatient waiting area. The main outpatient corridor also had a pharmacy available and the pathology unit was at the end of the corridor. The oncology outpatient team were located in a separate part of the hospital. The children's and young persons activity area had small tables and chairs alongside books.

The outpatient area displayed various information to patients and visitors such as the vision and purpose. There was a children's waiting area within the outpatient waiting area.

There was waste disposal available in the department for clinical and non-clinical waste.

Consulting and treatment rooms had doors with keypad locks attached which enhanced the security of the rooms.

The outpatient department had a resuscitation trolley available for use. We checked recent dates for these and these were checked as required. The resuscitation trolleys were checked daily and the trolleys were secured. We found one of the security tags was not completely secure, however, we raised this with staff and this was dealt with.

We saw one asset where the portable appliance testing sticker date was 25 June 2016. We raised this with leaders who advised servicing was up to date, but the sticker had not been replaced and they were going to address it.

There was signage directing staff to the various parts of the department. Wheelchairs were available for patient use across the department.

Staff had access to personal protective equipment such as gloves and aprons. These were available in each of the consulting or treatment rooms. There was enough equipment for staff to use and computers were available in the department. The hospital had a maintenance team which staff could contact if required. There was access to an information technology team for advice and support as required.

The physiotherapy experience survey from November 2019 showed 82% of respondents said the environment was excellent and 18% of respondents said the physiotherapy environment was good.

Good

Outpatients

The services took part in the patient led assessments of the care environment (PLACE) audits and the report from 2019 included outpatients. The report showed all relevant questions for the cleanliness part of the audit had passed.

The hospital provided examples of equipment replacement from 2018 which showed various equipment such as gym equipment replacement.

The hospital provided and had a maintenance schedule for 2019 and 2020 in place for the hospital including the outpatient department. The was also a service schedule for the outpatient department.

Assessing and responding to patient risk

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

Safety checklists were in use in the outpatient department in the orthopaedic clinics for injections. During the inspection we saw four of these checklists and three were completed as required, however one was not fully complete. These safety checklists included information such as the step one sign in, step two time out and step three signature. We were told these were used each time for injections.

Where patients were clinically unwell or deteriorated during their visit to outpatients, staff would contact the resuscitation team. There was medical and nursing staff available in the outpatient department during the day when outpatients was open. The hospital provided information stating outpatient staff were trained in basic life support with compliance at 93%.

The service could access a children's nurse at another Spire hospital site for advice if required and there was a resident medical officer at the hospital. The department also had access to a paediatric resuscitation trolley.

The safeguarding policy for children and young people had a section for 'was not brought' for staff to access for guidance.

Leaders told us staff would receive a debrief where required if there had been an incident in the outpatient department.

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.

Leaders told us there were no concerns with staffing levels in the outpatient department and they had recently recruited to the department and currently had no vacancies. Staffing rotas were planned in advance and took into account the type and number of clinics the service had, and the department leaders used a safer staffing tool which assisted in planning for staffing levels. The service provided information stating safety assurance was provided by the safe staffing tool and daily assurance was provided by the daily huddle which was held in outpatients each morning and took into account staffing in outpatients. The department manager or senior nurse also attended the hospital multidisciplinary team huddle each morning where safe staffing was discussed.

The service provided an audit for the safe staffing tool which they completed and this showed there had been no incidents reported relating to safe staffing in outpatients.

Oversight of staffing was maintained by the leadership team and where required and there were vacancies, the service would recruit. Where needed to ensure staffing levels were as required, bank staff would be utilised.

The service provided information showing there were six registered nurses, nine healthcare assistants and there were three bank staff available as required. There was an outpatient manager and a senior nurse in outpatients.

Medical staffing

For our detailed findings on medical staffing please see the Safe section in the surgery report.

Medical staff were not managed directly by the outpatient department.

Medical staff worked at the hospital under practising privileges and held outpatient appointment clinics as required in the department. The granting of practising privileges is a well-established process within

independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice or within the provision of community services.

The service provided information stating an Ad-hoc resident medical officer clinic was available Monday to Fridays for patients requiring urgent or planned medical reviews. The information provided by the service also stated resident medical officers worked on a seven-day rota.

The hospital had access to a safe staffing policy with a review date of April 2022.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were stored securely and easily available to all staff providing care.

Records were mainly paper records across the outpatients department. Records were stored securely during the inspection and there was a locked cupboard in the department for patient records and the clinic room doors had key pad locks to enhance the security of records. In the consulting and treatment rooms there were also cupboards which could be locked. Patient records were brought to the clinic rooms as required.

We reviewed ten records during the inspection and found these were not always completed as required. For example, there were three records which did not have a signature. There was evidence of multidisciplinary team working in the records.

Staff told us it was rare for patient notes to not be ready and available for outpatient clinics and where they were not available, staff would contact the patient records department or would create a temporary set of records if required. The hospital provided information stating less than 5% of patients were seen without a record being available.

The hospital provided further information on the processes which assisted in managing the risk if a patient was to attend and the records were not available. The hospital stated the administration manager reported to the daily huddle if there were any records unavailable for patients attending that day and that actions would be taken by staff to locate the records in time for the patient attending the hospital.

There was a patient records policy which had a review date of September 2022.

The medical records audit from the 27 November 2019 showed that out of twenty records audited, all of these were completed as required with only one record not having the last clinic letter in notes and the consultant documentation not legible. There was an action plan following the clinical audit in November 2019 which detailed the issues raised, action required, outcome measure, action lead and the date due.

Medicines

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

For our detailed findings on medicines please see the Safe section in the surgery report.

Medicines seen during the inspection were stored securely and the medicine cupboard keys were kept by a registered nurse or locked away in a cupboard. Medicines seen during the inspection were found to be in date. The outpatient department did not keep any controlled drugs and did not have any patient group directives in place. Prescription pads were stored securely.

There was a pharmacy department with dedicated pharmacy staff available within the outpatient department where support and advice could be sought. There was a management of medicines policy available to staff which had a review date of October 2019, however the document stated it had been extended for six months whilst it was under review. This policy had a section on antibiotic prescribing and the principles of stewardship. There were antibiotic prescribing guidelines with a review date of February 2020.

Medicines refrigerator checks were completed as required in the temperature logs we saw.

Incidents

Good

Outpatients

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.

The service had an incident reporting policy which had a review date of January 2022.

There had been no never events or serious incidents across outpatients in the previous 12 months.

The department staff had access to an electronic incident reporting system in outpatients and staff we spoke with were aware of this system and could describe how they would report an incident.

Leaders in the department would investigate the incidents or would ask the relevant person to investigate the incident and we were told the clinical governance lead also had oversight of incidents across the service. Root cause analysis were completed for serious incidents if they occurred and the hospital provided information highlighting they were supported by a national patient safety team.

Leaders told us there had not been many incidents in the previous 12 months across outpatients but where there had been an incident this would be shared at the monthly team meetings with the team. Team meeting minutes showed incidents were part of the monthly agenda.

The hospital provided information highlighting incidents where there had been learning from the incidents identified and how this learning from incidents had been completed.

They had added the outpatient department to the incident reporting system in April 2019. The hospital provided a document with the incidents which had occurred in the previous eight months and each incident reported stated 'no harm caused'.

Staff we spoke with could describe the duty of candour. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Are outpatients services effective?

We previously inspected outpatients with diagnostic imaging, so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Mandatory training

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

The hospital set a target of 95% for mandatory training for staff.

Staff received and kept up to date with their mandatory training. Mandatory training was provided as a mixture of e-learning and face to face training depending on the training course. Where staff were not up to date with training, leaders told us they were booked on to complete the training.

The department management maintained oversight of mandatory training compliance and leaders had access to electronic systems which enabled them to monitor training compliance levels across the services. During the inspection, we were told mandatory training compliance was at 93% against the 95% target and this was not 100% because a staff member had recently started at the hospital and was working through the training modules.

The mandatory training included training modules such as safeguarding, information governance and infection control amongst other modules. The information provided by the service showed the compliance for outpatient's administrative staff with mandatory training was 100% across the various modules. Compliance for outpatient's staff ranged between 86% and 100% for mandatory training, however this was from September 2019 and during the inspection mandatory training compliance had improved.

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 up to date safeguarding policies in place which staff could access. The department did not

see many children as they were part of a hub and spoke model for children's outpatients with another Spire hospital. Where children did attend for outpatient appointments, it was mainly for ear, nose and throat, dermatology, orthopaedic and general surgery consultations or there was child psychology clinics around once a month.

Staff described the 'was not brought' policy regarding children not being brought to their appointment. The safeguarding policy for children and young people had a section for 'was not brought' for further guidance.

Staff had awareness of safeguarding including female genital mutilation (FGM) and there was an information folder in the outpatient managers office for FGM which included a flow chart with what to do if there were concerns.

The hospital had safeguarding leads in place and these were the clinical governance lead and there was a lead physiotherapist for children and young persons in outpatients. These staff were available for support and advice and we were told these staff, along with the hospital director, director of clinical services and outpatients sister, were trained to level four safeguarding. The level four safeguarding training was provided at another Spire site.

Staff we spoke with could describe the action they would take if they had safeguarding concerns for adults or children across outpatients. Safeguarding posters were on display in the department.

The hospital provided information on safeguarding levels and training across the hospital. This showed the hospital had a requirement for consultants who provided care and treatment to children to be level three safeguarding trained along with registered nursing staff and allied health professionals involved in the care of children. Some reception staff and ward administrators were also required to be trained to level three children safeguarding. All other staff were trained to level two safeguarding children and adults.

We requested compliance levels for safeguarding adults and children split by the safeguarding level. The hospital provided information on safeguarding training compliance as at 17 December 2019 which showed for outpatients, compliance with safeguarding adults level two was 91%.

Compliance with safeguarding children level two was 91% and safeguarding children level three was 100%. The date for remaining staff to complete the training was March 2020. The information showed compliance in physiotherapy for safeguarding adults' level two was 100%, compliance with safeguarding children level two was 100% and safeguarding children level three was 100%. This showed that one staff member was trained to level four training and compliance was 100%.

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.

Areas visited were visibly clean and tidy. During the inspection we saw staff adhering to 'bare arms below the elbow' and also saw posters on display regarding this in some clinic rooms. Hand sanitiser was available and there were washing sinks available in the areas visited. Personal protective equipment was available in the department, for example gloves and aprons. Hand wash was available in the areas visited.

Consulting and treatment rooms had paper on each of the trolley beds and we were told this was replaced after each patient. There were fabric curtains in some of the treatment rooms and the changing dates on these were generally completed as required and in date, except for one. We highlighted the point about dates on equipment and consumables during the inspection and the leaders told us they would address it.

The clinical governance lead for the services was also the infection prevention lead and staff could contact the infection prevention lead for advice and support as required.

Information provided by the hospital highlighted there had been no infections in outpatients and staff told us if there was an infection, a root cause analysis would be completed along with an incident form. Staff told us patients with a communicable disease would be allocated to the end of a clinic list and there would be a deep clean afterwards as required.

There was daily cleaning in the outpatient department and waste disposal available for various types of waste across the outpatient services. At the previous inspection,

there were concerns regarding cleaning logs. At this inspection we found these to be present outside the consulting and treatment room doors and the December 2019 cleaning logs were completed as required. We saw some of the previous three months cleaning logs and found these to be generally completed as required with one day not documented in one of the previous three months. The department managers had recently revised the cleaning logs, and these included the daily, weekly and monthly cleaning schedule.

The ear, nose and throat outpatient clinics used endoscopes for procedures. Staff told us there was a system for cleaning these which used specific cleaning wipes and the endoscopes were then sent to the internal sterile services department for cleaning. Leaders told us there was a green bag and red bag system used to indicate which endoscope was clean.

The hospital completed environment audits to enable leaders to monitor the environment as required. This audit also considered the oncology area. In July 2019, the score for oncology was 100%. The cleaning checklist in the children's outpatient waiting area was completed as required.

Staff had access to an infection prevention and control policy which had a review date of February 2022. There was also a management of MRSA document which had a review date of April 2020. The meeting minutes from July 2019 for the infection prevention committee included agenda items such as antimicrobial stewardship and management of risks.

The departments completed hand hygiene audits on the environment, observation and technique. The quarter three 2019 hand hygiene environment audits showed positive answers to all, but one question and the September 2019 hand hygiene technique audit had all questions answered positively. The service provided an observational hand hygiene audit compliance report which showed 100% compliance across four sessions.

Environment and equipment

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

The outpatient department was located along a corridor which had consulting and treatment rooms along with a reception area where reception staff could book and organise appointments for patients as they were leaving the department. Patients checked in at the main hospital reception and would then be called for their appointment as required. Toilets were available in the outpatient department.

The corridor next to the outpatient department was where the physiotherapy team were based and there was a phlebotomy room on the corridor for outpatient use. The physiotherapy department had a waiting room which highlighted the patient outcome information, had a number of patient information leaflets and a folder with children's packs for when children attended the department.

There was seating available in the waiting rooms for patients waiting for appointments. There was also a quiet room available for patient and visitor use in the outpatient waiting area. The main outpatient corridor also had a pharmacy available and the pathology unit was at the end of the corridor. The oncology outpatient team were located in a separate part of the hospital. The children's and young persons activity area had small tables and chairs alongside books.

The outpatient area displayed various information to patients and visitors such as the vision and purpose. There was a children's waiting area within the outpatient waiting area.

There was waste disposal available in the department for clinical and non-clinical waste.

Consulting and treatment rooms had doors with keypad locks attached which enhanced the security of the rooms.

The outpatient department had a resuscitation trolley available for use. We checked recent dates for these and these were checked as required. The resuscitation trolleys were checked daily and the trolleys were secured. We found one of the security tags was not completely secure, however, we raised this with staff and this was dealt with.

We saw one asset where the portable appliance testing sticker date was 25 June 2016. We raised this with leaders who advised servicing was up to date, but the sticker had not been replaced and they were going to address it.

Good

Outpatients

There was signage directing staff to the various parts of the department. Wheelchairs were available for patient use across the department.

Staff had access to personal protective equipment such as gloves and aprons. These were available in each of the consulting or treatment rooms. There was enough equipment for staff to use and computers were available in the department. The hospital had a maintenance team which staff could contact if required. There was access to an information technology team for advice and support as required.

The physiotherapy experience survey from November 2019 showed 82% of respondents said the environment was excellent and 18% of respondents said the physiotherapy environment was good.

The services took part in the patient led assessments of the care environment (PLACE) audits and the report from 2019 included outpatients. The report showed all relevant questions for the cleanliness part of the audit had passed.

The hospital provided examples of equipment replacement from 2018 which showed various equipment such as gym equipment replacement.

The hospital provided and had a maintenance schedule for 2019 and 2020 in place for the hospital including the outpatient department. The was also a service schedule for the outpatient department.

Assessing and responding to patient risk

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

Safety checklists were in use in the outpatient department in the orthopaedic clinics for injections. During the inspection we saw four of these checklists and three were completed as required, however one was not fully complete. These safety checklists included information such as the step one sign in, step two time out and step three signature. We were told these were used each time for injections.

Where patients were clinically unwell or deteriorated during their visit to outpatients, staff would contact the resuscitation team. There was medical and nursing staff available in the outpatient department during the day when outpatients was open. The hospital provided information stating outpatient staff were trained in basic life support with compliance at 93%.

The service could access a children's nurse at another Spire hospital site for advice if required and there was a resident medical officer at the hospital. The department also had access to a paediatric resuscitation trolley.

The safeguarding policy for children and young people had a section for 'was not brought' for staff to access for guidance.

Leaders told us staff would receive a debrief where required if there had been an incident in the outpatient department.

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.

Leaders told us there were no concerns with staffing levels in the outpatient department and they had recently recruited to the department and currently had no vacancies. Staffing rotas were planned in advance and took into account the type and number of clinics the service had, and the department leaders used a safer staffing tool which assisted in planning for staffing levels. The service provided information stating safety assurance was provided by the safe staffing tool and daily assurance was provided by the daily huddle which was held in outpatients each morning and took into account staffing in outpatients. The department manager or senior nurse also attended the hospital multidisciplinary team huddle each morning where safe staffing was discussed.

The service provided an audit for the safe staffing tool which they completed and this showed there had been no incidents reported relating to safe staffing in outpatients.

Good

Outpatients

Oversight of staffing was maintained by the leadership team and where required and there were vacancies, the service would recruit. Where needed to ensure staffing levels were as required, bank staff would be utilised.

The service provided information showing there were six registered nurses, nine healthcare assistants and there were three bank staff available as required. There was an outpatient manager and a senior nurse in outpatients.

Medical staffing

For our detailed findings on medical staffing please see the Safe section in the surgery report.

Medical staff were not managed directly by the outpatient department.

Medical staff worked at the hospital under practising privileges and held outpatient appointment clinics as required in the department. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice or within the provision of community services.

The service provided information stating an Ad-hoc resident medical officer clinic was available Monday to Fridays for patients requiring urgent or planned medical reviews. The information provided by the service also stated resident medical officers worked on a seven-day rota.

The hospital had access to a safe staffing policy with a review date of April 2022.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were stored securely and easily available to all staff providing care.

Records were mainly paper records across the outpatients department. Records were stored securely during the inspection and there was a locked cupboard in the department for patient records and the clinic room doors had key pad locks to enhance the security of records. In the consulting and treatment rooms there were also cupboards which could be locked. Patient records were brought to the clinic rooms as required.

We reviewed ten records during the inspection and found these were not always completed as required. For example, there were three records which did not have a signature. There was evidence of multidisciplinary team working in the records.

Staff told us it was rare for patient notes to not be ready and available for outpatient clinics and where they were not available, staff would contact the patient records department or would create a temporary set of records if required. The hospital provided information stating less than 5% of patients were seen without a record being available.

The hospital provided further information on the processes which assisted in managing the risk if a patient was to attend and the records were not available. The hospital stated the administration manager reported to the daily huddle if there were any records unavailable for patients attending that day and that actions would be taken by staff to locate the records in time for the patient attending the hospital.

There was a patient records policy which had a review date of September 2022.

The medical records audit from the 27 November 2019 showed that out of twenty records audited, all of these were completed as required with only one record not having the last clinic letter in notes and the consultant documentation not legible. There was an action plan following the clinical audit in November 2019 which detailed the issues raised, action required, outcome measure, action lead and the date due.

Medicines

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

For our detailed findings on medicines please see the Safe section in the surgery report.

Medicines seen during the inspection were stored securely and the medicine cupboard keys were kept by a registered nurse or locked away in a cupboard. Medicines seen during the inspection were found to be in date. The outpatient department did not keep any controlled drugs and did not have any patient group directives in place. Prescription pads were stored securely.

Good

Outpatients

There was a pharmacy department with dedicated pharmacy staff available within the outpatient department where support and advice could be sought. There was a management of medicines policy available to staff which had a review date of October 2019, however the document stated it had been extended for six months whilst it was under review. This policy had a section on antibiotic prescribing and the principles of stewardship. There were antibiotic prescribing guidelines with a review date of February 2020.

Medicines refrigerator checks were completed as required in the temperature logs we saw.

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.

The service had an incident reporting policy which had a review date of January 2022.

There had been no never events or serious incidents across outpatients in the previous 12 months.

The department staff had access to an electronic incident reporting system in outpatients and staff we spoke with were aware of this system and could describe how they would report an incident.

Leaders in the department would investigate the incidents or would ask the relevant person to investigate the incident and we were told the clinical governance lead also had oversight of incidents across the service. Root cause analysis were completed for serious incidents if they occurred and the hospital provided information highlighting they were supported by a national patient safety team.

Leaders told us there had not been many incidents in the previous 12 months across outpatients but where there had been an incident this would be shared at the monthly team meetings with the team. Team meeting minutes showed incidents were part of the monthly agenda.

The hospital provided information highlighting incidents where there had been learning from the incidents identified and how this learning from incidents had been completed.

They had added the outpatient department to the incident reporting system in April 2019. The hospital provided a document with the incidents which had occurred in the previous eight months and each incident reported stated 'no harm caused'.

Staff we spoke with could describe the duty of candour. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Are outpatients services caring?

Good

We previously inspected outpatients with diagnostic imaging, so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Compassionate care

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

Overall, patient feedback regarding the care they received was positive. Patients felt involved in the care and treatment they received. The hospital provided the friends and family test results from November 2019 which showed 81% of respondents were extremely likely to recommend the hospital and 15% of respondents were likely to recommend the hospital.

Where required the service had implemented patient satisfaction survey action plans, for example for quarter three in 2019. This included information, for example of the actions required and the date it was due to be completed.

Good

Outpatients

Privacy and dignity was maintained in the outpatient reception area as patients did not wait for appointments in this area and therefore this reduced the risk of being overheard whilst speaking with reception staff in the outpatient corridor.

Staff maintained patient privacy and dignity by ensuring consulting and treatment room doors were closed and where required there were curtains available in the rooms. Patients told us their privacy and dignity was maintained during their visit.

Staff told us chaperones were available and provided as necessary across the outpatient department. There was a chaperone policy available for reference which could be used by staff. There were also chaperone posters advising patients about chaperones displayed in various areas of the outpatient department. Staff had access to a chaperone guidelines document which had a review date of August 2022.

The mandatory training document for the outpatient service showed 100% of staff in outpatients had completed compassion in practice training.

Emotional support

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

The outpatient department had access to a quiet room near the reception area which patients could use. This room had seating available and the department manager told us the room could also be used for patients who may be anxious or for vulnerable patients. The quiet room had facilities for patients with dementia and also facilities for people of different faiths.

There were nursing staff with additional knowledge and skills who could provide further support and advice. For example, there was a lead nurse for oncology working across the outpatient department. The oncology service linked with some external groups to provide additional support and advice to patients.

The oncology team had set up support groups for patients, for example the service provided information stating they had set up a breast support group for patients.

Staff we spoke with understood how to support patients attending who may need additional support, for example, patients living with dementia or vulnerable patients.

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.

During the inspection, patients told us they were involved in decisions about their care and treatment. Staff were approachable, and we saw some staff introducing themselves to patients and visitors.

Patients we spoke with told us staff involved patients and those close to them and there was opportunity to ask questions. Patients were provided with patient information leaflets as required.

There was a patient satisfaction poster in the hospital and outpatient waiting area which stated 96% of respondents highlighted that staff understood their needs.

Letters were provided and communicated to the general practitioners as required.

To assist in communication with patients there were picture cards which could be used.

Are outpatients services responsive?

Good

We previously inspected outpatients with diagnostic imaging, so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Service delivery to meet the needs of local people

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

For our main findings please refer to the surgery report.

Outpatients offered a variety of services and clinics. The outpatient's leadership team worked together to deliver

the services to patients. Leaders across the services worked with other internal and external teams to manage services, for example some teams met with directorate managers within local NHS trusts to plan and deliver services. Leaders utilised business cases as required to develop the services provided. Leaders told us quality and safety was considered as part of business cases.

Leaders worked with local healthcare providers where required to deliver services to patients.

The services received referrals from local NHS healthcare providers and we were told there were agreements in place for these services.

Services were provided to adults and children in outpatients, however we were told there were not many children seen across outpatients. Of the total number appointments in outpatients, 0.5% of appointments were for patients under the age of 18. There were 12 clinic rooms which were mainly consulting rooms, although there were treatment rooms available. There was a phlebotomy department available. There was also a physiotherapy department with a gym.

The hospital had introduced one stop breast clinics. These clinics enabled patients to attend to visit a doctor and a mammogram or ultrasound could be performed along with results. Where needed a biopsy could be done.

The oncology clinic had a counselling area available for patients.

There were evening and weekend appointments available in outpatients to provide flexibility to patients attending for appointments. Choice of appointment times were available when patients were booking appointments. The service provided information stating where a patient required an urgent appointment following a consultation they would try to do this at the same time, for example scans.

The 'did not attend' rate in September 2019 was 1.93%, was 1.72% in October 2019 and 2.08% in November 2019. The hospital provided information stating that in the previous six months to the inspection there had been 28,294 outpatient bookings and 453 'did not attends' which was 1.6%. To assist in addressing the 'did not attend' rate, the service had introduced text message reminders for appointments. The hospital provided further information stating 'did not attends' were logged as an incident on the electronic systems and that the process regarding management of DNA's included attempting to contact patients and offering the opportunity to rebook the appointment.

The hospital provided the clinic utilisation rates for outpatients. This showed that between June 2019 and November 2019 the clinic utilisation rate varied between 46% and 59%.

Parking was available on site, however some patient feedback indicated finding a parking space could be challenging.

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.

For our main findings please refer to the surgery report.

The service had access to translation services.

There was a quiet room available in the department which could be used for patients who may be anxious or where patients preferred a quieter environment. Appointment times varied depending on the clinic and the treatment or consultation, although in general a first appoint was around 20 minutes and a follow up appointment around 10 minutes. Where appointments were delayed, staff informed patients of the delay.

There were staff who had completed training for patients living with dementia and the service would make reasonable arrangements as required for patients. Staff had access to a dementia champion who was available for advice and support.

There were a range of patient information leaflets available throughout the department.

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.

Good

Outpatients

There were various specialties which operated from outpatients, for example, orthopaedic surgery, general surgery and ear, nose and throat. 33.7% of all outpatients were from the general surgery speciality.

Waiting lists and appointments were managed by three teams across the hospital, the National Health Service (NHS) appointments team, the self-pay team and the team which dealt with insured customers.

Waiting lists for National Health Service patients were managed by a team in the hospital. We were told patients were not lost to follow up because all patients were booked onto the system with appointments unless they required an appointment at a date later in the future in which the referrals were kept in a folder which was reviewed daily by an administrative member of the team.

During the inspection, we were told there were only 15 patients waiting to be booked into an appointment and these were only waiting because the appointments were not due for a long period but were monitored daily by the NHS appointments team. Where there was an appointment slot issue on the e-referral system the team would contact the general practitioner and ask them to rebook the patient onto the appropriate appointment slot to resolve the issue.

The hospital provided the referral to treatment times for National Health Service (NHS) patients, self-funded patients and insured patients. This information showed waiting times for NHS patients for first and follow up patients across all specialities were between 14 and 21 days. Waiting times for first and follow up appointments for insured patients and self-funded patients was two days. The report showed that waiting times for urgent appointments for NHS patients, self-funded patients and insured patients were within targets.

The service was not commissioned to provide cancer services for NHS patients, this service was only available to private patients. For insured and self-funded patients, the report stated waiting times for cancer appointments would be one to two days. The hospital provided information stating when a appointment for urgent cancer appointments was requested, the call handler prioritised the booking and informed the medical staff.

Referral to treatment waiting lists for NHS patients was ten weeks for the specialties and 7 to 14 days for insured and self-funded patients.

The NHS appointments team in the hospital managed referrals from five specialities and e-referrals could be used by patients to book their appointments. We were told there were no backlogs with waiting lists and the average time from referral to treatment across all five specialties was around 10 weeks. Where a patient had received an appointment but had received diagnostic tests elsewhere the hospital would try and request the tests through the electronic system to ensure the patient was seen promptly. Referrals were received and dealt with daily by the team. The longest follow up appointment times were for rheumatology which were around four weeks. We were told there would not usually be a wait for a follow up appointment of more than four weeks.

The 18-week breach rate was around 3% every quarter and we were told the only reason a patient would breach the 18 weeks wait if it was patient choice. We were told that where a patient required an appointment, the doctor would request the follow up appointment date and this date could be requested without delay in appointments.

During the inspection we were told there were not waiting lists for other appointments, for example from self-pay patients and were told that when an appointment was requested the service could provide that appointment for the date when it was required as long as the doctor and speciality had a clinic running. This was the case for new and follow up appointments.

When a follow up appointment was required, the patients would book this on their way out of the clinic with the reception team to ensure they received an appointment as required. A choice of appointments was available to patients.

The department had completed an audit for patient waiting times in the clinics. This was completed between 31 August 2019 and 6 September 2019. The audit considered 371 appointments in outpatients and found 68% of these were called to their appointment on time with 32% being called to their appointment later than their scheduled appointment time. The average delay to their appointment time was 16 minutes and on one occasion the delayed appointment was around 60 minutes. The service had produced an action plan following this audit which included four actions. Three of the actions were documented as completed and one action was ongoing. The July 2019 patient survey for

outpatients showed that between February 2019 and July 2019 the percentage of appointments being on time in the hospital was between 60% and 77%. During our inspection, appointment and clinics were generally on time, however there were limited instances where the clinics were running later. Staff informed patients of the delay when this occurred.

There had been cancelled appointments in the previous months, however we did not see any action being taken to address cancelled appointments during the inspection. We requested the number of cancelled clinics and this showed there had been 87 cancelled clinics between June 2019 and November 2019 within six weeks which was low at only 0.40% of appointments. The hospital stated a proportion of these clinics had no patients booked into them and were therefore cancelled. Where possible staff called patients to notify them of the cancelled appointment and the leaders of the department monitored cancelled appointments and clinics.

The hospital provided a document for onward referrals which detailed information on referrals from the services, for example this document highlighted clinic letters were typed and sent to the general practitioner with a copy provided to patients.

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.

There were posters on display in the department advising patients and visitors on how to complain to the service. Leaders told us they attempted to address complaints informally if appropriate, however encouraged patients and visitors to complain formally if they were unsatisfied with the service and it could not be dealt with informally. The outpatient department kept a log of informal complaints to enable the leaders to identify trends and still deal with complaints when they were not formally provided to the hospital. The hospital provided examples of learning, which included for example where an ad hoc clinic had been established to improve patients being seen in a timely manner.

Complaints could be raised with the hospital through email and there was a section on the website regarding complaints.

Staff and leaders had access to a complaints policy. This had a review date of September 2021.

Where complaints were received they were investigated by the leaders of the department and we were told where there was learning from complaints available, this would be shared at the team meetings or the daily huddles. Team meeting information was also provided to staff who could not attend. The clinical governance quarter two 2019 report highlighted that learning from complaints would be cascaded to relevant departments through departmental leads at team meetings and minutes. This report also highlighted learning from complaints through the incident and complaints learning outcomes newsletter, clinical governance quarterly newsletters and safety brief and team lead events.

The hospital provided a complaints log for complaints between January 2019 and June 2019. This showed one complaint for outpatients and included the actions taken.

Are outpatients services well-led?

Good

We previously inspected outpatients with diagnostic imaging, so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

Leadership

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

The hospital had a management structure which included a hospital director and director of clinical services. Managers in the outpatient department reported to the director of clinical services, however we were told they could also contact the hospital director if required. There was a clear management structure in the outpatient department. There was an overall department manager which two senior registered nurses reported to and the registered nurses and healthcare assistants

reported to the senior nurses. We were told there was a registered nurse on duty each day in outpatients. The service had access to a maintenance team at the hospital who we were told were accessible and available.

The hospital had a meetings organisational chart for 2019 which showed there were meetings across the hospital, for example a complaints meeting, risk committee, infection prevention meeting, clinical governance committee and the hospital leadership meeting. The outpatient department had a morning huddle where they discussed staffing and the service tried to have a monthly team meeting where they discussed any outpatient issues and information from the hospital was communicated to the team.

The hospital leadership team meeting from July 2019 included pathology and outpatients as an agenda item.

Leaders understood the challenges faced by the department and could describe these along with the risks associated with the risk register.

Feedback regarding leadership in the hospital was positive and we were told leaders were visible and approachable. We were told leaders had an open-door policy and could be contacted as required by staff.

During the day in outpatients, there was a registered nurse in charge supported by the outpatients and diagnostic imaging manager.

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 which was to be recognised as a world class healthcare business and the hospital had a set of values which included driving clinical excellence, doing the right thing, caring is our passion, keeping it simple, delivering on our promises and succeeding and celebrating together. There was a hospital management structure in place.

There was a documented hospital strategy for 2019 which included points such as 'develop and involve our staff in decision making with clear communication processes'. This also included information from the various departments such as outpatients and inpatient bookings. The section for outpatients and oncology highlighted a point regarding 'work closely with the administration team in order to ensure room utilisation is efficient'. The governance section of the strategy 2019 highlighted they service wanted to 'ensure all investigations and RCA's are completed within the agreed timescale of 45 days. The strategy also included pathology and physiotherapy.

We asked senior managers across the service about the vision and strategy and were told this was aligned with the overall hospital and Spire strategy.

Staff had been involved in the development of the strategy of the hospital and service which involved staff attending an event which assisted in the development of the strategy.

The hospital provided information stating they had recently introduced a new Spire purpose which was completed using workshops with staff.

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.

Overall, morale across the department was good. Staff felt supported, respected and valued by the hospital and described good teamwork across the services. We were told there was openness and honesty. There were regular staff meetings to share information and discuss issues or challenges.

Staff and leaders, we spoke with could describe the duty of candour.

There was a poster called 'Have your voice heard' which highlighted ways to have your voice heard and referenced the freedom to speak up guardian and the whistleblowing policy. There was a hospital freedom to speak up guardian.

The hospital provided information stating staff had access to an assistance line for staff wellbeing.

Good

Outpatients

Governance

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

Leaders we spoke with could describe the governance arrangements for the department which included daily meetings and a hospital wide weekly governance meeting. Leaders could describe the ward to board governance arrangements and were told incidents were reported via the incident reporting form and staff would speak with managers. Where there was a serious incident, this would be discussed with the senior leadership team. Risks and governance issues were also discussed at the daily meetings which included any issues from the previous day. Each week incidents were discussed at the weekly clinical governance meeting. There was also a weekly meeting which senior managers such as the hospital director and director of clinical services attended and included representatives from the medical advisory committee.

The clinical governance meeting from December 2019 showed for example, agenda items such as clinical effectiveness, clinical audit and matters to escalate to the clinical governance committee or senior management team.

Incidents across the service were sent to the department manager for initial investigation. The clinical governance lead also had oversight of incidents.

Leaders told us their assurance around patient safety came from the daily huddles which for example included items such as safe staffing and how many patients were attending. We were told leaders asked staff if they had any concerns on the day. The clinical scorecard was also used to assist in providing assurance to department leaders and the leadership team.

There was an annual plan for governance and improvement for 2019. This included information such as improving the audit structure, continuing to build and promote a prominent safety culture and utilising national documents on patient safety to improve the quality of care.

The clinical governance and audit committee meeting minutes from July 2019 included information such as National institute for Health and Care Excellence guidance to review, the clinical scorecard, mandatory training and audits.

The service had produced a quarterly clinical governance report, we saw the quarter two 2019 report. This documented the priorities and challenges across the services, adverse events, safeguarding, safe staffing, clinical scorecard information, patient satisfaction survey and complaints.

There was a medical advisory committee which leaders told us they had good links with and the hospital provided information stating they provided medical advice and support to the hospital.

We were told the oncology service had service level agreements with local healthcare providers.

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.

There was a risk management policy available to staff which had a review date of July 2021. The policy included various sections, for example on the process for managing risk and the risk register.

The service utilised risk registers to assist in managing and monitoring risks across the service. The hospital had a hospital wide risk register which included risks for example from pathology and oncology. This risk register had a key controls and actions section.

Leaders used performance reports and information to monitor and manage the risks, issues and performance across outpatients' services.

Leaders attended a daily meeting which was in place to ensure the departments could plan for the days work and ensure staff were aware of any safety information.

The hospital provided information showing there were service level agreements in place with other providers as required and this document showed what the service level agreements were for and whether they were in date and valid.

Good

Outpatients

The outpatient staff meeting minutes from October 2019 showed for example, agenda items such as the risk register update, mandatory training update, complaints and lessons learned. The outpatient managers meeting from November 2019 showed for example, agenda items such as incidents, competencies, issues and the monthly safety brief.

There was a business continuity document with a review date of July 2022.

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 had access to the required information systems. Staff could access the intranet for information and news about the hospital. Policies and procedures were available on the hospital intranet and there were folders available in the department with relevant policies and procedures available for staff to access. Staff had access to an information technology team for support as required.

Leaders had access to performance reports and there was performance and risk information on display in staff areas. These enabled staff to understand the risk across the services along with being able to access relevant information and news about the various departments.

Information systems were used across the department to provide care and treatment to patients. There was also access to information systems to enable risk to be managed such as the incident reporting system.

There was information on display regarding the accessible information standard in the hospital.

Leaders in outpatients told us there had been no recent information governance breaches.

Engagement

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

The service utilised friends and family tests to gather feedback and enable improvements to be made if required.

There was an annual staff survey to enable staff to provide feedback to the leadership team. Leaders told us this had improved on the previous year and there were no areas of significant concern. The hospital produced staff and consultant newsletters, held monthly staff forums and staff told us there were monthly team meetings across the outpatient department.

The service provided further information stating they produced three clinical newsletters which included a monthly safety update, monthly lessons learnt and an infection prevention newsletter. The hospital had awards for staff which contributed to staff engagement.

The service provided information stating they had engaged with external groups and planned to provide a talk to promote the services offered at the hospital.

The main waiting area had a board which highlighted the senior management team at the hospital.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The department had implemented a safe staffing tool to ensure the appropriate number of staff were on duty as required throughout the day in outpatients.

The oncology team in outpatients had a long established breast cancer support group in the service which met monthly. This included for example, holistic therapy sessions.

The services shared risk and governance information on notice boards in the various departments for staff to view.

There were plans to introduce a patient experience lead in 2020 to contribute to the hospital patient experience work.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

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

We rated it as **good.**

Mandatory training

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

The hospital set a target of 95% for mandatory training for staff. The information provided by the service showed the compliance for diagnostic imaging across all mandatory training modules was 95% or above for all modules except one where compliance was 90%. The date for remaining staff to complete the training was March 2020.

Staff received and kept up to date with their mandatory training. Mandatory training was provided as a mixture of e-learning and face to face training depending on the training course. Where staff were not up to date with training, leaders told us they were booked on to complete the training. Training compliance records, for example the resuscitation training log highlighted staff were booked on to complete training.

The department management maintained oversight of mandatory training compliance and leaders had access to electronic systems which enabled them to monitor training compliance levels across the services.

The mandatory training included training modules such as safeguarding, information governance and infection control amongst other modules.

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 safeguarding policies in place which staff could access.

The hospital had safeguarding leads in place and these were the clinical governance lead and a lead physiotherapist for children and young persons. These staff were available for support and advice and we were told these staff were trained to level four safeguarding. We saw safeguarding training compliance levels which showed the different levels of safeguarding staff were trained to. The level four safeguarding training was provided at another Spire site.

Staff we spoke with could describe the action they would take if they had safeguarding concerns for adults or children. Safeguarding posters were on display in the department.

Staff could describe using the 'pause and check' checklist which we were told had been adapted to include the three-point identification checks. The three-point identification check included name, date of birth and address. We saw evidence of the three-point checks in records seen. The 'paused and check' checklist was on display in departments during the inspection. The 'paused and check' poster is a clinical imaging operator

checklist used in radiology departments for procedures. The pause part of the checklist indicates patient, anatomy, user checks, systems and settings checks, exposure and draw to a close.

We requested compliance levels for safeguarding adults and children split by the safeguarding level. The hospital provided information on safeguarding training compliance as at 17 December 2019.

Compliance with safeguarding adults and children level two was 97% and safeguarding children level three was 70% and adults 100%. This showed that fourteen staff had completed level three safeguarding children training and one staff member was trained to level three safeguarding adults.

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.

Areas visited were visibly clean and tidy. During the inspection we saw staff adhering to 'bare arms below the elbow' and also saw posters on display regarding this in various areas. Hand sanitiser was available and there were hand washing sinks available in the areas visited. Personal protective equipment was available in the department, for example gloves and aprons.

Staff told us ultrasound probes were cleaned after each patient with specialist cleaning wipes. Scanning beds were wiped down after each patient as needed and a new paper cover was put on the scanner bed.

The clinical governance lead for the services was also the infection prevention lead and staff could contact the infection prevention lead for advice and support as required.

Information provided by the provider highlighted there had been no infections in diagnostic imaging and staff told us if there was an infection, a root cause analysis would be completed along with an incident form. Staff told us patients with a communicable disease would be allocated to the end of a clinic list and there would be a deep clean afterwards as required.

There was daily cleaning in the radiology department and waste disposal available for various types of waste across the radiology services. We found cleaning logs had been completed as required across diagnostic imaging. We saw 'I am clean' stickers in use across the department.

Staff had access to an infection prevention and control policy which had a review date of February 2022. There was also a management of MRSA policy which had a review date of April 2020. The meeting document from July 2019 for the infection prevention committee included agenda items for example, such as antimicrobial stewardship and management of risks.

The departments completed hand hygiene audits on the environment, observation and technique. The hand hygiene audit showed 100% compliance across radiology services.

Environment and equipment

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

The diagnostic imaging department was located along a corridor next to the outpatient corridor. There was a reception area where patients could check in and speak with reception staff and there was a waiting area with seating available. This waiting area had a television, water dispenser and information for patients on display. There was changing facilities available in the department for patients to use when they were having scans.

Patients checked in at the main hospital reception and would be directed to the diagnostic imaging department. Toilets were available in the department.

The various departments within the diagnostic imaging unit had relevant warning signage on display to highlight restricted areas to staff, patients and visitors. The x-ray areas had lights warning of x-rays. There was also warning signage such as 'authorised persons only' on display.

There were three reporting rooms available in the department for staff to report scans.

There was also a quiet room available for patient and visitor use in the waiting area. There was a children's and young person's activity area in the main waiting area which had small tables and chairs alongside books.

There was waste disposal available in the department for clinical and non-clinical waste.

The department had a resuscitation trolley available for use. We checked recent dates for these and these were checked as required. The resuscitation trolleys were checked daily and the trolleys were secured.

There was signage directing staff and visitors to the various parts of the department. Wheelchairs were available for patient use across the department.

Staff had access to personal protective equipment such as lead aprons. These were available in each of the imaging rooms. There was enough equipment for staff to use and computers were available in the department. The hospital had a maintenance team which staff could contact if required. There was access to an information technology team for advice and support as required.

We visited the magnetic resonance imaging unit (MRI) and found equipment was MR compatible and staff told us they did not remove the equipment or bring other equipment into the MRI room. For example, there was an MR safe wheelchair and MR safe trolley in the room and there was equipment with MR safe stickers attached.

The MRI unit had warning signage on display to highlight the risks to staff and patients. Patients had to complete a safety questionnaire before they could enter the MRI unit with staff.

Equipment such as lead aprons had annual audits to check for the lead apron integrity. Staff wore dosimeters where applicable to monitor exposure to radiation. There was a daily huddle board on display in the department and the dosimeter information was put on this board to inform the staff whether there were any issues or not.

The services took part in the patient led assessments of the care environment (PLACE) audits and the report from 2019 included radiology. The report showed all relevant questions for the cleanliness part of the audit had passed. The patient led assessment of the care environment (PLACE) report for radiology showed 99.09% compliance for cleanliness and 97.62% for condition, appearance and maintenance.

There was a document on display in the staff office for equipment which showed the equipment available and the servicing dates.

There were consumable expiry date check logs on display in the department and the logs seen were completed as required.

There was a maintenance and planned preventative maintenance schedule for equipment in the diagnostic imaging department. This showed the equipment which had been serviced, the number of services and the dates. This ensured the management team in the diagnostic imaging department had oversight of planned preventative maintenance for equipment.

Assessing and responding to patient risk

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

The department had access to an external medical physics expert, radiation protection expert and the department had two radiation protection supervisors for advice. The radiation protection supervisors worked across magnetic resonance imaging (MRI) and computed tomography (CT). Staff told us they had access to a radiologist for advice as needed.

Where patients were clinically unwell or deteriorated in the department, staff would call the hospital resuscitation team and had access to a resuscitation trolley. The resuscitation equipment was checked regularly and records confirmed it had been checked daily as required. Where a patient was clinically unwell or deteriorated in the MR imaging room, staff would transfer the patients to a trolley and remove the patient from the room. There was an emergency protocol in place to remove the patient from the scanner if required.

The service had local rules in place for staff to follow for their speciality area. These were on display in the various areas of the department. Patients attending the MR department had to complete a safety form prior to entering the scanning area. Staff could describe the critical care pathways for patients and there was a resident medical officer available on site for advice as needed.

The World Health Organisation (WHO) checklist was used for invasive procedures, for example injections. During the inspection, we saw one of these safety checklists completed as required in the department.

Staff in the department wore dosimeters and these were changed every two months. These were worn to monitor the staff exposure to radiation in the department.

Staff told us patients receiving contrast in the CT department stayed in the department for around 30 minutes after the procedure for safety precautions. Staff completed basic life support training as part of mandatory training.

There were diagnostic reference levels on display in the various areas of the department. There was a procedure in the reporting room for significant findings on scans.

The safety forms used in the MRI department included questions, for example regarding pregnancy. This form was completed prior to patients going in for a scan and these were then scanned onto the electronic system for record keeping.

Staff used the 'paused and check' checklist in the department to check the correct patient was receiving the correct scan. We were told this was audited and we saw audits completed by the service and the recent results had been positive. A previous month had not shown 100% compliance and the department leaders had put actions in place to address this and checked the documents for a week to ensure staff were completing the checks.

Risk assessments had been completed for various risks across the department. For example, there was an IRR17 radiation hazard and risk assessment for the general radiology room fluoroscopy. Fluoroscopy is a type of imaging which uses x-rays. This detailed who assessed the hazard, detailed a brief description of the work undertaken, list of existing documented control measures and the recording of any identified actions. The last review date was August 2018 with a three-yearly review scheduled.

Lead apron audits were completed annually to check for the lead apron integrity and there was a list available for staff detailing the ongoing lead apron audits. Leaders told us they would replace the aprons where issues were identified during the audits.

Leaders told us staff would receive a debrief where required if there had been an incident in the department. There were patient emergency buttons in the scanning rooms. There were anaphylactic packs in the department. These packs were sealed and in date. For example, the pack contained adrenaline. These packs were provided by the pharmacy department.

Where appropriate, we were told the service would try and access previous images and if possible and appropriate, the service would try and use these.

There was a local MRI safety policy with a review date of January 2023. There was also a radiation safety policy which had a review date of June 2021.

There were posters on display in the department regarding 'How safe are x-rays'.

There was a resident medical officer on site at the hospital.

Diagnostic Imaging 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 and agency staff a full induction.

Leaders told us there were no concerns with staffing levels in the diagnostic imaging department and the department had only one vacancy which they were recruiting to. This was for a whole-time equivalent radiographer. There were five radiographers in the department. There was one assistant practitioner and healthcare assistant in the department.

Staffing rotas were planned seven days in advance and took into account the type and number of imaging services the department had. Rotas were on display in the staff offices. Staff worked on shifts between 08:30 and 20:00 Monday to Friday and there was on-call for out of hours. Staff in the MRI and CT department were trained in both areas so there was additional flexibility in the service where required.

Staffing was displayed on the notice board in the department. On the day of the inspection, the planned staffing level was for four staff in diagnostic imaging and the actual documented on the notice board was four staff.

Good

Diagnostic imaging

The department manager or a representative attended the hospital multidisciplinary team huddle each morning where safe staffing was discussed.

Oversight of staffing was maintained by the leadership team and where required and there were vacancies, the service would recruit. Where needed to ensure staffing levels were as required, bank staff would be utilised.

The hospital had access to a safe staffing policy with a review date of April 2022.

Medical staffing

For our detailed findings on medical staffing please see the Safe section in the surgery report.

Medical staff worked at the hospital under practising privileges and worked in the diagnostic imaging department as required or as planned with the managers in the department. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice or within the provision of community services.

Leaders told us there were no concerns with availability of Radiologists and where required they would recruit and that as a contingency and if required, the department could contact other Spire hospitals elsewhere for assistance in remote reporting. The radiologists were not always on site but were accessible and available for advice and support. The radiologists had set sessions and times for attending the department.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were stored securely and easily available to all staff providing care.

Records were kept electronically, and scans were available electronically after the scan was complete. There was electronic access to scans and results across the hospital. Where paper safety checklists were used, these were scanned onto the system. Records were stored securely at the time of the inspection.

We reviewed fifteen records during the inspection and found these to be mostly completed as required. For example, we saw evidence of identification checks and patient information included. Although we did see four records which did not have all the checks documented. We raised this with managers at the inspection and they were going to address it.

Managers also showed us recent referral proforma review audit results which showed between January and March 2019 there were two records without documented pregnancy checks out of twenty sets of records audited. The audit between April and June 2019 showed 100% compliance of the same checks. Between October and December 2019/2020, the audit results showed 100% compliance for checking whether a person may be pregnant or not.

There was evidence of multidisciplinary team working in the records. MRI safety forms we saw were completed as required.

The hospital provided further information on the processes which assisted in managing the risk if a patient was to attend and the records were not available. The hospital stated the administration manager reported to the daily huddle if there were any records unavailable for patients attending that day and that actions would be taken by staff to locate the records in time for the patient attending the hospital.

There was a patient records policy which had a review date of September 2022.

Medicines

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

For our detailed findings on medicines please see the Safe section in the surgery report

Medicines seen during the inspection were stored securely and the medicine cupboard keys were kept by a registered professional or locked away in a cupboard. Medicines seen during the inspection were found to be in date. The department did not keep any controlled drugs or prescription pads.

We looked at patient group directions (legal framework which allows registered health professionals to supply

and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber) used in the department and found all to be in date and signed by the appropriate individuals.

Refrigerator checks were found to have been completed daily as required. The rooms had consumable and medicine expiry checklists on display and the ones we saw were completed as required.

There was a pharmacy department with dedicated pharmacy staff available where support and advice could be sought. There was a management of medicines policy available to staff which had a review date of October 2019, however the document stated it had been extended for six months whilst it was under review.

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.

The service had an incident reporting policy which had a review date of January 2022.

There had been no never events or serious incidents across diagnostic imaging in the previous 12 months. There had been two IRMER incidents in the department, although staff had contacted the radiation protection advisor, and these had not been reportable incidents to the Care Quality Commission. Staff had completed reflective practice from these incidents and leaders had shared the lessons learnt from these incidents at the November 2019 team meeting. These were documented in the team meeting minutes so staff who were not in attendance could read them.

We saw an example of the actions and learning document from an incident which showed the action required, outcome measure, who was leading on the action and the date due to be completed. This confirmed the actions had been completed in November 2019.

The department had not reported any IRMER notifications to the Care Quality Commission in the previous 12 months. There was an IRMER incident log on display in the manager's office.

The department staff had access to an electronic incident reporting system in diagnostic imaging and staff we spoke with were aware of this system and could describe how they would report an incident. There had been 33 incidents in the previous 12 months, of which 25 were reported as no harm, seven reported as low harm and one as moderate harm.

Leaders in the department would investigate the incidents or would ask the relevant person to investigate the incident and we were told the clinical governance lead also had oversight of incidents across the service. Root cause analysis were completed for serious incidents if they occurred and the hospital provided information highlighting they were supported by a national patient safety team.

Staff we spoke with could describe the duty of candour. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Are diagnostic imaging services effective?

We do not rate effective in diagnostic imaging.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were available and accessible through the hospital systems. Policies viewed as part of our inspection were found to be in date. Staff in the service had access to policies such as incident reporting, mental capacity act and deprivation of liberty safeguards and the chaperone policy amongst others.

There was a folder which included examples of the royal college of radiologists guidance, for example the standards for intravascular contrast administration to adult patients.

Good

Diagnostic imaging

Diagnostic reference levels (DRL) were used in the department and these were on display in areas visited. These were not audited annually, although the department did have a book in which any issues with diagnostic reference levels would be logged for reference.

Information provided by the hospital highlighted it used various tools to monitor and benchmark the services against other providers, for example the national clinical scorecard.

The services across the hospital had access to an annual audit programme 2019 which highlighted the various audits that were completed by the services, for example the records audits. The quality audit schedule which was displayed in the manager's office and showed audits such as hand hygiene and infection prevention were completed.

Information provided by the hospital highlighted the services followed the Spire care pathways which had been developed for the specialties and aligned to best practice and guidelines.

Nutrition and hydration

There was drinks available for patients attending the department. Staff told us they could provide patients with food and drink if required and for example, if a patient was a diabetic patient. Leaders told us the hospital had recently started to provide hot food until 8pm.

The service provided information stating they could tailor menus to meet the needs of patients dietary requirements.

Pain relief

Pain relief was not generally provided in diagnostic imaging, although there were medical staff available on site for advice if required and where needed the service could provide some pain relief.

Patient outcomes

The services at the hospital participated in a number of audits.

Leaders told us the medical staff were part of discrepancy meetings at their respective trusts.

Safety checklists were use in the department for invasive procedures to contribute to patient safety.

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 received appraisals which were three times a year. These were overseen and managed by the leaders of the department. Appraisals were an opportunity to discuss objectives for the year. Staff told us there was opportunity for development and continued professional development. Compliance with appraisals was 100%.

Staff had received radiation safety training which had been delivered through a presentation and the service provided three types of course to staff depending on their role. For example, there was a presentation for staff who directly worked in the department and a presentation for staff who may work in the department but not all of the time, for example engineering staff. The training slides for this routine radiation worker training showed it included training on IRMER 2017 and lessons learnt from the regulators.

Three staff had attended the radiation protection supervisors' course.

There was a video available for staff who do not always work in the MR department for staff to watch regarding MR safety.

Some of the radiographers had attended study days in November 2019 for continued professional development and some staff had visited MRI departments in other hospitals to keep up to date with evidence based practice.

There was a document for clinical supervision which referenced the policy and this document highlighted that it was available to staff and to contact the people highlighted on the document to arrange clinical supervision. The clinical supervision policy had a review date of March 2021.

Staff received an induction programme to the hospital when they started working at the service.

There were competencies which staff were required to complete and there were two types of competency, the

Good

Diagnostic imaging

level two competency for new staff and a level three competency for staff who had previous experience. The competency packs included mandatory training and the induction training.

The department had an education lead.

Multidisciplinary working

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

For our main findings please refer to the surgery report.

There were radiographers, assistant practitioners, healthcare assistants, radiologists, reception staff and managers working collaboratively to meet the needs of patients using the diagnostic imaging services.

The department was part of the one-stop breast clinic where staff worked together across departments to provide one-stop services to patients and to reduce the number of repeat visits they needed to make to the hospital.

Seven-day services

The department was open Monday to Friday between 08:30 and 20:00. The department was also open on a Saturday between 08:30 and 12:30. The department was closed on Sundays. Staff were on call when the department was closed for any emergency scans.

A computed tomography (CT) scan service was scheduled every Thursday but was available for more urgent scans seven days a week.

Health promotion

There were patient information leaflets and posters on display regarding the various specialties across the hospital and diagnostic imaging department.

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.

There was a deprivation of liberty safeguards policy with a review date of October 2019, however the policy stated it was currently under review and the review date had been extended by six months. Staff had access to a consent to investigation or treatment policy with a review date of September 2021.

Patients told us consent was taken as required in the clinics. Staff could describe gaining verbal consent in the diagnostic imaging department and described taking written consent for invasive procedures such as injection. Records seen showed consent forms being signed.

Staff we spoke with understood consent. We saw evidence of consent in the patient notes reviewed.

Are diagnostic imaging services caring?

Good

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

We rated it as **good.**

Compassionate care

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

The reception was in a separate room to the waiting area so patients could speak with reception staff without being overhead to contribute to privacy and dignity in the department. The patient led assessment of the care environment (PLACE) report for radiology showed 100% compliance for privacy in the assessment.

Chaperones were available in the department and there were posters on display regarding this in the department and the waiting areas.

Privacy and dignity was maintained in the department by ensuring doors were closed where required and there were changing rooms in the department. 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 spoke with four patients during our inspection and patient feedback was positive.

Good

Diagnostic imaging

Results from a patient experience survey from October to December in 2019 showed 97% of respondents were likely to recommend the service. Of the respondents, 95% said the service met or exceeded their expectations.

Emotional support

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

Staff responded to patients where they may be anxious or claustrophobic and could offer visits to the department before appointments to address patient concerns.

Patients told us staff were friendly and caring and patients received relevant information before their examination.

Additional appointment and scanning time could be provided to patients if additional support and care was required. There was equipment such as items to cover the eyes of patients if they required this to reduce patient anxiety during their MRI scan.

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 provided information to patients and explained the procedures to the patients. Patients told us they knew who to contact if they had any concerns after the procedure or scan.

Staff supported patients to make informed decisions about their care. Staff communicated with patients throughout their treatment and procedures in the department. Where required, patients' families were involved and could stay with patients during their scans if requested and appropriate.

There was information regarding x-ray's available and on display in the waiting room to provide further information on x-ray safety to patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

The patient experience survey results from November 2019 which were completed across the hospital showed 75% of appointments were on time, 14% were up to 15 minutes late and other appointments were delayed over 15 minutes.

Are diagnostic imaging services responsive?

Good

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

We rated it as **good.**

Service delivery to meet the needs of local people

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

For our main findings please refer to the surgery report.

The diagnostic imaging department provided a variety of scans to meet the needs of patients. The diagnostic imaging leadership team worked together to deliver the services to patients. Leaders across the services worked with other internal and external teams to manage services, for example some teams met with clinical commissioning groups (CCG) to plan and deliver services according to the needs of the population.

The services received referrals from local NHS healthcare providers and we were told there were service level agreements in place for these services. Waiting list information showed waiting times were less than six weeks across all services.

The hospital had introduced one stop breast clinics. These clinics enabled patients to attend to visit a doctor and a mammogram or ultrasound could be performed along with results. The one stop clinic included the diagnostic imaging department and scans would be reported during the one stop clinics.

Leaders received a monthly report regarding 'did not attend' appointments and we were told the service

monitored these and would contact the patient if they 'did not attend' appointments. The hospital had undertaken work for the local NHS which had a 'did not attend' rate between August 2019 and January 2020 at 8.2%. We saw a 'did not attend' action plan which highlighted the action taken when a patient 'did not attend' their appointment. The administrative team would try and contact the patient twice and then send a letter if required. If the patient had been referred from another hospital, the team would refer this back to the hospital.

Parking was available on site.

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.

For our main findings please refer to the surgery report.

The service had access to translation services. Information was on display in various areas of the department in different languages regarding access to interpreters. There were a range of patient information leaflets available throughout the department. There were posters on display asking whether a patient may be pregnant and these were in different languages.

There was a quiet room available in the department which could be used for patients who may be anxious or where patients preferred a quieter environment. Appointment scanning times varied depending on the type of scan and needs of the patient.

There were staff who had completed online training on how to care for patients living with dementia. Staff had access to a dementia champion who was available for advice and support. The service would make reasonable arrangements as required for patients and adjustments could be made for patients when referral forms were received and reviewed and additional needs were identified.

Patients were offered a choice of appointments and provided with information prior to the examination.

The provider highlighted some imaging equipment had a weight limit, therefore some patients were not suitable for imaging at the hospital. For patients accessing bariatric services, specialist equipment could be brought from the ward to support the appointment as needed e.g. bariatric chairs.

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.

Request for scans were put in the administration team protocol tray. The radiography staff would then process and vet these requests and state the scan and time required on the document. During the inspection we were told, procedures which were ready to be appointed would be done so and the wait time would generally be less than five days. Appointment times were allocated depending on what the patient was having done.

We were told all patients had an appointment booked in and no patients were waiting on a list for an appointment. There were procedures where patients would be required to complete a questionnaire prior to the appointment being booked and where this was required, the administration team would send the patient a letter asking them to contact the hospital. Once this questionnaire was complete the team could book an appointment.

The average number of days from receipt of the request to the date of the test across all specialties in diagnostic imaging was 8.8 days.

We were told that as long as there was a referral from the patient's general practitioner, patients could access the x-ray service the same day or the next day. Information from December 2019 on waiting times showed the average number of days from receipt of the request to the date of the test for an x-ray was 1.5 days.

Waiting times showed the average number of days from receipt of the request to the date of the test for an MRI scan was 20 days.

Waiting times showed the average number of days from receipt of the request to the date of the test for an ultrasound was 20.4 days.

Good

Diagnostic imaging

Waiting times showed the average number of days from receipt of the request to the date of the test for fluoroscopy was 2.1 days.

Waiting times showed the average number of days from receipt of the request to the date of the test for an CT scan was 7.6 days. This was a scheduled weekly service, not available every day.

Waiting times showed the average number of days from receipt of the request to the date of the test for Barium procedures was 18.5 days.

The service was meeting the six-week waiting time indicator and we were told during the inspection all specialties were within four weeks for waiting times. The only time where there would be a wait of over six weeks would be if it was patient choice. Information showed only 1.6% of patients waited more than 42 days for an appointment.

The service had previously completed an audit of waiting times for patients whilst in the department. Leaders told us this had not highlighted any issues with waiting times when in the department. The audit in ultrasound on the 23 July 2019 showed the longest wait when in the department was ten minutes. In fluoroscopy, MRI and CT, the longest wait was 20 minutes.

We asked about waiting times for patients for reporting and were told the radiologists had specific times they came in to report on scans and we were told it would not be longer than five working days for any reporting across all specialties in diagnostic imaging. Information we saw for October 2019 to December 2019 for all procedures regarding reporting times showed CT scans had an average of 1.52 working days for reporting turnaround times, MRI had an average of 1.97 working days for reporting turnaround times and x-ray had an average of one working day for reporting turnaround times.

The reporting turnaround times audits for October to December in 2019 across all areas of the department showed 97% of reporting was done within 5 days of the scan.

Two scanning slots were kept open each day to ensure urgent and priority scans could be accommodated. We were told the medical staff would inform the administration team if the appointment required was urgent and the team would liaise with the relevant team, for example the MRI team. The urgent slots could be used for these urgent and priority referrals.

We were told reporting of scans was based on the priority and urgency of the report. For example, the system highlighted scans that must be reported and categorised as urgent in orange. There was a document on display in the reporting room which highlighted the requirement to report on scans which were categorised as orange.

We were told cancelled scans by the service were rare and did not happen often. Where they did happen, the hospital would contact the patient and reappoint as required. Between August 2019 and January 2020, CT had cancelled 0.5% of their appointments, MRI had cancelled 0.7% of their appointments, Ultrasound had cancelled 0.3% of their appointments, fluoroscopy had cancelled 1.5% of their appointments and x-ray had cancelled 3.8% of their appointments.

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.

There had been three complaints in the previous 12 months relating to the diagnostic imaging service.

There were posters on display in the department advising patients and visitors on how to complain to the service. Leaders told us they attempted to address complaints informally if appropriate, however encouraged patients and visitors to complain if they were unsatisfied with the service and it could not be dealt with informally.

Complaints could be raised with the hospital through email and there was a section on the website regarding complaints. Patients told us they knew how to make a complaint if required.

Staff and leaders had access to a complaints policy. This had a review date of September 2021.

Where complaints were received they were investigated by the leaders of the department and we were told where there was learning from complaints available, this would be shared at the team meetings or the daily huddles. Team meeting information was also provided to staff who

could not attend. The clinical governance April to June 2019 report highlighted that learning from complaints would be cascaded to relevant departments through departmental leads at team meetings and minutes. This report also highlighted learning from complaints through the incident and complaints learning outcomes newsletter, clinical governance quarterly newsletters and safety brief and team lead events.

The complaints log detailed the learning outcomes and the actions taken from the complaints.

Are diagnostic imaging services well-led?

Good

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

We rated it as **good.**

Leadership

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

The hospital had a management structure which included a hospital director and director of clinical services. Managers in the department reported to the director of clinical services, however we were told they could also contact the hospital director if required. There was a clear management structure in the diagnostic imaging department. There was a department manager and there were senior radiographers working in the department. The service had access to a maintenance team at the hospital who we were told we accessible and available.

The hospital had a meetings organisational chart for 2019 which showed there were meetings across the hospital, for example a complaints meeting, risk committee, infection prevention meeting, clinical governance committee and the hospital leadership meeting. The diagnostic imaging department had a morning huddle where they discussed staffing and the service tried to have a monthly team meeting where they discussed any diagnostic imaging issues and information from the hospital was communicated to the team.

Diagnostic Imaging was discussed as part of the regular hospital leadership team meetings. For example, the hospital leadership team meeting from July 2019 included diagnostic imaging as an agenda item.

Leaders understood the challenges faced by the department and could describe these along with the risks associated with the risk register.

Leaders utilised business cases as required to develop the services provided. Leaders told us quality and safety was considered as part of business cases.

Feedback regarding leadership in the hospital was positive and we were told leaders were visible and approachable. We were told leaders had an open-door policy and could be contacted as required by staff.

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 which was to be recognised as a world class healthcare business and the hospital had a set of values which included driving clinical excellence, doing the right thing, caring is our passion, keeping it simple, delivering on our promises and succeeding and celebrating together.

There was a documented strategy for the diagnostic imaging department. For example, the radiology strategy included increase customer satisfactions for insured and self payors by providing an appointment within 48 hours or at the convenience of the client, support the breast service by providing 2 additional imaging specialists that are able to perform mammography, ensure that self-pay customers are issued with a formal quote for their imaging costs and ensure green key performance indicators whilst providing safe and efficient staffing levels.

Good

Diagnostic imaging

We asked senior managers across the service about the vision and strategy and were told this was aligned with the overall hospital and Spire strategy.

Staff had been involved in the development of the strategy of the hospital and service which involved staff attending an event which assisted in the development of the strategy.

The hospital provided information stating they had recently introduced a new Spire purpose which was completed using workshops with staff.

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.

Overall, morale across the department was good. Staff felt supported, respected and valued by the hospital and described good teamwork across the services. We were told there was openness and honesty. There were regular staff meetings to share information and discuss issues or challenges.

The November 2019 team meeting included agenda items such as mandatory training, the risk register, complaints, business and financial updates and the safety brief.

There was a poster called 'Have your voice heard' which highlighted ways to have your voice heard and referenced the freedom to speak up guardian and the whistleblowing policy. There was a hospital freedom to speak up guardian.

The hospital provided information stating staff had access to an assistance line for staff wellbeing.

Governance

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

Leaders we spoke with could describe the governance arrangements for the department which included daily meetings and a hospital wide weekly governance meeting. Leaders could describe the ward to board governance arrangements and were told incidents were reported via the incident reporting form and staff would speak with managers. Where there was a serious incident, this would be discussed with the senior leadership team. Risks and governance issues were also discussed at the daily meetings which included any issues from the previous day. Each week incidents were discussed at the weekly clinical governance meeting. There was also a weekly meeting which senior managers such as the hospital director and director of clinical services attended and included the medical advisory committee chair.

There were annual radiation protection committee meetings with the external radiation protection advisor and the leaders in the department.

The clinical governance meeting from December 2019 showed for example, agenda items such as clinical effectiveness, clinical audit and matters to escalate to the clinical governance committee or senior management team.

Incidents across the service were sent to the department manager for initial investigation. The clinical governance lead also had oversight of incidents.

Leaders told us their assurance around patient safety came from the daily huddles which for example included items such as safe staffing and how many patients were attending. We were told leaders asked staff if they had any concerns on the day. The clinical scorecard was also used to assist in providing assurance to department leaders and the leadership team.

There was an annual plan for governance and improvement for 2019. This included information such as improving the audit structure, continuing to build and promote a prominent safety culture and utilising national documents on patient safety to improve the quality of care.

The clinical governance and audit committee meeting minutes from July 2019 included information such as National institute of Care and Clinical Excellence guidance to review, the clinical scorecard, mandatory training and audits.

The service had produced a quarterly clinical governance April to June 2019 report. This documented the priorities and challenges across the services, adverse events, safeguarding, safe staffing, clinical scorecard information, patient satisfaction survey and complaints.

There was a medical advisory committee which leaders told us they had good links with and the hospital provided information stating they provided medical advice and support to the hospital.

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.

There was a risk management policy available to staff which had a review date of July 2021. The policy included various sections, for example on the process for managing risk and the risk register.

Staff had access to radiation protection supervisors and external radiation protection advisors for advice and support. Staff told us they worked well with the external teams.

Leaders could describe the quality assurance programme to ensure equipment was serviced and maintained as required. There were folders for each of the scanners and rooms which included servicing reports and dates of previous servicing of the equipment. The different areas within the department led on their own quality assurance on a monthly basis and leaders described the daily or weekly testing which would be done on the equipment. The department had an external team come in and complete some of the quality assurance.

The service had an annual radiation protection meeting and from this received a report and recommendations or actions if required. The service had an ongoing action plan. There was one outstanding action and the most recent audit was in late 2019. The radiation protection advisor and staff from the hospital attended this meeting and there was terms of reference for the radiation protection committee meeting. The last meeting was September 2019. The agenda included discussion of the RPA audit report, MPE report feedback and radiology incidents.

The service utilised risk registers to assist in managing and monitoring risks across the service. The diagnostic imaging risk register included three risks. These were radiology equipment breakdown causing patient cancellations and delayed diagnosis. This risk register documented the key controls which for example included, annual physicist inspection, local quality assurance performed by RPS, equipment replacement plan in place, regular maintenance on equipment and the service contract in place. The second risk was a compliance risk regarding discrepancy audits which leaders told us medical staff participated in their trust discrepancy audits. Medical staff completed a form at the hospital to confirm this. The third risk was staff absence, recruitment and retention reducing the departments capacity and efficiency. Leaders told us action to this included ongoing recruitment and using bank staff.

Leaders told us they did consider reject analysis across the department and the team were required to document what they had rejected. The target was less than 2%. In January 2020 this was 0.5%. Reject analysis is the analysis of images which were rejected.

Leaders used performance reports and information to monitor and manage the risks, issues and performance across outpatients' services. Leaders had access to a radiology quality dashboard. Leaders attended a daily meeting which was in place to ensure the departments could plan for the day's work and ensure staff were aware of any safety information.

There was a communication diary which included information that staff could read when they were not in the department at the time the information was shared with staff. The staff meeting agenda was emailed to staff.

The service level agreement for services provided to the diagnostic imaging department was in date with a review date of March 2020.

The mammography room had an uninterrupted power supply and the hospital and department had access to a backup generator.

There was a business continuity document with a review date of July 2022.

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 submitted to external organisations as required.

Staff had access to the required information systems. Staff could access the intranet for information and news about the hospital. Policies and procedures were available on the hospital intranet and there were folders available in the department with relevant policies and procedures available for staff to access. Staff had access to an information technology team for support as required.

There was access to the electronic scans through the systems in the hospital and staff told us results would be emailed back to the referrer, for example the general practitioner.

Leaders had access to performance reports and there was performance and risk information on display in staff areas. These enabled staff to understand the risk across the services along with being able to access relevant information and news about the various departments.

Information systems were used across the department to provide care and treatment to patients. There was also access to information systems to enable risk to be managed such as the incident reporting system.

There was information on display regarding the accessible information standard in the hospital.

Leaders in diagnostic imaging told us there had been no recent information governance breaches.

Engagement

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

The service utilised friends and family tests to gather feedback and enable improvements to be made if required. There was a 'have your voice heard' poster and we saw 'you said, we did' information on display in the department.

There was an annual staff survey to enable staff to provide feedback to the leadership team. Leaders told us this had improved on the previous year and there were no areas of significant concern. The hospital produced staff and consultant newsletters, held monthly staff forums and staff told us there were monthly team meetings across the department.

The service provided further information stating they produced three clinical newsletters which included a monthly safety update, monthly lessons learnt and an infection prevention newsletter. The hospital had awards for staff which contributed to staff engagement.

The service provided information stating they had engaged with external groups and planned to provide a talk to promote the services offered at the hospital.

The main waiting area had a board which highlighted the senior management team at the hospital.

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 services shared risk and governance information on notice boards in the various departments for staff to view.

There were plans to introduce a patient experience lead in 2020 to contribute to the hospital patient experience work.

Where required, the diagnostic imaging service was part of the one stop services the hospital offered to patients.

The department management was part of the daily hospital meeting and information provided by the hospital highlighted these meetings ensured the departments could plan for the day's activity and be aware of key safety information.

Good

Termination of pregnancy

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

Are termination of pregnancy services safe?

Good

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 consultants who led this service were employed by a local NHS trust, and, as part of the process of acquisition and maintenance of their practising privileges with Spire Washington Hospital, they provided evidence of ongoing mandatory training and professional development in their NHS trust roles.

Specific training in termination of pregnancy was not part of the induction training or mandatory training packages for all Spire Washington Hospital staff, as staff were permitted to opt out of treating and/or caring for patients who used this service. For those staff who did treat and care for these patients, the lead consultant provided regular training sessions, at least annually, covering areas specific to the service.

Staff we spoke with confirmed that they were up-to-date with mandatory training.

Staff we spoke with also told us that they were allowed sufficient time to complete mandatory training and were encouraged to develop professionally.

See also information under this sub-heading in the surgery section.

Safeguarding

Staff understood how to protect women from abuse. They had training on how to recognise and report abuse, and they knew how to apply it.

The hospital had up-to-date safeguarding policies for adults and children, and staff we spoke with were aware of these policies and related procedures. They could describe what they would do if they were to have concerns about the safety of a vulnerable adult or child. The service did not treat children under 18 years old and any patient presenting at this age would be referred to NHS services.

The lead nurses for the service were trained to safeguarding level 3 for both vulnerable adults and children. They worked closely with the hospital lead for safeguarding, who was trained to level 4.

All other staff, including those in non-clinical roles, were trained to at least level 2.

Staff underwent annual refresher training in safeguarding.

Safeguarding information was clearly visible on information points on the ward.

Staff were aware of child sexual exploitation (CSE) and female genital mutilation (FGM), and they could explain what they would do if they were to become concerned about signs of one or both of these in any woman using the service.

Local commissioners had carried out a safeguarding assurance visit to the hospital a few weeks prior to our inspection, and they had concluded that there were robust processes in place for safeguarding adults.

Staff told us that any lessons learned from safeguarding concerns would be disseminated through regular staff meetings and via safety briefings, which were issued to all staff.

See also information under this sub-heading in the surgery section.

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.

The hospital had an up-to-date infection prevention and control policy, and staff we spoke with were aware of the policy and related procedures.

All wards, clinical areas, and non-clinical areas were visibly clean. Theatre equipment bore 'I am clean' stickers, which were updated between each usage following cleaning.

Clear information about infection control was displayed throughout the hospital.

The clinical governance lead for the hospital was also the infection prevention lead, and they were available to staff for advice and support as required.

Separate hand-washing basins, hand wash, and hand sanitizer were available on the wards, in theatres, and in waiting areas. There was also a supply of personal protective equipment, including gloves and aprons.

We observed staff following good hand-hygiene practice, including washing their hands and using hand gel between instances of patient contact. Staff adhered to the bare-below-the-elbow rule.

All patients undergoing elective surgery who met the hospital's screening criteria were screened for Methicillin-resistant Staphylococcus Aureus (MRSA), and there were procedures in place to isolate patients when appropriate, in accordance with infection control policies.

There were no reported cases of Clostridium Difficile, MRSA or Meticillin-sensitive Staphylococcus aureus (MSSA) within the service during the 12 months prior to our inspection.

Staff told us that any woman using the service for who had a communicable disease would be allocated to the end of a clinic or theatre list and there would be a deep clean of the theatre after use.

Standards of cleanliness were monitored, and infection control audits were completed every month to monitor compliance with key organisational policies such as hand hygiene. An annual plan showed all infection control audit results.

There had been no instances of surgical-site infection in patients who had undergone surgical termination of pregnancy during the 12 months prior to our inspection. For further information on infection control please see surgery report.

The 2018 Patient-led Assessment of the Care Environment (PLACE) audit rated the hospital at 99.41% for cleanliness, which was better than the national average (98.5%).

See also information under this sub-heading in the surgery section.

Environment and equipment

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

The hospital reception had a private room nearby, which was available on request to anyone attending who wished to speak to a receptionist without being overheard.

The reception and waiting areas were comfortable and spacious, with adjacent toilets, drinks machines, and plenty of seating.

There were four general-purpose consulting rooms available to the service. These were spacious and comfortable.

The ward comprised a corridor of single rooms, each with en-suite bathroom facilities. The rooms were fitted with suction equipment, piped oxygen, and emergency call facilities. There was a nurses' station at the centre point of the ward corridor.

There were four theatres including a JAG accredited endoscopy theatre, and five adjacent recovery areas available to the service, with the smallest of the four theatres being that mainly used by the service. We inspected this theatre and found that it was spacious and fitted with laminar airflow equipment.

Resuscitation equipment was available in case of emergency and was checked daily to ensure that it was operational. Records showed that checks were complete and up-to-date. The equipment was also serviced regularly, in line with the hospital's policy.

We checked a sample of single-use items and found that they were each in good condition, sealed, and within-date.

Safety testing of electrical equipment had been carried out, and labels were clear and within-date.

See also information under this sub-heading in the surgery section.

Assessing and responding to patient risk

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

All patients were risk-assessed at the point of admission, and national early warning scores (NEWS) were recorded during all nursing observations. All surgical terminations of pregnancy were carried out under general anaesthetic. For further information regarding anaesthetic cover please see the surgery report.

Pregnancy testing was carried out at the initial consultation with the service, to confirm the pregnancy, and women using the service then underwent an ultra-sound scan to determine gestation of the pregnancy, unless formal results of a dating scan carried out elsewhere were available.

Screening for sexually-transmitted infections (STIs) was offered at the initial consultation to all women using the service.

Before each surgical termination, a risk-based pre-op assessment was carried out, in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG). This included a pre-op assessment by the anaesthetist and a venous thromboembolism assessment.

Prior to termination procedures all women should have a blood test to identify their blood group, so that any patient who has a rhesus-negative blood group can be given an injection of anti-D to protect against complications in any future pregnancy. The records that we reviewed demonstrated that each woman using the service underwent a blood test prior to the termination procedure, and each of those who had a rhesus-negative blood group received an anti-D injection.

Women undergoing medical termination of pregnancy (MToP) were required to be readmitted to the hospital for the second stage of the medical treatment; there was no option to take the second treatment home, and the lead consultant told us that, given the small size of the service, he had no plans to offer this as an option

There were clear patient pathways for the service, including escalation policy for the deteriorating patient.

Nursing staff had good access to medical support in the event a patient's condition were to deteriorate. If the patient's consultant gynaecologist was not available on site, they could be contacted at any time by telephone and would return to the hospital as quickly as possible. The lead consultant told us that they did not operate at any time when they would not be available to the patient over the following 24 hours.

Should a patient require urgent medical attention, staff could call upon the resident medical officer (RMO), who was available on site 24 hours per day every day.

There were emergency transfer arrangements in place to local NHS hospitals should they be required.

Women with special conditions such as fetal anomaly and ectopic pregnancy were not treated at the hospital; they were referred to local NHS providers.

See also information under this sub-heading in the surgery section.

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.

Either the lead nurse for the service or the ward manager who was trained in this service was on site whenever a woman attended for a termination and during any post-op recovery. Because the number of procedures carried out was so small, this could be planned in advance by liaison between the consultant carrying out the procedure and the appropriate nursing staff.

There was also always at least one sister or senior nurse also on duty.

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.

Both consultants who carried out the termination of pregnancy service held weekly gynaecology clinics at the hospital. They did not use locum cover; they would provide cover for each other when required.

A consultant who accepted a woman for a termination of pregnancy procedure was responsible for the full episode of her care. Admissions were therefore booked in a way that ensured the consultant would be available for the whole time required to provide safe care. Staff told us that consultants were always available should they need support.

The hospital held information outlining consultant-cover arrangements electronically. All staff could access this information. Information regarding anaesthetic cover can be found in the surgery report.

Records

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

Patient records were paper-based. We reviewed five sets of patient records for the service; we found these to be clear, compliant with hospital policies, and well-organised. Records bore clear dates, times, and designations of the persons completing the documents.

All sets of notes recorded informed consent, current medicines, allergies, medical history, and family history. Notes relating to surgical terminations also contained an anaesthetics record. Care pathways were completed clearly.

There was some use of green ink within the notes. This was less easy-to-read than notes completed in standard black ink.

Patient information and records were stored safety and securely in lockable cabinets, in line with the Data Protection Act 2018.

Staff followed local protocols to ensure that patient records were made available to consultants and other relevant staff in a timely and accessible way when women attended for clinic appointments and for termination procedures.

Record-keeping and documentation audits were carried out monthly within the service. We reviewed these audits for each of the six months prior to our inspection and found that compliance was 100% every month.

Medicines

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

Only registered medical practitioners are legally permitted to prescribe medicine that is intended to procure a miscarriage. All medicines were prescribed by one of the HSA1 signatories who was a consultant.

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.

The hospital had an up-to-date incident-reporting policy and used an electronic system to report incidents. All staff we spoke with told us that they were encouraged to report incidents and near misses. Staff were familiar with how to use the system and understood the importance of reporting.

In the 12 months prior to our inspection there had been no incidents relating to termination of pregnancy patients or procedures.

Staff we spoke with told us that they received feedback on incidents they had reported.

Good

Termination of pregnancy

Hospital governance meetings were held weekly, and there was opportunity for learning from incidents within the service at these meetings. Information about reported incidents was shared and discussed, and relevant risk assessments were updated. Learning and actions were cascaded to clinical staff at local team meetings.

Duty of candour applies when things go wrong with care and treatment; a service must be open and honest with patients and other relevant persons, giving them reasonable support, truthful information, and, in some cases, a written apology. Staff we spoke with understood the principles of their Duty of Candour towards patients and could explain what they should and would do in such circumstances.

Are termination of pregnancy services effective?

Good

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 evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients who were subject to the Mental Health Act 1983.

Consultants providing this service adhered to Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, The Abortion Act 1967, and other legislation relevant to termination of pregnancy.

Policies relating to the service had been developed in line with Department of Health Required Standard Operating Procedures (RSOP) relating to termination of pregnancy. Staff followed a local work instruction for termination of pregnancy based on RSOP that also included standard operating procedures specific to Spire Washington Hospital and best practice following RCOG clinical guidelines for medical and surgical terminations.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Women who were to undergo surgical termination of pregnancy were given clear advice about how long they would need to fast prior to the procedure.

Women experiencing nausea and/or vomiting were formally assessed using a scoring system, and this assessment was recorded and monitored

Water was available at all times, and other beverages were offered regularly to women who were not required to fast.

A variety of food was available, including vegetarian, gluten-free, and lighter options.

The hospital catered for a variety of cultural and religious preferences.

The hospital took care to ensure that food allergies were recorded and brought to the attention of kitchen staff.

Pain relief

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

Pre and post-procedural pain relief was prescribed for all women using the service, where required.

The National Early Warning Score (NEWS) charts used by the hospital included a pain assessment scale. Patients records we reviewed showed that pain had been assessed in each case and pain relief offered where appropriate.

Nursing staff told us that, following medical termination of pregnancy, they would ask the patient about pain during nursing observations. If further pain relief was required, the consultant gynaecologist would be asked to reassess the patient. Should the consultant be unavailable, the resident medical officer (RMO) would be asked to assess the patient for pain relief.

Following surgical abortion, the anaesthetist would visit patients on the ward to check pain levels and prescribe further pain relief as necessary.

No patient was discharged without a full assessment by their consultant.

Patient outcomes

Good

Termination of pregnancy

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

The service carried out 15 medical terminations of pregnancy and seven surgical terminations of pregnancy in the 12-month period between August 2018 and July 2019. All women who underwent medical termination of pregnancy were required to attend the hospital on two separate occasions, two days apart, to take the medicines required. There was no option to take the second medicine at home. This meant that women were on site for the second part of the procedure, and staff could monitor the process closely.

All women who underwent surgical termination of pregnancy had the procedure within five working days of their initial outpatient appointment. This was compliant with RCOG and RSOP guidance.

No patient who had undergone surgical termination of pregnancy in the 12 months prior to our inspection had required a return to theatre. There had been no unplanned transfers to NHS trust hospitals, no failed terminations, and no instances of retained products following surgery.

The lead staff nurse for the service carried out a monthly audit of terminations of pregnancies, examining patient records for compliance with legal reporting requirements, consent for procedure and disposal of pregnancy remains, drug prescription and dispensing, and care pathways followed. Compliance was consistently 100% in the 12 months prior to our inspection.

A full audit of all terminations of pregnancies was also carried out annually by the deputy director of clinical services. We reviewed the most recent of these, from January 2019.

Only 50% of patient records for women who had undergone termination of pregnancy at the hospital during the period covered by the audit (September 2017 to October 2018) showed that the consultant had offered screening for sexually-transmitted infections (STIs). This fell short of the hospital's target of 100%. Actions to address this shortfall were noted in the audit documentation. These included reminding the consultants of the need to both offer screening and record that it had been offered.

Compliance with all other measures covered by the audit was at least 96% and was 100% in most cases. Actions to address the small shortfalls were noted in the audit documentation. These included reminding the consultants of the omitted factors, amending the consultation history sheet to show where the missing information should be recorded, and introducing the use of labels in patient records.

Records that we reviewed during the inspection indicated that, for the measures audited, compliance with hospital targets had improved.

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.

To acquire and maintain practising privileges with Spire Washington Hospital, the consultants providing its termination of pregnancy services had provided evidence of annual whole-practice appraisal, indemnity cover, an up-to-date disclosure and barring service (DBS) report, and up-to-date HEP B, HEP C, and HIV status.

All new staff were supported through an induction process, which included competence-based training relevant to their general nursing roles. However, staff at the hospital were not subject to any specific formal training or competency assessments in respect of termination of pregnancy. Instead, informal training was provided to those caring for women using the service by its lead consultant.

Staff we spoke with told us that they had annual appraisals and that these were up-to-date. There were also six-monthly reviews for each member of staff, and an additional review would be arranged should there be any change to practice or concern about individual competency.

See also information under this sub-heading in the surgery section.

Multidisciplinary working

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

Good

Termination of pregnancy

Medical staff, nursing staff, allied health professionals and other, non-clinical, staff told us that they worked well together as a team and that the service had clear lines of accountability.

The hospital had service level agreements with neighbouring NHS trusts which allowed them to transfer a patient to the hospitals in case of medical or surgical emergency.

Seven-day services

Services were not available seven days per week, but advice to patients was accessible at all times, to support timely patient care.

The gynaecology-outpatient clinics, which women seeking a termination of pregnancy would attend, were held on only one weekday, during the afternoon and evening.

Most terminations of pregnancies at the hospital were carried out as day procedures. However, facilities were available for overnight stays where required.

Terminations were arranged at times that were mutually convenient to the patient and consultant.

The Department of Health and Social Care Required Standard Operating Procedures (RSOP) set out that women should have access to a 24-hour advice line which specialises in post-termination support and care. Staff told us that, should any woman call the hospital with concerns or questions following a termination, a message would be taken and passed to her consultant, who would then contact her with advice, either directly or via the hospital staff. The lead consultant confirmed that they were always available for contact by patients for at least 24 hours following a termination procedure.

Health promotion

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

Women who used the service were provided with information about contraception. Any woman who chose not to start a contraception method immediately following a termination was given information about local contraception providers and/or encouraged to see her GP.

Information about national health-improvement priorities was also available; for example, the service provided information about sources of support to quit smoking and reduce alcohol intake.

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.

Staff were clear about their roles and responsibilities under the Mental Capacity Act 2005. They were able to describe what they should and would do if they were concerned about a women's capacity to make an informed decision to undergo a termination procedure. No children were seen by the service.

There had been no instances in which staff had had concerns about the capacity of a woman using the service to make an informed decision in the 12 months prior to our inspection. Staff gained consent from women according to the policy of the hospital and also ensured that women were certain of their decision.

Are termination of pregnancy services caring?

Not sufficient evidence to rate

We had insufficient evidence to rate 'caring' within this service.

Compassionate care

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

There were no women attending clinics or the ward for consultation, procedure, or advice during our inspection. We were therefore unable to observe the way patients were treated by staff.

Staff described to us how they treated women with compassion, kindness, dignity, and respect.

Emotional support

Good

Termination of pregnancy

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

All women who sought to use the service were offered counselling prior to a termination of pregnancy procedure. Details of professional pregnancy and termination counsellors were given to women at their initial consultations.

Following a termination procedure, women were also offered counselling and were given information and names and contact details for counsellors.

Nursing staff told us that they would answer any queries and offer support in the 24 hours following a termination procedure.

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 told us that women's preferences for sharing information with their partners and/or family members were established, respected, and reviewed throughout their care.

Staff told us that a nurse would offer to be present during consultations and examinations, or the woman could bring her own chaperone.

Although we were unable to observe any initial assessments, staff told us that they explained the available methods for termination of pregnancy that were appropriate and safe to each woman. The consultant would consider gestational age and clinical needs when suggesting the most suitable option.

The records we reviewed recorded post-discharge support available for women and those close to them; women were given written information about accessing support in the 24 hours following their procedure.

Staff told us that they made women aware of the statutory requirement to return anonymised data to the Department of Health and Social Care on an HSA4 form. They explained how they reassured women that this was required for statistical purposes only and would not contain any information by which they could be identified.

Are termination of pregnancy services responsive?

Good

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

Service delivery to meet the needs of local people

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

The hospital's consultant gynaecologists usually provided appointments on one weekday afternoon and evening, however should a patient require a more immediate appointment, ad hoc clinics could be arranged.

The hospital was able to offer contact information for other Spire Healthcare Limited hospitals and/or local NHS trust hospitals if a woman expressed a preference for a different day, time, or location, or if she did not want to pay for the procedure or found the fee prohibitive.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

The service treated fit and healthy women without any unstable medical condition. Women who did not meet these criteria were referred to the most appropriate NHS provider to ensure that they received the treatment they required in a timely and safe way.

No women aged under 18 years underwent a termination of pregnancy at the hospital. Should any woman under 18 years old contact the hospital about this service, she would be referred to local NHS providers.

At initial consultation, women attending the service were given information leaflets about different options available for termination of pregnancy, including what to expect when undergoing a surgical or medical termination. They

were also given information about potential risks, counselling services, and sensitive disposal of the pregnancy remains. This information was available in other languages and accessible formats if required.

A professional interpreting service was available face to face or via telephone to enable staff to communicate with women whose first language was not English. There were also staff within the hospital who spoke other languages fluently and had agreed to be called upon to translate basic information or put patients at ease. Staff told us that they would always use the interpreting service to ensure the patient understood, and could therefore make an informed decision about, the termination procedure.

Staff told us that support was available for women with learning disabilities or other complex needs.

Nurses and medical staff undertaking pre-surgical assessments had a range of information available to them that they could give to women as required. This included advice on contraception, sexually-transmitted infections, services to support women who were victims of domestic violence, and how to access sexual-health clinics.

Following a termination procedure, women were given leaflets which explained what to expect in the subsequent 24 hours, to support the verbal information that they had already been given. These leaflets were available in other languages and accessible formats if required.

The hospital had a policy for the disposal of pregnancy remains. Women using the service were provided with an information sheet which explained how the pregnancy remains would be managed. In all cases, pregnancy remains were stored securely, before being collected and transported to the pathology department of a neighbouring NHS hospital for respectful cremation.

During the 12 months prior to our inspection, no woman using the service had expressed an interest in disposing of pregnancy remains herself, but staff told us that this could be accommodated by collection of remains from the hospital's pathology department. Staff in the pathology department confirmed that they were aware that this might be requested and that they knew how to respond to such a request.

Access and flow

Women received care promptly. Waiting times from referral to treatment and arrangements to admit, treat, and discharge patients were in line with national standards.

Most women using the service self -referred or were referred by their GPs. Those who self-referred were asked whether they wanted their GPs to be informed by letter about their treatment and care. Their decisions were recorded, and their wishes were respected.

The service monitored its performance against waiting-time guidance from RCOG and RSOP. No woman waited longer than the recommended time of five working days from referral to consultation, and none waited longer than five working days from decision to proceed to termination of pregnancy.

Women who had undergone a surgical termination procedure were offered a follow-up appointment, but staff told us that women did not usually accept this offer.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service had processes to treat concerns and complaints seriously, investigate them, and share lessons learned with all staff. It had processes to include patients in the investigation of their complaint.

The hospital had a clear and up-to-date complaints policy. Staff we spoke with were aware of the policy and of how to guide any woman in their care who might wish to make a complaint.

The complaints process appeared robust, with any themes or trends identified being marked for review by the clinical governance lead, senior management team, and medical advisory committee. Actions to be taken, outcomes, and lessons learned were to be shared with clinical teams and all departments.

Staff we spoke with told us that patients would be given opportunity to raise concerns with any staff member whilst at the hospital; all staff would know how to help a patient to access the complaints process. Staff said that they felt empowered to attempt to resolve situations themselves where appropriate.

Leaflets explaining the complaints policy were available in reception, on the ward, and in consultation rooms.

Good

Termination of pregnancy

The service had not received any complaints in the 12 months prior to our inspection.

Are termination of pregnancy services well-led?

Good

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

Leadership

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

The Department of Health and Social Care certificate of approval for carrying out termination of pregnancy was displayed at the hospital entrance.

Staff we spoke with told us that they were supported by the consultants who led the service and would feel able to raise concerns with them.

See also information under this sub-heading in the surgery section.

Vision and strategy

There was no separate vision or strategy for the termination of pregnancy service within the hospital.

Culture

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

Staff we spoke with told us that they felt respected, supported, and valued by leaders of the service. Leaders spoke about staff in a respectful and caring way.

Staff displayed a caring, compassionate, and supportive attitude to the care they delivered to women seeking and undergoing terminations of pregnancy and were focused on the needs of these women.

Staff described the service as having an open culture, in which patients, their families, and staff could raise concerns without fear.

See also information under this sub-heading in the surgery section.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities.

Staff had access to both online and hard copies of electronic and paper access to relevant guidelines, policies, and procedures in respect of termination of pregnancy, to support and guide them in their work. Staff we spoke with knew how to access these and whom they could consult for additional support and information. They were clear about their roles and accountabilities.

There was no delegation of duty in relation to medical termination of pregnancy; medicines were administered by the woman's consultant, in line with hospital policy.

The service ensured that conscientious objection was managed appropriately by allowing staff to opt out of caring for patients who were undergoing procedures to terminate pregnancy.

The consultants who led the service measured outcomes and processes against other private services in the region, using these to form locally-agreed standards against which performance could be audited.

If a woman using the service was unwilling/unable to involve her GP in signing the form that, under Section 1 of the abortion act 1967, must be completed, signed, and dated by two registered medical practitioners before a termination procedure can be carried out (form HSA1), the two consultants who provided the service at this hospital would make arrangements to review and countersign the forms of one another's patients within 24 hours. The resident medical officer would never be asked to countersign an HSA1 form.

In the five sets of records we reviewed, all gestations were 10 weeks or below prior to termination. All HSA1 forms had two appropriate signatures; one from the consultant carrying out the procedure and the second from either the patient's GP or another consultant carrying out terminations at this hospital. Completed HSA1 Forms were audited monthly, these audits showed that the second signatory either saw the patient in person or reviewed their records.

Good

Termination of pregnancy

See also information under this sub-heading in the surgery section.

Managing risks, issues, and performance

Leaders and staff 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.

See information under this sub-heading in the surgery section.

Managing information

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

Paper records were stored securely on site for 12 months before being transferred to a national record-storage centre, from where they could be retrieved if required.

The lead staff nurse for the service carried out a monthly audit of terminations of pregnancies, examining patient records for compliance with legal reporting requirements, consent for procedure and disposal of pregnancy remains, drug prescription and dispensing, and care pathways followed. Compliance was consistently 100% in the 12 months prior to our inspection.

A full audit of all terminations of pregnancies was also carried out annually by the deputy director of clinical services. There were arrangements to ensure that information was used to monitor, manage and report on quality and performance. These include a range of audits, monthly and annually. However, actions were not always taken to address the gaps in audit performance for example in the screening of STIs.

Patient information and records were stored safety and securely in lockable cabinets, in line with the Data Protection Act 2018.

The Department of Health and Social Care (DHSC) requires hospitals to maintain registers of women undergoing terminations of pregnancy. The service kept paper registers, which were mostly completed clearly and accurately. During our inspection we pointed out a small number of inconsistencies of process, and these were rectified immediately. Additionally, some recent procedures had not yet been entered in the appropriate register(s), but the service had plans to rectify this and had begun to carry them out.

The DHSC requires every provider undertaking termination of pregnancy to submit demographical data following each procedure, using an HSA4 form. We saw that this data had been collected at initial consultations and passed to the DHSC within the 14 day deadline

Engagement

Leaders and staff engaged with patients and each other to plan and manage services.

See information under this sub-heading in the surgery section.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Consultant gynaecologists provided the service using skills and experience gained in their NHS posts. Although there was no formal training on site for staff caring for women who were undergoing termination of pregnancy procedures, the lead consultant carried out regular informal training sessions with these staff.

Outstanding practice and areas for improvement

Outstanding practice

The hospital provided information for local GPs by holding training courses and education lunch and learning and evening sessions for GPs. The hospital offered a varied GP education programme responsive to current 'hot topics' demonstrating an example of a systematic approach being taken to work with other organisations to improve care outcomes for patients.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure patient records are always signed by the consultant.
- The provider should consider ways to ensure all safety checklists used in outpatients are completed as required.
- The provider should improve consistency of practice in completing the WHO checklist.
- The service should ensure that all Department of Health and Social Care (DHSC) register entries relating to termination of pregnancy are made in a timely way.
- The service should make sure patients have the choice whether the second medication of misoprostol is taken at home or at the clinic.