# Spire Liverpool Hospital

## Quality Report

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

## Ratings

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Spire Liverpool Hospital is operated by Spire Healthcare Limited. The hospital offers surgery, outpatients and diagnostic imaging services. The hospital provides services for NHS and privately funded patients.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection of Spire Liverpool Hospital between 23 and 25 April 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided 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.

**Services we rate**

This is the first time we have rated this hospital. We rated it as **Good** overall.

We found the following areas of good practice:

- The service had enough staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff had training on how to recognise and report abuse and they knew how to apply it. Staff completed and updated risk assessments for each patient.
- The service controlled infection risk well. The service had suitable premises and equipment and looked after them well. The service followed best practice when prescribing, giving, recording and storing medicines.
- The service had enough nursing, medical, allied health professional and support staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service provided care and treatment based on national guidance and evidence of its effectiveness to achieve positive outcomes for patients.
- Managers appraised staff's work performance and made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff cared for patients with compassion, dignity and respect. Feedback from patients confirmed staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of local people. People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- There was a clear governance structure in place, which all staff we spoke with understood. The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

# Summary of findings

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

- Some patient records contained gaps and omissions, such as missing staff and patient signatures and rationale for treatment. This had also been identified by the service's own records audit processes.
- We found one patient had received treatment although they were out of the provider's usual admission / exclusion criteria. There was no medical record available to record the rationale for the surgery to take place outside of the services policy.
- The hospital's policy for reporting safeguarding incidents was not always followed by staff.
- Not all staff (such as consultants) directly reported patient safety incidents on the incident reporting system.
- Clean linen was not always suitably stored. However; the service had ordered new trollies to improve this and were awaiting delivery at the time of our inspection..
- Changes to the early warning system for monitoring deteriorating patients had not been fully embedded in the surgical 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  | 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.<br>We rated this service as good because it was safe, effective, caring, responsive to people's needs and well-led. |
| **Outpatients** | Good  | We rated this service as good because it was safe, caring, responsive to people's needs and well-led. We do not rate effective for outpatient services. |
| **Diagnostic imaging** | Good  | We rated this service as good because it was safe, caring, responsive to people's needs and well-led. We do not rate effective for diagnostic imaging services. |

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Good

# Spire Liverpool Hospital

**Services we looked at**

Surgery; Outpatients; Diagnostic imaging;

# Summary of this inspection

## Background to Spire Liverpool Hospital

Spire Liverpool Hospital is operated by Spire Healthcare Limited. The hospital was registered with the Care Quality Commission (CQC) by Spire Healthcare Limited in July 2016. Spire Liverpool Hospital is a private hospital in Liverpool, Merseyside. The hospital primarily serves the communities of Liverpool and its surrounding areas. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in place since registration with the CQC in July 2016. The current registered manager has been in post since August 2018 and is also the hospital director.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the first time we have inspected this hospital since registration with CQC in July 2016. The hospital was previously registered under a different provider.

The service is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury
- Diagnostic and screening

## Our inspection team

The team that inspected the service comprised a CQC lead inspector,four other CQC inspectors, and a specialist advisor with expertise in theatre nursing. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

## Information about Spire Liverpool Hospital

The hospital has three outpatient areas, two wards with a total of 30 single rooms, a six bedded day-case unit, four operating theatres (one of which is a mobile theatre and two are laminar flow theatres mainly used for orthopaedic surgery), a radiology department, an ultrasound scanner, a magnetic resonance imaging (MRI) scanner and a mobile computerised tomography (CT) scanner. The physiotherapy, pharmacy and sterile services are also available on site.

Day surgery and inpatient treatment is provided for patients including urology, ophthalmology, orthopaedics, pain injection, minor hand surgery, minor neurosurgery, ear, nose and throat (ENT), gynecology, endoscopies, general surgery (such as upper and lower gastrointestinal surgery) and cosmetic surgery.

The outpatient services provided by the hospital cover a wide range of specialties including neurology, orthopaedics, ear nose and throat (ENT), general medicine, physiotherapy, urology, audiology, ophthalmology and dermatology. The diagnostic and imaging department carries out routine x-rays as well as more complex tests such as magnetic resonance imaging (MRI) scans, computerised tomography (CT) scans and ultrasound scans.

As part of this inspection, we inspected the following core services:

- Surgery
- Outpatients
- Diagnostic imaging

We visited all outpatient areas, the diagnostic imaging department, all wards, the operating theatres and the mobile computerised tomography (CT) scanning unit. We spoke with 35 staff including registered nurses, health care staff, reception staff, ancillary staff maintenance staff,

# Summary of this inspection

medical staff, operating department practitioners, managers and senior managers. We spoke with 18 patients and four relatives. We also reviewed 41 sets of patient records.

The hospital does not provide surgical care for patients under the age of 16. Surgery is available for children and young people aged 16 to 17 years. Patients aged 16 and 17 years old can only be admitted for treatment following the completion of Gillick competency assessments by a trained paediatric (children's) nurse and deemed as suitable for adult clinical pathways. Children aged between three to 16 years have limited access to services for outpatient consultations or non-interventional procedures only.

The children and young people services provided at the hospital account for approximately 1.2% of all patient treatments, therefore we did not inspect this as a standalone core service. We have reported our findings relating to children and young people's services in the three core services we inspected as part of this inspection.

**Activity;**

- In the reporting period January to December 2018, there were 9,187 inpatient and day case episodes of care recorded at the hospital; of these 80% were NHS-funded and 20% other funded.
- 11% of all NHS-funded patients and 30% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 66,553 outpatient total attendances in the reporting period; of these 33% were other funded and 67% were NHS-funded.
- In the period between April 2018 and March 2019, there were 762 outpatient attendances by patients under 18 years of age. This included 42 attendances for diagnostic imaging services. All these were privately funded or insured patients.
- In the period between April 2018 and March 2019, there were 11,271 diagnostic imaging attendances; of these 45% were other funded and 55% were NHS-funded. The most frequent procedures carried out were; radiology (36%), magnetic resonance imaging (35%) and ultrasound (11%).

The hospital had 182 consultants working under practising privileges. This included 83 surgeons, 38 anaesthetists, 46 physicians and 15 radiologists. Two regular resident medical officer (RMO) worked on a two-week rota. The hospital employed 32.4 whole time equivalent registered nurses and theatre staff, 40.6 whole time equivalent theatre staff and care assistants and 113 other staff (including reception staff), as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

**Track record on safety** (January to December 2018)

- No Never events
- 887 clinical incidents; 740 no harm, 119 low harm, 28 moderate harm, no severe harm, no deaths
- No serious injuries
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- 123 complaints

**Services accredited by a national body:**

- SGS Accreditation for Sterile Services Department

**Services provided at the hospital under service level agreement:**

- Clinical and or non-clinical waste removal
- Interpreting services
- Laser protection service
- Maintenance of medical equipment
- Pathology and histology
- Blood matching
- RMO provision
- Patient transfers

# 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

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

- The service had enough staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff had training on how to recognise and report abuse and they knew how to apply it. Staff completed and updated risk assessments for each patient.
- Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. The service had suitable premises and equipment and looked after them well.
- The service followed best practice when prescribing, giving, recording and storing medicines. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

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

- Some patient records contained gaps and omissions, such as missing staff and patient signatures and rationale for treatment. This had also been identified by the service's own records audit processes.
- We found one patient had received treatment although they were out of the provider's usual admission / exclusion criteria. There was no medical record available to record the rationale for the surgery to take place outside of the services policy.
- The hospital's policy for reporting safeguarding incidents was not always followed by staff.
- Not all staff (such as consultants) directly reported patient safety incidents on the incident reporting system.
- Clean linen was not always suitably stored. However; the service had ordered new trollies to improve this and were awaiting delivery at the time of our inspection.
- Changes to the early warning system for monitoring deteriorating patients had not been fully embedded in the surgical service.

# Summary of this inspection

## Are services effective?

Good

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness to achieve positive outcomes for patients.
- Accurate and up-to-date information about the effectiveness of care and treatment was shared internally and externally. The information was used to improve outcomes for patients and any improvement plans were checked and monitored.
- Staff assessed and monitored patients regularly to see if they were in pain and administered appropriate pain relief.
- Managers appraised staff's work performance and made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

## Are services caring?

Good

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

- Staff responded compassionately when patients or their relatives needed help. Support was given by caring staff as and when required by patients to meet their individual needs.
- Feedback from patients confirmed staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress.
- Staff provided information to patients in a way they could understand. Patients were supported to understand their condition, care, treatment and any advice.

## Are services responsive?

Good

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

- The service planned and provided care and treatment in a way that met the needs of local people. Facilities and premises were appropriately adapted to meet the individual needs of patients.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

# Summary of this inspection

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

- The absence of the complaints lead led to a six-month period where complaint responses did not meet the services targets.

## Are services well-led?

Good

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

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Managers at every level demonstrated shared values that encouraged pride and positivity in the organisation and focussed attention on the needs and experiences of patients.
- The service had a clear vision and strategy to outline what it wanted to achieve and workable plans to turn it into action. Staff understood the vision and applied it in practice.
- There was a clear governance structure in place, which all staff we spoke with understood.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There were systems in place that supported improvement and innovation work.

# 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 |
| 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

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

This is the first time we have rated this service. We rated safe as good.

### Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure most staff completed it.**
- Staff received equality and diversity, compassion in practice and anti-bribery training once as part of their induction. Staff completed annual mandatory training in fire safety, information governance, infection control, health and safety and safeguarding adults and children. Moving and handling training took place every two years. Staff also received training in the sepsis six pathway.
- Information provided before the inspection showed 97% of staff had undertaken the mandatory training in 2018. Following the inspection, we received updated training figures up to April 2019. Ward staff had achieved 82% and theatre staff achieved 90.2% in meeting their mandatory training requirements the service was on target to achieve 95% of all mandatory training by the end of the calendar year (2019).
- Staff were required to complete annual mandatory training, both on line and face to face. Staff said they were well supported to undertake mandatory training and felt this had equipped them with the basic skills required to keep patients and others safe.

### Safeguarding

- **Staff understood their role in recognising and preventing potential abuse. There were systems in place to ensure that patients were appropriately protected.**
- Records showed 75% of theatre staff and 81% of ward staff had already completed level two safeguarding training for adults by April 2019 and that 71% of theatre staff and 72% of ward staff had completed level two safeguarding for children by April 2019. The target for April 2019 was 25% training completion which was exceeded. The deadline for the completion of training of the remaining staff was the end of December 2019.
- There was a tracker that ensured that when a patient under 18 years booked in, a member of staff with Safeguarding Level three training was on duty in the appropriate area.
- Staff who directly supported children and young people had also completed level three safeguarding training. There was a dedicated safeguarding lead to provide expert advice and guidance when necessary.
- Safeguarding information for visitors and staff was displayed in public areas to support them to identify the signs of abuse and inform the appropriate persons.
- Staff were able to tell us how they would recognise and report potential abuse in line with local and national safeguarding procedures. However, there was an inconsistent approach in actioning safeguarding concerns.

- We saw good practice where staff had involved dedicated safeguarding staff and other agencies when patients were at risk of, or had experienced, abuse. Staff had recognised and addressed safeguarding concerns in a manner that protected the patients. However, we saw an incident when a safeguarding concern had not been reported in a timely manner, plans were in place to protect the individual, but the lack of reporting did not meet the services own policy.
- There were up to date policies for safeguarding and protecting adults at risk and safeguarding children.
- Safeguarding concerns were monitored within the services incident and complaints process as needed. Significant concerns were monitored directly by the safeguarding lead who gave staff guidance and support as needed. Where there were lessons to be learnt this was cascaded to staff in a variety of means to make sure that staff could readily access the information and guidance
- There was information on Female Genital Mutilation (FGM) in the safeguarding adults and children's policies.
- Meeting minutes we looked at showed that safeguarding incidents were routinely discussed at clinical effectiveness meetings and clinical governance meetings (held every two months) to review trends and to share learning.
- The safeguarding lead (matron) told us safeguarding supervision took place approximately every six weeks to provide support and guidance and support for staff involved in safeguarding incidents. The safeguarding lead also attended external adult safeguarding meetings and child protection board meetings when required.

**Cleanliness, infection control and hygiene**

- **The service controlled infection risk well. They used control measures to prevent the spread of infection.**
- All ward and surgical areas viewed were visibly clean and were well-maintained.
- We saw hand gel dispensers and hand wash facilities throughout all the areas that we inspected. There was signage to remind patients, their carers and visitors to wash their hands or use the hand sanitising gel.
- Cleaning records viewed were up to date and demonstrated that all areas were checked appropriately and in accordance with the services policy.
- The Patient-Led Assessments of the Care Environment (PLACE) score for cleanliness in the service was 97.8% for 2018 this was marginally below the national average score for cleanliness of 98.5%. PLACE is a system for assessing the quality of the patient environment. It is an organisational voluntary patient-led self-assessment which takes place annually.
- Audits viewed, and staff spoken with demonstrated that staff adhered to infection control principles, including handwashing. Staff we saw were complaint with bare below the elbow guidelines.
- All patients were screened for potential infections (such as MRSA) prior to admittance and appropriate action taken as needed.
- Measures were in place for the decontamination of surgical instruments, and single usage equipment was disposed of after its use.
- Sharps bins were labelled and not over filled. We saw that foot operated clinical waste bins were in use. We saw suitable arrangements for the disposal of clinical waste in accordance with the services waste management policy.
- Storage of linen was on a trolley in the main corridor on a ward as the ward had been reorganised. This presented a potential infection risk that had been recognised by the service and suitable storage arrangements had been ordered, However, this were not in place at this visit and there was no clear date as to when they would be delivered or what arrangements were in place to manage the risk in the interim.
- The hospital had a named infection, prevention and control lead that was responsible for overseeing infection control processes and audits as well as producing an annual infection control plan and audit schedule. The matron was the director of infection prevention and control (DIPC) for the hospital.
- The hospital had an Infection Control Committee that held meetings every three months and was attended by representatives across the hospital's departments and a microbiologist. Meeting minutes for September 2018 and December 2018 showed discussions around infection control risks, policies and processes took place during these meetings.

**Environment and equipment**

- **The service had suitable premises and equipment and looked after them well.**

- Equipment suitable to assess and monitor patients' health was seen in clinical areas.
- Emergency trolleys and resuscitation equipment on the surgical wards and theatres were in date and monitored. The resuscitation trolleys contained equipment to assist staff to resuscitate patients.
- Doors to the theatre areas were secured by staff with the use of digital locks to prevent them from being accessed by unauthorised people.
- All patient bedrooms were well presented and decorated and all had access to private bathing facilities. Four bedrooms had been adapted for use for patients living with dementia.
- We saw evidence that in 2018 checks of the air ventilation in theatres had been carried out. The verification process comprised several tests to ensure compliance with the relevant Health Technical Memorandum (HTM).
- Daily morning surgical meetings were held to ensure that all staff had the required equipment for the surgeries planned for that day.
- Patients had access to call systems to summon help and assistance as needed. Call bells were tested daily in each clinical area and results were reported into the theatre safety huddle. The hospital monitored and reported call bell response times every three months.
- Maintenance issues were reported directly to the maintenance team and responded to in a timely manner. Maintenance issues and the response were discussed at the daily safety huddle undertaken at 9:30am for all leaders throughout the service. This allowed staff to escalate and resolve any equipment-related issues in a timely manner. The maintenance team had an electronic system that alerted them to checks that needed to be made such as legionella. Records viewed showed that all environmental safety checks such as fire risk assessment and Portable appliance testing (PAT) as examples were up to date and maintained patient safety.
- Specialist equipment used in surgery had a specific cleaning and safety testing schedule in place that was adhered too.
- The Patient-Led Assessments of the Care Environment (PLACE) score for the condition, appearance and maintenance domain was 89.84%, below the national average of 94.3%. The survey raised concerns with regards to bedrooms being tired and some chairs and blinds needing to be replaced. All of these had been addressed at the time of our inspection, including refurbishment of patient bedrooms and replacement of the chairs and blinds across the site.
- Recording systems were in place to ensure that details of specific implants and equipment could be provided rapidly to the health care products regulator. An implant register was kept within surgery of all cosmetic implants and prosthesis and serial numbers were also noted. We reviewed the register and found that it was legible, up to date and contained the necessary serial numbers of implants or prosthesis used.
- The theatre stock room was well organised, and the stock had been rotated. The theatre employed staff to work in the stock room to ensure that stock levels were well maintained and to ensure adequate daily supplies.

**Assessing and responding to patient risk**

- **There were defined systems, processes and standard operating procedures for the management of risk that were appropriate for the care setting and understood by staff.**
- Each ward and theatre area undertook a "huddle" each morning this was to review any risks including patient safety risk and plan how to address these. There was also a service wide huddle that we observed, this took place each day and provided a summary of any risks and staffing responses to all staff each day.
- A Safety Summit was held fortnightly to ensure rapid discussion and management of incidents, and effective action and learning. Learning was shared widely across the service through daily huddles and routine meetings.
- Paper patient records were available on wards and in theatre. Every patient received an appropriate assessment on admission which was updated if incidents occurred or the patients' condition changed.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the hospital. For example, Patients with an American Society of Anesthesiologists (ASA) physical status score of 3 and 4 were excluded. The patients attending to the hospital had an ASA score of 1 or 2. This meant patients that were generally healthy or suffered from mild systemic disease and considered to be "low risk" of developing complications during treatment.

- Patients with complex pre-existing medical conditions or a body mass index (BMI) of greater than 45 were also excluded from undergoing treatment at the hospital.
- Allergies were checked as part of the preoperative assessment and were checked again once the patient was admitted and rechecked again prior to anaesthetic.
- As part of the preoperative assessment process, patients completed a comprehensive questionnaire. These were reviewed at pre-assessment appointments to assess the suitability of patients for surgery and to carry out health assessments such as blood tests and swabs. It also gave an opportunity to ensure that patients were fully informed about the surgical procedure and the post-operative recovery period that included discharge and post-operative care.
- Risks to patients were assessed and monitored at pre-assessment, and then checked again prior to treatment. The assessment included risks relating to mobility, medical history, last menstrual period, bleeding risk, pressure ulcer risk and venous thromboembolism (VTE - blood clots). During our inspection we looked at patient records, which showed all risk assessments had been completed correctly.
- In response to a National Patient safety alert a theatre staff member devised a “Using an oxygen cylinder” training guide for staff. The National Patient Safety Alert identified there was a risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders. This training guide was a step to step visual guide on how to use an oxygen cylinder which was shared throughput the service.
- The service had a dedicated policy and service level agreement with a patient transport service to ensure patients who required support from other providers were transferred quickly.
- The service followed clear admission criteria to identify any risks associated with patients’ specific conditions. Pre-operative assessments and diagnostic investigations were undertaken before any decision on whether surgery would be offered.
- Staff used recognised risk assessment tools to monitor patients’ condition. Such as an early warning system which supported staff to monitor a patient’s condition and seek medical support as needed. The service had recently changed from NEWS (National Early warning system) to NEWS2. NEWS2 whilst similar the NEWS had a different parameter. We found one patient record where the NEWS2 parameters had not been recognised appropriately by staff or appropriate action taken when the NEWS2 score needed staff to seek further assistance. This showed that the changes to early warning system had not yet fully embedded in the service.
- Staff spoken with and records seen reflected that staff were aware of and dealt with any specific risk issues, such as falls.
- Staff followed the sepsis six pathway. Sepsis is a medical emergency that requires prompt treatment. Management of sepsis after admission is known as the "sepsis six". Staff could access the sepsis pathway on the intranet.
- We saw that World Health Organisation (WHO) surgical safety checklists were in place for all patients undergoing surgery. WHO checklists are a simple tool designed to improve the safety of surgical procedures.
- We observed three theatre teams undertaking the ‘five steps to safer surgery’ procedures, including the use of the WHO checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the ‘five steps to safer surgery’ procedures.
- The service undertook audits and set a target of 95% on compliance. The latest audit reviewing staff practice and records had a rate of 100% compliance on an observational audit and 96% compliance on the documentation audit.
- Following surgery, patients were provided a 24-hour helpline for advice and help if needed.
- For patients undergoing an assessment prior to surgery there was a nurse led assessment in place who assessed patients and referred this to an anaesthetist as needed. The nurse led assessment used a recognised scoring system of risk known as American Society of Anaesthesiologists (ASA). The service screened out any patients with an ASA risk score of above 2 as this was above their risk threshold. However, we saw that one patient had received treatment with an ASA score of 3 which is above the threshold for exclusion. There were no records available that evidence the rationale for the surgery to take place outside of the services policy. We discussed this with a manager to investigate and take appropriate action as needed.

- A medical emergency team (resuscitation) callout tracker has been designed by the hospital resuscitation lead. This has been shared nationally and implemented as a process across the Spire network as an example of best practice.
- The service reported that members of the theatre team had attended critically Ill transfer training to support the Cheshire and Mersey Critical Care standards for level three transfers.
- The service reported that operating department practitioners had attended difficult airway training and theatre staff had introduced a difficult airway visual alert system to flag any patients with previous airway problems or potential problems to the wider teams.

**Nursing and support staffing**

- **Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. Any staff shortages were responded to in a timely manner.**
- Managers had calculated the number and grade of nurses and healthcare assistants required to meet patients' individual needs. On the wards the service used a Spire Healthcare staffing tool developed in line with the safer staffing guidelines. This calculated the number of registered nurses required based on patient needs and dependency. The tool was used daily in advance to ensure that a safe ratio of staff was available. As surgery is elective staffing levels can be planned in advance of each shift
- Staffing was reviewed each day at the service huddle. Additionally, each areas safety huddle and took account and monitored staffing levels. Staff were shared across departments as appropriate.
- The ward manager could and did adjust staffing levels daily to take account of patients' needs. Adjustments were made where patients required higher levels of support and additional staff were needed.
- Theatres used the association of perioperative practice guidelines for staffing to calculate staffing levels in theatre and recovery areas.
- Records reviewed showed that the number of registered nurses, healthcare assistants and operating department staff on duty matched the numbers determined as safe.
- When necessary, managers deployed bank and agency staff to maintain safe staffing levels. Where bank and agency staff were used, they received an induction with arrangements made to match staff with wards they were familiar with.
- The service also had a clinical on call rota made up of senior nurses who were available to provide extra Registered Nurse cover on the wards if required due to short notice sickness, a member of staff having to leave a shift unexpectedly or to support with a patient transfer.

**Medical staffing**

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service had a service level agreement with an agency to supply two resident medical officers who worked rotating periods to cover the service 24 hours per day, seven days per week. The agency provided appropriate training for the resident medical officers.
- The service employed medical staff under practising privileges approved under comprehensive policies and procedures by the Medical Advisory Committee (MAC). Practising privileges is when, after appropriate checks, a medical practitioner is granted permission to work in an independent hospital or clinic.
- A contact list was maintained for all doctors with practising privileges and the consultant surgeon was responsible for ensuring alternative anaesthetic cover if their usual anaesthetist was not available. Consultants remained on call whilst they had a patient in the service and attended on request. To maintain practising privileges, doctors had to live within an accessible distance of the service to attend within 30 minutes. Spire Liverpool Hospital required all consultants to document cross cover arrangements in the event they are unable to be contacted. This was stored with their practicing privileges file.
- There was a doctor on site 24 hours a day to provide guidance and advice to staff. When necessary there were arrangements in place for the doctor to contact patients' consultants for additional advice if they were not in the service. Each day at the huddle the team determined in the responsible medical office (RMO) was well rested and fit for the day in order to maintain the safety of patients.

- Once the risk of post-operative complications had passed the patient's named anaesthetist remained on call to provide guidance and advice to staff out of hours. For the deteriorating patient there were two consultant physicians available for supporting surgeons if a patient became unwell secondary to a medical problem.

**Records**

- **Staff kept detailed records of patients' care and treatment.**
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely, in line with the data protection guidelines. We observed no records left out on the ward or theatre and were stored in lockable cabinets once used.
- Staff kept paper records of patients' care and treatment. We reviewed 23 sets of patient records. Patient records were largely complete, legible, and entries were timed, dated and signed. There was a clear written diagnosis of the patient's condition and a comprehensive management plan. We saw that there were some gaps in the record keeping such as missing signatures and rational for actions notes.
- All inpatient rooms had folder holders installed and a new process was launched in February 2019 for ease of access of monitoring records.
- Patients' records were stored securely and staff practices protected confidential information from being accessed by unauthorised persons.
- The service had undertaken its own audit of records in October 2018. This identified some gaps in the quality of the record keeping (such as gaps in intentional rounding records) and noted that progress was in place in maintaining the accuracy of records. More recent audit results from December 2018 and February 2019 showed improved performance, indicating actions had been taken to improve compliance.
- The surgical register in the operating theatre was completed and recorded procedures undertaken. Information included the names of surgeon and scrub nurse, the time each patient entered and left theatre, the patient's name and unique identifier as well as implants and swab counts. This enabled senior staff to check patients had received the appropriate support and who to approach when patients required follow up care or had concerns about their treatment.
- We observed patient records and saw that each patient that attended for surgery was placed on a pathway that ensured they received the appropriate care and treatment. Pathways were available to staff on the intranet for printing as required.
- Patient records we viewed were integrated to ensure that they contained all information from pre-assessment, through surgery, to the ward.
- Records contained evidence of input from patients' consultants and the multidisciplinary team (MDT), care plans, and risk assessments. Members of the multidisciplinary team wrote relevant information in the medical notes to ensure that information was shared appropriately.
- Staff confirmed there had not been any instance of patient records not being available in surgery when required.

**Medicines**

- **The service followed best practice when prescribing, giving and recording medicines.**
- We looked at how medicines were given at the correct time. We saw for most of the patients the prescriber's instructions for medicines had been correctly followed.
- There were arrangements for managing medicines, medical gases and contrast media. Registered nurses were able to explain the process for safe administration of medicines and were aware of policies on preparation and administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management. We saw that there was an up to date policy for the safe storage, recording of, administration and disposal of medicines. This was available for staff on the intranet.
- Members of the pharmacy team reviewed patient's records, so their medicines were available and up to date.
- We observed that the majority of medicines were appropriately stored in suitable locked cabinets. Patient medicines could be locked in small cabinets in their rooms and staff held the keys.
- Patients' weights, known allergies and any sensitivities to medicines were recorded on the medicine charts to support staff to prescribe and administer the correct dose of medicine and reduce the risk of it being given in error or causing harm.

- We reviewed prescription and medicine records and found them all to be legible, dated and signed, allergies documented and saw antibiotics were administered appropriately.
- Fridges were all within normal ranges which meant that medicines were stored at the correct temperatures. Staff completed daily fridge temperature checks in line with the hospital policy. On one ward the temperature of the room that medicines were stored in was medicines had been consistently over the manufacturer's instructions for a minimum of three weeks. The service was aware of this and had made arrangements for an air conditioning unit to be put into place. In the interim the service had a risk-based approach to monitor that the medicines efficacy remained suitable in line with the provider's policy.
- Controlled drugs which require special storage and recording were stored and monitored appropriately. This prevented them from being accessed or administered by people who were not authorised to do so.
- There were blood fridges available. The fridges had key pad entry and appeared visibly clean, and temperature records were maintained.
- Patients were counselled and educated about their medicines prior to discharge. This supported patients to continue to receive their medicines as prescribed once they had left the hospital.
- Pharmacists provided cover daily and at weekends and operated a 24/7 on call service to meet the demands of the service. Managers we spoke with confirmed that they received adequate support from this service.
- The hospital ward completed medicines audits. The most recent audit, sent prior to inspection, of November 2018 showed that there were some areas of improvement needed regarding records. An action plan was in place and more recent audit results for February 2019 showed improved performance at the time of our inspection indicating the actions taken had been effective.
- Sepsis treatment kits were available. The kits were sealed, within their expiry date and stored securely in the medicine store rooms. There were kits available for patients with allergies to specific antibiotics.
- Patients were encouraged to be independent, we saw evidence that some patients were given the option to self-administer some of their own medicines and staff provided support to enable this.
- The pharmacy team recognised concerns for medications being prescribed for breastfeeding mothers. They created and displayed a poster to remind patients who were breast feeding to ensure that they inform the pharmacist.
- The service reported that short dated medicines logs were displayed on medicine storage cabinets to make staff aware of medicines that were coming up for expiry.

**Incidents**

- **The service managed patient safety incidents well.**
- There was a comprehensive safety system, a focus on openness, transparency and learning when things go wrong. Learning was based on an ongoing analysis and investigation of safety incidents. All staff were encouraged to participate in learning to improve safety.
- All incidents and near misses were recorded and reviewed on an electronic system and subjected to a risk appraisal. Serious incidents requiring investigation were subjected to a root cause analysis. This identified the factors which led to the incident and how the risk of similar incidences happening again could be reduced.
- Policies and procedures for incident reporting were available to staff. Staff spoken with were able to clearly detail when and how incidents would be recorded. Staff were confident in using the system to report and record incidents. Direct access to reporting system for incidents was available for all staff. However, in discussion with staff and managers, consultants did not directly report patient safety incidents. The arrangements in place meant that a member of staff recorded the patient safety incident on behalf of the consultants This meant that the accuracy of incidents was not recorded directly first hand and there was a risk of them being reported inaccurately.
- There had been no never events in the last 12 months. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The service recently held an event for the theatre team to celebrate 1000 days since their last never event.
- There had been no deaths in the service in the last 12 months. There had been no serious incidents. Any incident determined at moderate or above activated the services duty of candour policy. Duty of Candour is a

statutory duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

- The staff we spoke with could clearly articulate what Duty of Candour meant. We saw examples of incidents where the service had followed the Duty of Candour guidelines and responded in a person-centred way to the patient or their families.
- The service produced 48-hour flash reports. These were used to highlight either complaints or incidents that had led to a change of practice. The 48-hour flash reports were shared throughout every hospital within the group and each hospital had to acknowledge that they had been read and distributed throughout the local service. The service had created a similar process to flag near misses or incidents internally. We saw these discussed at the daily huddle.
- Incidents were discussed at the Medical Advisory Committee (MAC) and meetings. Records showed learning from incidences was shared with staff.
- All NHS patient safety alerts were discussed in the surgical safety committee and actions sent to relevant staff to ensure the alerts were acted upon. We observed staff discussing relevant alerts in a theatre briefing.
- The hospital reported 887 clinical incidents from October 2017 to September 2018. Of these 740 resulted in no harm, 119 resulted in low harm and 28 resulted in moderate harm. During the same period the hospital reported 72 non-clinical incidents.
- There were mechanisms in place to ensure lessons learned were identified and improvements made were necessary. Data was shared with the Spire organisation for overview and scrutiny.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated. Information including learning from medication incidents was cascaded to staff to prevent similar incidences from reoccurring.
- Theatre staff had undertaken learning from the providers' internal safety alerts from incidents. They had created learning briefs to assist in identifying where the service would need a change in to avoid potential patient harm.
- The hospital had appointed a surgical safety guardian with 'angel' representatives in non-theatre clinical areas. Regular surgical safety meetings were established to discuss safety concerns and ideas for improvement and a surgical safety guardian newsletter was shared across the hospital monthly to share learning and best practice.

**Safety Thermometer (or equivalent)**

- **The service used safety monitoring results well.**
- The service used safety thermometer data to monitor its performance and identify any significant risks. Safety Thermometer data is used to record the prevalence of patient harms and to provide immediate information and analysis to monitor performance in delivering harm free care.
- Senior staff collected safety data to record harmful incidences and provide immediate information and analysis. This enabled theatre and ward staff to monitor their performance in delivering harm free care.
- Records showed there were six cases of hospital acquired venous thromboembolism (VTE – blood clots) in the reporting period October 2017 to September 2018 for surgical services. We saw that wards had up to date safety thermometer data available. Managers discussed how information was shared with them and used to develop the safety arrangements in the service.
- The hospital carried out venous thromboembolism (VTE) audits every three months. Audit results for January to December 2018 showed the hospital achieved 100% compliance for completion of VTE assessments and for providing chemical prophylaxis for the prevention of VTE.
- The hospital updated a scorecard every three months that showed the outcomes for various clinical measures. It recorded there were low incidences of venous thromboembolism, falls or pressure ulcers.

## Are surgery services effective?

Good

This is the first time we have rated this service. We rated effective as good.

**Evidence-based care and treatment**

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Evidence based care pathways from established professional bodies such as The National Institute for Health and Care Excellence, World Health Organisation (WHO) and the National Patient Safety Agency (NPSA) were in use.
- The service used the Five Steps to Safer Surgery checklist from the NPSA, based on a World Health Organisation document which promotes the recording of staff briefing, sign-in, timeout, sign-out and debriefing, and is advocated for all patients in England undergoing surgical procedures.
- Patients were monitored using a range of evidenced based and nationally recognised tools, such as the National Early Warning Score tool (NEWS). This promoted a standardised approach to monitoring patients' conditions and triggering an effective care pathway when their condition deteriorated.
- We observed staff in theatres and wards adhering to National Institute for Health and Care Excellence guidance on infection control and preventing surgical site infections.
- The service had processes to monitor deteriorating patients that were in line with National Institute for Health and Care Excellence guidance on managing acutely ill patients in hospital. We saw sepsis screening in line with the Sepsis Six pathway (a set of six tasks to be completed within an hour of identifying probable sepsis).
- The Association for Peri-operative Practice's position statement on the perioperative care collaborative recommendations for surgical first assistants was utilised. Surgical first assistants are registered practitioners that provide continuous, competent and dedicated surgical assistance to surgeons throughout a procedure. The role was designed to help ensure safe surgical practice. The hospital also provided us with assurance that staff were not undertaking dual roles as scrub practitioners and surgical first assistants which could reduce safety.
- We saw evidence that patients had a full assessment of their needs, including social needs. Those patients that had carers, or required input from the local authority were identified during initial consultations and pre-assessment. The hospital used care pathways that had been developed to meet best practice guidelines which staff followed to ensure patients received safe care and treatment. Care pathways were in place for all treatments provided and staff were able to access them from the hospital intranet. The pathways incorporated pre-assessment through surgery to post-operative care. The records we reviewed showed that the pathways were being used for all patients.
- NICE guidelines were reviewed centrally by Spire and were cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. We saw evidence through corporate key learning summaries and through departmental team meetings that changes in practice and guidance updates were discussed. For example, in the theatre team meeting, policies were discussed to ensure staff compliance with the latest guidance.

**Nutrition and hydration**

- **Staff supplied patients with enough food and drink to meet their needs and improve their health.**
- Staff identified patients who were at risk of dehydration and had processes in place to ensure they had consumed enough fluids to meet their needs.
- In the pre-operative assessment clinic, eating and drinking instructions were given prior to surgery being undertaken. Patients were also asked if they had any special dietary requirements and fasting details and instructions were given.
- Records showed that patients were assessed for any risks of poor food and fluid intake or special dietary needs such as diabetes. Where risks were identified, plans were put into place to review the patient and obtain additional support with eating and drinking as needed. Patients were screened using the 'Malnutrition Universal Screening Tool'. The screening tool is a simple assessment that identifies if patients are at risk of poor nutrition. A dietitian was available to refer patients to if the scores indicate risk.
- Training was provided for ward staff on fluid balance monitoring and on preventing Acute Kidney Injury. Fluid balance monitoring was in place to monitor patients' drinks. We also saw records that were staff had monitored patients eating post-surgery.

- Surgical inpatients could choose their meals from a daily menu. Catering staff took dietary requirements into account. There were alerts on menus to assist patients with an allergy.
- Patients with any special nutritional, cultural or allergy dietary requirements were provided with direct contact details of the chef in the kitchen. This allowed any personal anxiety or concerns that patients may have with the food available to be discussed and menus tailored to each individual's needs. The same applied where patients were feeling unwell and the chef offered to make their favourite foods.
- Any patients requiring support to eat were identified during handovers.
- Patients we spoke with told us that they all were provided with water that they could easily reach and overall the standard of the food was good and excellent.
- Patients were provided with hot and cold meals and snacks, tea and coffee and cold drinks throughout their stay.
- The Patient-Led Assessments of the Care Environment (PLACE) score for food and hydration in the service was 82.52% for 2018 this was below the national average score of 90.2%. The score for organisational food was 77.78% for 2018 this was below the national average score for of 90.0%. The ward score for 2018 was 91.67% above the national average of 90.5%. PLACE is a system for assessing the quality of the patient environment. It is an organisational voluntary self-assessment which takes place annually.

**Pain relief**

- **There was a system in place to recognise, monitor and address patient pain.**
- Pre-assessment nurses identified patients who may require additional pain management support prior to surgery.
- Staff assessed and monitored patients to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief when required. The hospital had an up to date pain management policy
- The hospital used a pain score system (zero to four; four being the worse pain), and its policy set out guidance on the type of pain relief that would most likely be effective, and guidance on uncontrolled or significant pain.
- Inpatients' pain scores were checked and documented on the national early warning score (NEWS2) chart. Staff enquired about pain during intentional rounds. Patients were asked about their tolerance of pain relief medicines that had potential side effects. Pharmacists counselled patients on analgesia and patient information leaflets were available to provide clear instructions.
- Staff used pictorial pain charts for patients who required additional communication support. Patients could point to the area of the body that hurt and then use smiley faces to show the level of pain they were in. For those patients with communication and mobility issues, staff told us they would look for signs of distress.
- Patient feedback on pain relief was captured on the electronic discharge survey and monitored at the Pain Relief Committee. The Pain Relief Committee undertook audits every three months. The most recent audit sent to the commission prior to the inspection found that all of the patients whose pain scores were more than two had been given pain relief within 15 minutes, all patients had their pain re assessed and all patient where given appropriate analgesia that brought their pain under control.
- Patient's consultants were available to provide advice if patients complained of pain after surgery. Pain management advice was available 24 hours, every day.
- Patients, spoken with, reported minimal pain and thought that this was managed effectively, they told us nurses responded rapidly to any requests for pain relief.
- We saw from the discharge summaries we reviewed that pain medication was included in the discharge summary which was sent to the GP.

**Patient outcomes**

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- Accurate and up-to-date information about the effectiveness of care and treatment was shared internally and externally. The information was used to improve outcomes for patients and any improvement plans were checked and monitored. The service used a range of tools to monitor and benchmark performance against other hospitals in the group.
- There was an active programme of assessing and learning from incidents and deaths. Learning from these events was widely shared amongst staff. We saw this monitoring information shared in newsletters, alerts, discussed at meetings and emails to staff.

- The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data showed the service was performing largely in line with national averages.
- Performance was reviewed at the clinical audit and effectiveness committee, Clinical Governance Committee and at the Medical Advisory Committee (MAC). We saw actions were taken to reflect outcomes and performance.
- Results from audits were displayed on the Theatre notice board to inform staff of performance.
- The service had systems in place for prevention of pressure ulcers with none reported for more than 3 years at level 2 or above.
- The rate for surgical site infections within the service (infections at the site of surgery which can lengthen the recovery time for patients) from January to December 2018 was 0.6%.
- Information sent from the service showed surgical site infection between January 2018 and December 2018 for hip replacement was 1.1% (compared to national average of 0.9%) and for knee replacement was 0.7% (compared to national average of 1.3%). Surgical site infection rates were monitored to determine best practice and promote learning.
- Staff and managers told us that there had been an active programme to recognise potential infections and to reduce their occurrence as a result the rates of infection had significantly reduced.
- The service had a comprehensive and detailed on going audit program. Spire Healthcare's Clinical Scorecard was to benchmark the service against Spire comparators for key performance indicators. Performance was reviewed at the Clinical Audit and Effectiveness Committee, Clinical Governance Committee and at the MAC.
- Breast implant registry data collection forms were completed and submitted. The registry records the details of any individual who has breast implant surgery for any reason, so they can be traced in the event of a product recall or other safety concern relating to a specific type of implant. The registry also allows the identification of possible trends and complications relating to specific implants.
- The National Joint Registry monitored the performance outcome of joint replacement operations. The data showed that between 2003 and 2018, the hospital was performing in line with the national average for patient outcomes for hip and knee replacement surgery.
- The service monitored its care and treatment utilising Patient Reported Outcome Measures (PROMS) for hip and knee replacement procedures. These provide an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS funded care since April 2009. Their outcomes were above the NHS average.
- The service submitted data to the National Joint registry (NJR) to assist in the national development of quality care and improvement, and to the North West Advancing Quality Alliance for benchmarking across the local region.

**Competent staff**

- **The service made sure that staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support.**
- At the request of staff and supported by the service a training hub was developed to allow staff a dedicated space to complete online and practical training with resources to support learning.
- New staff underwent a formal induction programme including corporate induction, and training on core competencies. The induction programme included training in dementia, dignity and Basic Life Support.
- Staff were able to access training internally and externally. There was an online learning system across Spire hospitals where staff could access additional training opportunities. All staff we spoke with reported that they were encouraged and able to access training to improve their skills and knowledge.
- We spoke with nurses and theatre staff and saw evidence that competency files were kept up to date. Staff competencies folders were kept on each department. We reviewed competency folders for staff and saw that competency files were well presented and contained assessments of competencies.
- Staff had the opportunity to develop and progression plans were discussed in their appraisals. We saw evidence that several staff had taken the opportunity to progress within the organisation and undertaken different roles.

- Appraisals were held yearly. Service data showed that 100% of staff had received a performance appraisal. Appraisals were linked to the service and corporate vision and values. Staff told us, their objectives were set at the appraisal and learning needs and further training was discussed and planned.
- All qualified nurses had their fitness to practice registration checked prior to employment. Ongoing checks were made during the nurses employment to check that they remained fit to practice and registered with the Nursing and Midwifery Council (NMC) and were fit to practice.
- The perioperative care collaborative (PCC) had set out clear guidance for competencies of surgical first assistants (SFA). Surgical first assistants were assigned a consultant as a mentor. They also had a log book detailing the work they had undertaken which would be signed off by their mentor. We reviewed seven competency records for scrub practitioners who had gained additional competencies to act as Surgical First Assistants (SFA). Each member of staff had been signed off as competent by a consultant and had a mentor to ensure continued development.
- When necessary agency staff that had experience of working at the service were used to ensure there were enough staff to meet people's needs. Managers checked agency staff had the right skills and training.
- Consultants working at the service had their practising privileges reviewed every two years. A review was undertaken to assess if they continued to have the skills and knowledge required to support surgical patients.
- Patients told us they were supported by staff who knew their conditions and how they needed to be cared for.
- Staff said there were frequent training sessions and felt confident to fulfil the tasks and responsibilities required of them.
- The service reported that the matron was in the process of setting up honorary contracts with a neighbouring trust for ward nurses and operating department practitioners to shadow staff within critical care or alongside the medical emergency / critical care outreach teams to acquire new skills and support local innovation.
- The Medical Advisory Committee (MAC) provided medical supervision and was responsible for reviewing and monitoring clinical practices for the service. Applications for membership of the hospital's Medical Society were managed in line with Spire Healthcare Consultants' Handbook. Applicants submitted documents including an application form, practice details, references and proof of identity. Applications were considered by the service's senior management team and approved by the Medical Advisory Committee along with a scope of practice document provided as part of the application
- A biennial review was undertaken for each consultant's practice by the hospital director, matron and Medical Advisory Committee representative where appropriate.
- No consultants had practicing privileges removed due to performance issues. However, six consultants had stopped practicing with Spire Liverpool in 2018 and 13 new doctors had joined the medical team.
- Theatre staff had completed medical device competencies for specialist equipment used during procedures. This ensured that staff were able to use specialist equipment competently and ensured patient safety. The service reported the department also had a medical device lead in post to coordinate use of all equipment.
- There were dedicated staff to provide guidance and support with specific aspects of the services, such as health and safety, infection control and safeguarding.
- Staff had opportunities to undertake further training such as operation department practitioner or registered nurse.
- Educational opportunities were made available for medical professionals. A recent education event regarding attracted 130 attendees including a mixture of GPs, physiotherapists, podiatrists, chiropodists and other health professionals.

**Multidisciplinary working**

- **All relevant staff, teams and services were involved in assessing, planning and delivering patients' care and treatment.**
- Staff held ongoing and effective multidisciplinary team meetings. A multidisciplinary team is where the different professionals in the service work together to provide care. We saw that daily 'safety huddle' multidisciplinary team meetings had taken place with members of the multidisciplinary team present where issues such as incidents and safeguarding were discussed.
- Staff from different disciplines worked together as a team to benefit patients. Consultants, registered nurses and allied healthcare professionals supported each other to provide quality care.

Good

# Surgery

- We observed good multidisciplinary working with effective verbal and written communication between staff. We saw that allied healthcare professionals' team, consultants, registered nurses and support staff worked closely to ensure that patients were supported. Staff confirmed that there were good working relationships between staff that included physiotherapists, nurses, and consultants.
- We observed a theatre briefing and saw that it was well attended by all levels of staff and included ward staff.
- Each consultant had overall responsibility for their patient. When the consultant was not on site, staff were able to contact them by home or mobile numbers which were accessible through a centralised system.
- Planning for surgery was comprehensive and included detailed multidisciplinary team working. We saw an example of where members of different teams across the service met to plan appropriate patient care from assessment to discharge.
- The service had systems in place to identify patients with a positive histology for cancer and they were referred to the NHS or other oncology provider for a cancer multidisciplinary team review. If a patient with a known cancer was referred for surgery, before booking was confirmed the service requested oversight of the multidisciplinary team plans to make sure the surgery requested was in line with the multidisciplinary team agreed pathway.
- Spire Liverpool submitted multidisciplinary team assurance to the group's cancer tracker (monthly audit) and the Spire policy was to report any incidence of non-multidisciplinary team approach as a serious incident.
- Evening ward rounds were undertaken by the resident medical officer and they worked collaboratively with staff to ensure resident medical officer tasks were communicated in a timely manner to minimise disturbance overnight.
- Staff shared information about patients at effective handover meetings within the teams and across the service. The ward teams had active working relationships with other relevant teams internally and externally to the organisation.

**Seven-day services**

- **The service offered seven-day services to ensure patients undergoing surgery would receive consistent care and outcomes.**
- Routine surgery was performed in the theatres during weekdays and on Saturdays. Theatre lists also operated out of hours and on Sundays in an emergency.
- The Lakeview and Rathbone wards were mainly used for patients requiring day case surgery. Both wards operated during normal weekday hours and on Saturdays as needed. Lakeview ward on occasions could be used as an overnight ward to meet patient needs.
- The Oakfield ward accommodated overnight patients seven days per week and staffing levels were suitably maintained during out-of-hours and weekends if patients were remaining on an overnight stay.
- The resident medical officer (RMO) was also on site to support staff with clinical care.
- Should a surgeon be on leave, cover was locally agreed with another consultant with practising privileges to ensure patients had continuity of care.
- The service had two resident medical offices that were available 24 hours a day, seven days a week on a week on week off rota.
- The hospital's allied healthcare professionals' team and pharmacy team provided cover including an on-call system 24 hours a day, seven days a week service. This included respiratory physiotherapists.

**Health promotion**

- **Patients were assessed for general health and given advice and support such as smoking cessation and information regarding alcohol intake as needed for their ongoing care.**
- Patients were provided with information which enabled them to make informed decisions about their life style choices and how they could improve the quality of their lives and outcomes.
- Wards had information about various physical and mental health issues and how to manage them. For example, sepsis awareness leaflets were available for patients their families and their carers. The information provided emphasised the importance of recognising the early stages of sepsis and if present the need for the patient to be taken to hospital as soon as possible.
- There was information displayed around the service about effective handwashing techniques to prevent and control the spread of infection.

- Information for healthy living was given out by staff to patients. Health promotion was also part of the discharge discussion and explored at multidisciplinary meetings to make sure that patients received the correct information.
- Where patients' needs were identified staff could ask for support from relevant professionals such as dietary advice and guidance.
- Information was sent to patients GP's on discharge to support any health promotion needs that the patient might require after discharge.
- There were information leaflets available about the management of health conditions which affected the local population such as smoking cessation and cholesterol management.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**
- Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and acted on in line with relevant legislation.
- Staff received training in the principles of the Mental Capacity Act 2005 and understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. Staff were aware of how to get advice regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and could access the services policy as needed.
- Staff told us and records confirmed when a patient lacked the mental capacity to consent to treatment, the service held best interest meetings with others who had an interest in the patient's welfare.
- Patients were given a full explanation of their proposed surgery and associated risks at a pre-operative assessment, so they could make an informed decision to proceed.
- Consultants additionally sought the consent and views of patients on the day of surgery to confirm they still wanted to undertake their chosen procedure.
- There was a recommended two-week cooling off period for cosmetic surgery patients in line with good practice. Records and staff spoken with confirmed that patients had discussed their treatment options in line with this timescale and had been given the opportunity to review and change their decision to undergo treatment.
- Staff were aware of their responsibilities under the Mental Capacity Act 2005 to seek consent from patients and provide care in line with their wishes and preferences.
- Patients confirmed they were given clear information about their treatment options and that consultants had discussed the benefits and risks of surgery and answered their questions before giving consent to proceed.
- We saw one record for a patient who required the services of a translator. Although the patient had signed the consent form and a previous consent had been obtained. The consent form had not been signed by the translator to state that they had given the patient the information. This was discussed with managers within the service who logged this as an incident to investigate it further.

## Are surgery services caring?

Good

This is the first time we have rated this service. We rated caring as good.

**Compassionate care**

- **Staff responded compassionately when patients or their relatives needed help. Support was given by caring staff as and when required by patients to meet their individual needs.**
- We spoke with 10 patients and four relatives. Feedback from patients was positive about the way staff treat them. Patients and their relatives were treated with dignity, respect and kindness.
- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Interactions observed between staff, patients and relatives were polite, caring and respectful. We saw that staff took the time to engage with patients and

communicated in a caring way and considered the wishes of the patient. Staff spoke sensitively and gently with people, providing reassurance before their surgical procedures.

- Patients confirmed they had access to call bells and that staff responded promptly and addressed the needs of patients when they were in pain or distress.
- Patients had their privacy and dignity maintained, we observed interactions between staff, patients and relatives and staff treated people with privacy and dignity. We saw that confidentiality was respected in staff discussions between patients and those close to them. Staff knocked before they entered patient's rooms and closed doors so they could speak with patients confidentially.
- Staff within the ward could easily maintain patients' privacy and dignity as every patient had private rooms. We observed staff asking patients whether they preferred their doors open or closed.
- We observed the service had received 'thank you' cards from patients and relatives, which thanked staff for the support.
- The service had systems in place that supported staff to direct patients to other services when appropriate and, if required, supported them to access those services.
- The Patient-Led Assessments of the Care Environment score for privacy, dignity and wellbeing for the service was 81.25% for 2018 slightly below the national average 84.2%. Patient-Led Assessments of the Care Environment is a system for assessing the quality of the patient environment. It is an organisational voluntary self-assessment which takes place annually.
- We observed theatre staff talking to patients in a friendly yet professional manner during surgical procedures. They clearly explained what would happen during the operations.
- All patients we spoke with explained how staff responded quickly when they were in pain, and that staff responded quickly to call buzzers. They told us how staff at all levels took time to interact with them. Patients did not consider nurses or medical staff to be rushed.
- We saw examples were staff had assisted patients beyond their normal scope including supporting patients who had been discharged from the service and accessing additional services to support them as individuals.
- The response rates and scores for Friends and Family from July to December 2018 stated that on average 94.5% of patients recommend this service. The average response rate was 17%. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements were needed. It is an anonymous way to patients and their families to state their views after receiving care or from an NHS funded service.

**Emotional support**

- **Staff provided emotional support to patients to minimise their distress and considered their individual needs.**
- Staff responded promptly when people requested support or had any concerns.
- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required (such as staff accompanying the patient during their procedure), especially if patients were apprehensive.
- We saw staff took their time with patients in order to get to know them and understand their anxieties or fears. We saw members of staff comforting patients on their way to theatre and in the anaesthetic room. Additionally, we saw staff providing emotional support to patients when they were recovering from an anaesthetic.
- Checks of patients and their care were in place during their stay on wards to ensure that they were comfortable, and to answer any questions they may have.
- Patients told us that physiotherapists provided support when mobilising following surgery and that they were encouraging and supportive.
- The psychological wellbeing of patients was discussed as part of the pre-operative assessment for cosmetic surgery. Following discussions with the consultant any patient deemed to require further psychological assessment could be referred to psychological services.
- Counselling services were not provided at the hospital. However, staff told us patients, or their relatives could be given information for external organisations if needed.

- Contact details were given to patients when they were discharged. They were able to contact staff at the hospital 24 hours a day, seven days a week if they had any concerns or anxieties.
- Relatives or carers are encouraged to stay overnight to reduce anxiety for patients living with dementia or with additional needs.

**Understanding and involvement of patients and those close to them**

- **Staff provided information to patients in a way that they could understand. Patients were supported to understand their condition, care, treatment and any advice.**
- Patients told us that they were involved in agreeing their care plans and offered choices when possible. This supported them to feel in control of their care and what to expect.
- Patients we spoke with said that staff communicated with them in a way they could understand. Patients told us that staff members also kept their carers updated as needed. We were told by patients that staff spoke to them about their care and treatment in a way they understood and where given information leaflets to assist in their understanding. We saw that overall staff communicated in ways that people could understand and took the time to answer questions.
- Family members said they were kept informed about how their relative condition and any changes in their treatment. Patients we spoke with said they had received clear information about their health needs and any treatment.
- Non-NHS funded patients received information including the cost of surgery in writing before their appointment so they knew what to expect and could decide if they wanted to proceed with treatment.
- Patients were supported to review the risks and benefits of surgery before their procedure, so they could ask questions and discuss any concerns. Fees for privately funded patients were clearly explained prior to commencing any treatment.
- Records we looked at for patients included pre-admission and pre-operative assessments that considered individual patient preferences.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.
- Patients said they felt safe and had been shown around the ward area on admission. Patients told us they were fully involved in their care and treatment and they felt able to ask for further details and explanation about any aspect of their treatment. Staff had made sure that patients who may require extra support after their surgery where given an opportunity to familiarise themselves with the rooms they would be using during their stay.
- The hospital arranged a celebration for a patient that was attended by the patient, their family, hospital staff and that patient's consultant.

## Are surgery services responsive?

Good

This is the first time we have rated this service. We rated responsive as good.

**Service delivery to meet the needs of local people**

- **Services were planned and delivered in a way that meets the needs of the local population.**
- The services provided at the hospital reflected the needs of the population they served, and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including cosmetic surgery, and general surgery. The procedures carried out were determined in conjunction with the local clinical commissioning groups to best serve the local population.
- There were reviews of demand for services and flexing of clinic and theatre times to suit the needs of patients. The hospital director and operations manager worked with local commissioning groups to plan and deliver services to meet the changing needs of local people.
- People could access services in a way and at a time that suited them including evening and weekend appointments.
- The service supported both private and NHS patients referred by their GP.
- The service had a policy to identify appropriate referrals and an appropriate admission / exclusion criteria. This was in place to make sure that only appropriate surgery that could be safely managed in the service was offered to patients.

- Senior staff held weekly management meetings, to assess the number of expected patients, ensure enough bed space and staffing numbers to meet their individual need.
- The service had an administration effectiveness group that meet every two monthly to discuss issues, share best practice and support one another and the administration teams across the service to provide a more efficient service to patients.
- Patients were referred to the surgeon of their choice where possible and seen by the same consultant as much as possible to ensure continuity of care.
- Facilities within the service were adapted to meet the needs of patients with a variety of needs such as disabled access, breast feeding facilities and equipment to assist for people with a hearing impairment.
- Information for patients was available in different languages to prevent harassment and discrimination in relation to protected characteristics under the Equality Act.
- The service mostly met the NHS England's Accessible Information Standard. This was a legal requirement for services to identify, record, flag, share and meet the information and communication needs of patients and other groups with disability, impairment or sensory loss.
- There were large information boards within each ward area containing photographs of the staff on ward and their roles. The board explained what the different uniform colours meant.
- We heard examples of where hospital staff had liaised with social services and occupational therapy services to ensure that patients had the right facilities in place following discharge.
- The hospital had links with local GP surgeries and supported a local GP education and professional development programme. This was part of an initiative within the local community to improve health promotion and education regarding a variety of surgical and medical specialties. The professional development programme was delivered by Consultants at the service with practising privileges.

**Meeting people's individual needs**

- **Patients' needs, and preferences were considered and acted on to ensure that services were delivered in a way that met their individual needs.**
- Care plans considered the specific needs and wishes of patients. We looked at the care plan for a patient with a learning disability who had previously displayed aggressive behaviour in response to anxiety. The care provided took account of the person's needs. We saw that the staff had undertaken innovation to remind the patient to attend the hospital for their pre-admission assessment and surgery. The patient's higher needs were discussed at the safety huddles and steps were taken to allocate the patient a direct member of staff in the organisation as a point of contact that they were familiar with. The patient's surgical procedure went well and they remained calm throughout their stay.
- Patients with fluctuating capacity or lived with dementia were supported in line with good practice. Some adaptations were made to rooms to assist patients with their stay. Additionally, where patients were identified with additional needs such as dementia had visited the hospital prior to surgery to help them be familiar with the environment.
- The service used a "This is me" form for patients living with dementia. This was a simple form that provided details about the person including their cultural and family background, events, people and place important in their lives, and their routine and personality. The form provided information to enable staff to know more about the patient and adapt to meet their needs.
- The service had a Dementia box which included equipment and activities designed to stimulate and support the patient during their stay.
- The service had developed links with Liverpool Dementia Action Alliance and invited independent visitors to review the facilities. At the time of the inspection, the service was working through the recommendations with a further visit scheduled for September. The recommendations have also been shared nationally to benefit other Spire hospitals.
- Staff supported people to follow their chosen faith and cultural preferences. There was a multi-faith prayer room. The hospital worked with different religious faiths to raise cultural awareness.
- Extended stay patients were supported with the provision of a "care parcel" to enable them to have some fresh food in the home on their return. This included fruit, bread, milk, eggs and tea and a sandwich for their return home.

- Patients with any special nutritional, cultural or allergy dietary requirements were provided with direct contact details of the chef in the kitchen. This allowed patients to discuss their dietary preferences and menus could be tailored to meet those preferences.
- A multi-faith box and prayer room were available. The box had a wide range of faith resources and a prayer mat for patient and staff use should they be required.
- Information was available in different formats, such as large print and different languages these could be printed out by the nursing staff and were easily available to patients prior to discharge.
- The services pre-assessment team identified those patients that required interpreter services and would pre-book support for appointments. Although we were aware that there had been six occasions when operations had been cancelled including during our inspection when surgery was cancelled due to the lack of a translator.
- The hospital had a dementia lead who supported staff that had questions about caring for patients living with dementia. The hospital reported that the theatre team had appointed a link member who had undergone dementia training and who acts as an advocate for Dementia patients with a designated, dementia friendly recovery bay to support patients living with dementia.
- The hospital reported that 43 staff had been recognised as Dementia Friends following Dementia Awareness training. The Dementia Friends were a mix of clinical and non-clinical staff and provided support to support patients and their families.
- The hospital reported that face to face training sessions on cultural sensitivity had taken place further training was scheduled and scheduled further training this year with an external provider for visual Impairment training to support patients and improve staff understanding of patient communication needs.
- The hospital gave examples of reasonable adjustments made for visually impaired patients attending the hospital. This included allowing patients to attend early and familiarise with the environment and considerations for accommodation of guide dogs and suitable format for medicine labels.
- The hospital reported a number of staff had signed up as dignity champions with the National Dignity Council to ensure consideration of people's privacy and dignity was embedded in staff practice.
- The hospital reported that although limited services for children were offered, play equipment and activity packs were provided for children visiting the hospital. There was also an assortment of plates and cutlery for any patients attending the hospital who may have children visiting them, to allow the children to eat with their parents.

**Access and flow**

- **Patients could access the right care at the right time. Access to care was managed to take account of patients' needs.**
- Patients accessed care and treatment at a time to suit them. Patients we spoke with told us they were given a choice of dates for their procedure and reported they did not wait long for their surgical procedure to take place.
- Hospital appointments were primarily sent by letter to patients. The pre-assessment clinic staff told us that text reminders were sent to patients in advance of their appointment. Patients would also be telephoned if they did not attend to ascertain the reason and to see if any adjustments could be made to help them attend.
- Appointment times include evenings and weekends to provide flexibility and choice to patients. Visiting times can be flexible, allowing family members to stay as long as they like and
- Admission times were staggered throughout the day so that patients did not have to wait for a long period of time once admitted to the ward. By staggering admission times, the hospital was able to ensure those patients with the most urgent needs were prioritised. For example, patients with diabetes were placed at the beginning of the theatre lists so that they had their surgery as quickly as possible.
- Pre-assessments and regular theatre planning meetings identified patient needs in advance and reduced the risk of inappropriate admissions or cancelled procedures.
- In the reporting period October 2017 to September 2018 there was a total of six unplanned returns to theatre, 18 unplanned transfers of inpatients and 11 patients readmitted for a related condition within 28 days. The service monitored any unplanned transfers and readmissions. Incidents were generated, and investigations undertaken as needed.
- Between April and November 2018 referral to treatment waiting times (RTT) for NHS funded patients who received treatment within 18 weeks of referral was on

average 95%. This was better than the national target of 90%. Referral times were reviewed to identify patients approaching the 18 week wait period so that these patients were prioritised.
- During our inspection the theatre lists generally ran on time. One theatre list had been cancelled due to the absence of the surgeon. Each of the patients had been contacted prior to the date and informed. All were rescheduled at a time of their choosing.
- Daily ward rounds identified patients if they were able to be discharged as planned.
- All new patients received a reminder 48 hours prior to their appointment. Between June 2018 and March 2019, the average rate of patients who did not attend appointments was 4.9%. The service took appropriate steps to follow up patients who did not attend.
- Between April 2018 and May 2019 there was a total of 164 procedures cancelled in surgery. 67.9% were for clinical needs. The pre-operative assessment stage had been identified as being the most common reason for cancellations. The service stated that this was due to assessment processes and patients being assessed as unsuitable for surgery. Cancellations were monitored and discussed at management meetings.

**Learning from complaints and concerns**

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- Information was easily available to assist patients to give feedback about their experiences, including how to raise any concerns or issues. All complaints were monitored and addressed.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff.
- The hospital had a complaint process available for all patients with leaflets displayed to assist patients on how to raise a concern. There was with a separate escalation process depending on whether patients were NHS or privately funded.
- The complaints procedure set out the three-stage process for the review of complaints, and appropriately referenced the relevant adjudication services the Independent Healthcare Sector Complaints Adjudication Service or the Parliamentary and Health Service Ombudsman.
- The complaints protocol required acknowledgement of complaints within three to five working days. The service set itself a target to investigate and respond to complaints within 20 days but aimed for earlier response when possible.
- Records showed that prior to March 2018 the hospital's compliance with complaint response targets was above 90% but this had dropped between April and September 2018 (ranging between 54 and 64%). The reduction in compliance was attributed to the complaints coordinator going on unexpected sick leave between April and November 2018. Compliance significantly improved from October 2018 to March 2019 (ranging between 93 and 97%) when another member of staff assumed the coordinator role.
- The hospital reported that in order to maintain compliance in future and reduce additional pressure on the team any lengthy absence within the team would be resolved with an earlier staff appointment.
- The hospital received 123 complaints between January and December 2018. Two complaints were escalated to the provider's level 2 (independent review stage), but none were referred to external organisations such as the Independent Sector Complaints Adjudication Service (ISCAS) or the Parliamentary and Health Service Ombudsman. The Parliamentary and Health Service Ombudsman are an independent body who resolve complaints from NHS patients.
- Patients were advised on how to make a complaint or raise concerns. We saw information was available throughout the service and on the services website.
- The service could demonstrate improvements made as a result of learning from complaints. For example, information leaflets for vasectomy procedures were updated following feedback from patients.

## Are surgery services well-led?

Good

This is the first time we have rated this service. We rated well-led as good.

**Leadership**

- **Leaders had the experience, capacity, capability and integrity to make sure that a quality service was delivered and risks to performance were addressed.**
- Leaders at every level demonstrated shared values that encouraged pride and positivity in the organisation and focussed attention on the needs and experiences of patients.
- The hospital director (who was the registered manager with the Care Quality Commission) had overall responsibility for the hospital. The hospital director was supported by the site management team, which consisted of the matron (also the head of clinical services), business development manager, operations manager and finance and accounts manager.
- The inpatient ward manager (also the deputy matron) was responsible for the day to day management of the ward areas and there was a theatre manager in place to oversee the theatre areas. The theatre manager and ward manager reported to the matron.
- We spoke with several staff about leadership within the hospital. We found that most staff considered the leadership team to be supportive, visible and approachable. Staff told us that new members of the senior manager team had introduced improvements to the service and felt they had the skills to sustain them.
- Ward and theatre managers were visible in the areas we visited. Staff knew the senior staff they were required to report to, seek advice from or raise concerns with. They said they were encouraged to engage with senior staff and felt comfortable to do so.
- There were regular safety huddles and briefings in both wards and theatres to ensure that frontline staff received all relevant information. Daily safety and business huddles took place with senior management teams and heads of department.
- Staff received regular communication from the directors and senior managers to understand how the service was performing, its plans and the challenges it faced.
- The hospital met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role. We looked at the senior managers' team employment files, which were completed in line with the FPPR regulations.
- Leadership development opportunities were available. For example, the matron was attending a tailored clinical leadership programme with other spire matrons.
- The hospital director held a daily meeting for managers from all areas, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Managers cascaded the key messages from the huddle at local staff meetings.
- Monthly staff forums were established and led by the hospital director. These gave the staff an opportunity to understand current hospital performance and new developments, as well as to discuss new ideas and raised any concerns or suggested improvements.
- Leadership development opportunities were available.

**Vision and strategy**

- **The service had a clear vision and strategy that all staff understood and put into practice. There was a clinical strategy focused on quality and service improvement.**
- There was clear communication from central Spire Senior Leadership on clinical quality and how this was being translated locally, sharing best practice and learnings across the service. We saw that these included improvements for teams to work well together resolving challenges, and supporting each other to deliver excellent patient care, embedding best practice.
- We saw that the vision and strategy was displayed around the hospital and staff we spoke with were aware of the vision and strategy. Staff appraisals were linked to the hospital values that included caring is our passion, succeeding and celebrating together and driving excellence.
- The service produced an annual non-clinical hospital strategy based on core values of each department, outlining commitment to patients, staff and consultants.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against strategy and plans. The quality report was produced every three months and provided detailed updates on the hospital progress towards its strategic targets and what actions were needed to ensure continued progress.
- The Medical Advisory Committee chair met with the hospital director and matron weekly.

**Culture**

Good

# Surgery

- **Leaders at every level demonstrated shared values that encouraged pride and positivity in the organisation and focussed attention on the needs and experiences of patients.**
- Staff told us they felt respected and valued by their immediate and service leaders.
- All staff told us of a good team working culture where staff helped each other. Staff told us they felt able to raise concerns without fear of retribution. They told us morale was positive and continued to improve.
- Staff knew how to use the whistle-blowing process and about the role of the freedom to speak up guardian. Freedom to speak up guardians are staff that work independently alongside the leadership team and are given additional training. The freedom to speak up guardian is in place to promote an open culture, to encourage staff to speak up about any concerns and to provides support and advice to staff that have raised concerns about the service.
- Staff spoken with told us that they felt comfortable to approach the freedom to speak up guardian. When staff raised concerns with a guardian the staff members' confidentiality was maintained and the issue was raised through internal communications with feedback given to the member of staff.
- There was an open culture where staff were encouraged to report concerns and incidents. This was demonstrated in the high rate of incident reporting within the service.
- Managers dealt with poor staff performance when needed.
- Staff appraisals included conversations about career development opportunities.
- A reward and recognition scheme was in place for staff, whereby they are nominated by their colleagues. Several staff from across the service have received awards for good practice. Staff also have access to a variety of discounts for shops, restaurants and travel via the reward scheme.
- Staff told us leaders promoted a 'no blame culture' and felt supported to speak out when patients were at risk of harm or they had concerns about their colleague's behaviour.
- Staff gave us examples of additional support they had received from senior staff when necessary to fulfil their required roles and responsibilities.
- Staff described a learning culture where they were supported to advance and learn new skills. There was a robust student nurse training programme in place which staff enjoyed and valued.
- Staff told us that the new senior leadership team, including the hospital director and the matron, had helped produce an open culture within the organisation, especially within the last 12 months.
- A monthly health and wellbeing calendar was established that linked to national initiatives and was displayed in staff and public areas. For example, in April 2019, the hospital was promoting stress awareness month and a display including diet and stress management and other ways to help staff manage stress was available in the staff restaurant with new posters in the main reception regarding mental health and wellbeing support.
- The hospital had an equality action plan that had had been developed and cascaded centrally by the corporate provider. The equality action plan incorporated the workforce race equality standards (WRES) and included four specific actions to improve systems for collating information in relation to ethnicity self-reporting, recruitment and disciplinary processes in order to improve outcomes for Black and Minority Ethnic (BME) staff.

**Governance**

- **There was a clear governance structure in place, which all staff we spoke to understood.**
- The surgical service had governance and management systems in place and they interacted effectively to provide assurance and service improvements were made.
- The heads of departments met monthly. The group discussed clinical incidents, accidents and near-misses. It also discussed medicines management, patient safety issues and reviewed new policies and procedures. Any action arising from the meeting were placed and tracked on an action log. The log contained details of the agenda item, action required and action owner, and target date for completion. The log also contained details of the progress to date.
- Staff on wards and theatres were kept updated on safety performance via several means, which included ward meetings, newsletters and via email.
- Staff undertook or participated in local clinical audits. Ward managers brought the information from the senior

nursing staff meetings and audits to the ward managers meetings, where governance, risks and serious incident reports were discussed. There were also departmental meetings, governance and business meetings. Information was fed into appropriate committees at board level.

- The hospital contributed governance data to the Spire organisation to provide additional oversight and external scrutiny of the services performance. There was a clinical score card in place that highlighted areas for development and areas that the service was doing well in. the services most recent score card showed, when complaints targets were not met and an improvement that took place. Forty-eight measures were in place, seven were new measures that did not yet provide a score. The service was meeting or above 23 of the measures, 16 of the measures maintained, five improved and nine had declined. The scorecard was discussed at all senior management meetings and submitted to the provider as part of an ongoing quality assessment. Action plans were in place for areas which were not in line with the services target, such as agency staff expenditure.
- The service had a comprehensive system in place to monitor practising privileges. The service had arrangements in place to remind consultants in advance of the expiry of certain information such as training.
- Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients.
- Staff were aware of their responsibilities and who they reported to. There were processes at all staff levels to review performance and compliance against set targets.
- Wards and theatres had developed local action plans to monitor and improve their delivery of patient care.
- The service had a Medical Advisory Committee which met every three months. The committee was set up to provide advice to the Hospital Director on any matter relating to the proper, safe, efficient and ethical medical use of the hospital. The committee also reviewed serious complaints and clinical incidents. The Medical Advisory Committee reviewed each medical practitioner that held practising privileges to ensure that their private work conducted at the hospital had been discussed with their GMC responsible officer and NHS appraiser as needed.
- Team meetings all used similar agendas to ensure consistency in what and how information was shared. We spoke with a housekeeper who confirmed that they had had monthly meetings to discuss any issues and spoke with the ward clerk to understand what patients were being admitted and what areas would need to be cleaned.
- There were several staff huddles to discuss staff activity and specific patients. There was a head of department huddle, led by the hospital director, at 9.30 am each morning. Any significant events that had taken part over the intervening 24 hours were discussed. Each department, including theatres, catering, wards, and housekeeping were involved. We observed two huddles and witnessed discussions about specific patients, complaints and incidents, and the sharing of best practice.

**Managing risks, issues and performance**

- **Risks were monitored and reviewed to maintain quality of care to patients and were understood by staff.**
- Senior staff knew there was a risk register, and managers could describe the key risks identified and their area of responsibility. They described how these risks were kept under review and updated. Senior managers had full oversight of the areas for development affecting front line staff and patient safety and experience.
- Staff had access to information relating to risk management, information governance and how to raise concerns. Staff were knowledgeable about the service's incident reporting process.
- Each ward and theatre maintained a risk register which was reviewed and discussed at staff meetings. Concerns were rated and prioritised against a set of clinical indicators to ensure those which presented a higher risk to patient care were prioritised.
- Multidisciplinary team meetings were held. Copies of the meeting notes were available on the wards and emailed to staff.
- Staff felt that the 'safety huddle' was effective. Safety huddles took place at the start of each shift in clinical areas. At 9.30am, a safety huddle led by the senior management team took place. Staff said that the direct communications with the executive team through this forum had made for constructive and meaningful team working.

- The service had local safety standards for invasive procedures in place, including the five steps to safer surgery. The safety team brief board was clearly visible and was effective and clearly used to improve and maintain patient safety.
- The hospital had appointed a Quality Lead to undertake clinical audit and service improvement.
- The service conducted internal audits to ensure that it was providing a quality service. It had a clear audit programme setting out the frequency of audits including sepsis, medical records and the surgical safety checklist. There was a full audit plan for the year which highlighted those that had been completed and those that were pending. These audit plans were in line with the wider group requirements. An overview was presented to all staff at the end of the year as part of a national audit week. Individual hospital areas were highlighted, including general findings and learning that had taken place.
- The service had two risk champions who facilitate communication. Regular corporate risk updates are given via conference calls from the group risk officer. A Health and Safety Risk Committee was held every two months attended by heads of department where non-clinical risks are discussed and reviewed.
- Human factors training had been completed by staff undertaking interventional procedures or minor surgery to prevent clinical incidents.

**Managing information**

- **The service collected, analysed, managed and used information to support all its activities.**
- The information used in reporting performance management and monitoring quality care was consistently found to be accurate, valid, reliable, timely and relevant.
- The hospital submitted data to the Private Health Information Network (PHIN). The network reported that between July 2017 and June 2018, the hospital had "good participation" when reporting data. This meant that the hospital was submitting complete health outcomes information for most eligible procedures.
- There was a demonstrated commitment at all levels to sharing data and information proactively to enable prompt decision making and the delivery of care. Wards and theatres had their own individual meetings each morning to discuss patient needs and operational issues. Action plans were in place that were monitored and shared with staff.
- Systems were in place to gather, analyse and share data and quality information with staff, key stakeholders and the public.
- The service had a website where people could access information about the surgical procedures available and which would be useful when visiting the hospital.
- Staff had access to the intranet to gain information relating to policies, procedures, professional guidance and training.
- Minutes from meetings and important documents such as the risk register could be accessed by staff on the intranet.

**Engagement**

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.**
- The service was transparent, collaborative and open with all relevant stakeholders consulted with about performance considering the needs of the population.
- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. This included through the intranet, internet, bulletins, newsletters, emails and displayed in clinical areas.
- Staff said they were listened to and had regular contact with senior staff. They told us senior managers acted upon their comments and recommendations or gave a rational where action could not be immediately taken.
- The theatre team also had monthly meetings and copies of the minutes were accessible to staff both electronically and printed. There was a shared theatre folder for ease of communication and meetings were supported with action logs to record open and closed actions.
- In the last 12 months staff had been involved in several events including participating in the Cancer Research 'Pretty Muddy' Event in Sefton Park in July 2018 when a team of clinical and non-clinical staff raised funds for Cancer Research.
- Staff said they felt valued and senior staff recognised their contribution to the service. Where a staff member

had led on a piece of work we saw, they had been acknowledged and praised by senior staff. This encouraged staff to engage with senior staff and share their suggestion for improving the service.
- There was a Patient Experience Committee for patients to provide first hand feedback to senior staff and influence the direction of the service.
- The hospital provided details of several support groups for patients and families, including information about early onset dementia. It also had chaplaincy services.
- The service had submitted a Commissioning for Quality and Innovation (CQUIN) plan. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. The service had a plan that included patient experience and equality and diversity.
- During a recent patient forum in April 2019, staff engaged with patients to help identify the “Always Events” for the hospital’s 2019 commissioning for quality and innovation (CQUIN) framework objectives.
- The service ran a patient forum and focus groups to listen to patients’ experience, observations and suggestions. Minutes of these were available and actions from these monitored. All patients were sent an online survey to complete after discharge. Results from surveys were overall positive.
- The service also supplied support to staff including emotional support and providing subsidised fitness opportunities.
- The matron had organised celebration events for nurses’ day and theatre staff. For nurses’ day, nurses contributed to poster displays, describing what inspired them to become nurses and what they enjoyed most in their careers which were to be displayed for patients and visitors during the event.

**Learning, continuous improvement and innovation**

- **There were systems in place that supported improvement and innovation work.**
- We were informed by senior managers that there were no examples of where financial pressures had compromised patient care. There was evidence that maintenance and replacement schedules were in place for equipment.
- There were practices on wards and in theatres to review performance and identify how their services could be improved. Improvement plans were displayed along with action improvement plans.
- There were meetings with the Clinical Care Group who commissioned services to assist in understanding the changing patterns of care needed for the future direction of services required.
- All staff we spoke with reported that the hospital developed staff and supported their training needs.
- The service produced 48-hour flash reports to share best practice to encourage improvement. The 48-hour flash reports were shared throughout every hospital within the group. Each hospital had to acknowledge it had read and distributed the report to the local teams.
- Incidences and good practice from the Spire organisation’s other locations was shared as learning material for staff to prevent similar incidences happing at the service.
- Key Performance Indicators (KPI's), such as patients being fasted within timescale, hand hygiene compliance and use of WHO surgical checklists, were reported every three months. Results were benchmarked nationally and performance against targets rated. Information was used to direct improvements.
- Matron had designed an annual “Expo” of clinical audit and service improvements, with a poster presentation exhibition to showcase staff striving for continuous improvement and clinical excellence.
- The service had a theatre managers group for all hospitals within the North West region. The group met every three months to conduct peer reviews and audits. The links with the other sites within the region helped provide staff cover if necessary.
- The matron was leading on a Spire national project to promote best practice in the prevention, recognition and management of acute kidney injury.
- The hospital was awarded the Lifestyle Magazine 2018 Best Healthy Lifestyle Business Award in February 2019.
- The deputy matron had set up a regional “cluster group” for inpatient ward managers, to share best practice and support each other through strong collaboration and cross service team working.
- The theatre manager was a member of Spire’s national perioperative working group to support the provider

with quality improvement and priorities for developing perioperative services across all Spire hospitals. This group was supported by a national head of clinical services for perioperative care.

- Staff were encouraged to visit other high performing hospitals to learn and seek to share best practice where new initiatives had been introduced. This enabled good ideas to be introduced across the Spire network.
- There was a national programme of clinical leadership conferences and training, where external speakers provided update training and allowed clinical leaders to network and share good practice.
- All specialist areas have a national lead and working group to provide expert advice and support, including induction of new starters in key roles. Key priorities are national networking, policy development, peer audits, training and onsite support.

Good

# Outpatients

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

## Are outpatients services safe?

Good

This is the first time we have rated this service. We rated safe as good.

**Mandatory training**

- **The service provided mandatory training in key skills to all staff and made sure most staff completed it.**
- Mandatory training was delivered through a structured programme with face to face sessions and e-learning modules. Staff we spoke with told us they were allowed sufficient time to complete their training when required.
- Staff received equality and diversity, compassion in practice and anti-bribery training once as part of their induction. Staff completed annual mandatory training in fire safety, information governance, infection control, health and safety and safeguarding adults and children. Moving and handling training took place every two years.
- Records showed that most staff across the outpatients department (98.8%) had completed their mandatory training during 2018. Training was provided annually and the completion rate for outpatients' staff during the current year was 77.8% at the time of our inspection, with the deadline being December 2019 for remaining staff.

**Safeguarding**

- **Staff had training on how to recognise and report abuse and they knew how to apply it.**
- There were policies in place for safeguarding vulnerable adults and safeguarding children and young people that provided guidance for staff on how to identify and report safeguarding concerns.
- Staff received mandatory training in safeguarding adults and children. Records showed 100% of outpatients' staff had completed level one and level two safeguarding training (adults and children) during 2018.
- Records showed 11 out of 26 outpatients staff (43%) had completed level three safeguarding training. The hospital reported that from March 2019 onwards a new level three safeguarding training module had been developed and all staff were required to complete level three safeguarding training during 2019.
- The matron and ward manager (acting as outpatients' manager) confirmed that only staff trained in level 3 children's safeguarding were involved in the care and treatment of children and young people under 18 years of age.
- The matron was the named lead for safeguarding at the hospital and had completed level 4 safeguarding training (adults and children), in line with the 2019 Royal College of Nursing guidelines for the adult and children's safeguarding roles and competencies for healthcare staff'. The ward manager (also deputy matron) had also completed level 4 safeguarding training.
- Records showed 100% of outpatient services staff had completed training in 'Prevent' (anti-radicalisation) and female genital mutilation (FGM).
- The outpatients' staff we spoke with were aware of how to identify abuse and report safeguarding concerns. Staff told us they would notify their line manager and the safeguarding lead if they identified any safeguarding concerns, in accordance with the hospital's safeguarding policies.

- Information on how to report safeguarding concerns was displayed in the areas we inspected.
- The hospital reported one safeguarding incident relating to outpatients between April 2018 and March 2019. The alleged abuse was identified in February 2019 and did not relate to any of the hospital's staff or activities and the concerns were appropriately escalated within the hospital and reported to social services to make sure the patient was safe.

**Cleanliness, infection control and hygiene**

- **The service controlled infection risk well.**
- The hospital's 'control of infection manual' outlined the processes for infection prevention and control. Records showed 100% of outpatients staff had completed mandatory training in infection control.
- There had been no cases of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) reported by the hospital between October 2017 and April 2019.
- The consultation rooms, treatment rooms, clinical areas and waiting areas were visibly clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules and daily checklists were in place and up to date, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Sharps bins were appropriately stored and labelled correctly. Staff used chlorine-based disinfectant to clean and decontaminate surfaces and equipment. The treatment and consultation room areas used disposable curtains that were replaced if contaminated or periodically every six months.
- All patients undergoing pre-operative assessments prior to admission at the hospital underwent MRSA screening. Staff told us that patients with a suspected or confirmed contagious condition at pre-operative assessment stage were reviewed by a consultant to determine whether they could be admitted for treatment at the hospital.
- Personal protective equipment, such as gloves and aprons, were readily available across all the areas we inspected. There were enough hand wash sinks and hand gels. Staff we saw were compliant with hand hygiene and 'bare below the elbow' guidance.
- A hand hygiene audit was carried out at least every three months to monitor staff compliance with hand washing guidelines. Audit results from October 2018 to March 2019 showed high levels of compliance by staff. There was an action plan in place to improve areas where poor hand hygiene compliance was identified and this was discussed with staff to improve compliance.
- In addition to the observational hand hygiene audits, a patient led hand hygiene audit was also conducted in November 2018. This was based on 40 observations by patients across the hospital. The patient led hand hygiene audit showed that the majority of staff were found to be compliant with hand hygiene both before and after the care of patients. The audit showed physiotherapists had high levels of compliance with hand hygiene practices and the group with the lowest level of compliance with hand hygiene were the doctors. There was an action plan in place to raise staff awareness in order to improve hand hygiene compliance.
- Infection control audits were routinely carried out to check compliance against national infection prevention and control guidelines and to monitor the cleanliness of the general environment and equipment. The April 2019 audit of the outpatients and diagnostic imaging department showed high levels of compliance. There was an action plan in place to improve concerns identified during the audit, such as consistency in the completion of cleaning checklists and the use of 'I am clean' labels to show equipment has been cleaned.

**Environment and equipment**

- **The service had suitable premises and equipment and looked after them well.**
- The outpatients department consisted of three main areas; the main outpatients area (mainly for pre and post-operative treatment and consultations), the bone and joint centre (mainly for orthopaedics assessment and rehabilitation) and the One Penny Lane clinic (mainly for private fee paying patients). We found the environment across the outpatient areas was well maintained, free from clutter and suitable for providing safe care and treatment for patients.
- The consultation rooms, treatment rooms and waiting areas across the outpatients department and treatment

were well maintained and free from clutter. All the equipment we saw was clean, well maintained and within the service, calibration and electrical safety test due dates.
- There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing was managed by the hospital's engineering manager who arranged for equipment to be serviced by external contractors.
- We found that single use sterile instruments were stored appropriately and kept within their expiry dates. Medical gas cylinders (such as oxygen) were stored securely.
- Staff told us that all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- Emergency resuscitation equipment for adults and children was available across all areas. The log sheets we looked at were complete and up to date, demonstrating that staff carried out daily and weekly checks on emergency equipment.
- The physiotherapy department included a gymnasium area with a range of equipment used for patient treatment. We saw this area was well maintained and free from clutter.

**Assessing and responding to patient risk**

- **There were systems and processes in place to reduce the risks to patients and staff.**
- Patients attending routine outpatient appointments underwent initial consultations by medical or nursing staff. As part of these consultations, patient's medical histories, infection history and allergy status were reviewed.
- Patient records included risk assessments for venous thromboembolism (VTE – blood clots), nutritional needs, falls and infection control risks. Patients that underwent minor procedures or treatments (such as injections) in the outpatient department were monitored under routine observations and staff also used an early warning score system to monitor these patients if required.
- There were policies and procedures in place for the management of patients whose health deteriorated during treatment. Where a patient's health deteriorated, outpatients staff were able to contact the resident medical officer, who was on site 24 hours per day.
- There was a hospital wide resuscitation team (consisting of the resident medical officer, senior outpatients nurse and trained nursing and care staff). There had been no instances where patients required resuscitation in the outpatient department during the past 12 months.
- The hospital had an arrangement with a local NHS trust and the local critical care network for transferring patients out if their health deteriorated and they required emergency treatment. There had been one instance where a patient required transfer to acute hospital during the past 12 months. The patient became unwell during a routine physiotherapy outpatient appointment and the patient was assessed by the resident medial officer and transferred to an acute hospital by ambulance promptly.
- Staff used a modified safety checklist, based on the World Health Organization (WHO) checklist for certain minor outpatient treatments and procedures. Staff completed safety checks before (Sign in), during (time out) and after (sign out) procedures and documented this on a standardised form, which was kept in the patient's records.
- We looked at seven patient records that included safety checklists and these were completed appropriately and up to date. An audit to monitor adherence to the WHO checklist was carried out every three months by observing at least 10 procedures and reviewing the completed checklist records. We looked at recent audit records and these showed 100% compliance was routinely achieved in the outpatient department.

**Nurse staffing**

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The current outpatients manager was due to leave the organisation and the role had been advertised for recruitment. The ward manager oversaw the department in the interim period.
- There were no other nurse or healthcare assistant vacancies in the department. The senior outpatients nurse and ward manager told us they were in the process of developing a new senior nurse (band 6) role and were conducting interviews at the time of the inspection.
- The outpatients service had 10 whole time equivalent nurses in post at the time of the inspection. One nurse

was on long-term sick leave. There were three trained pre-operative assessment nurses in place. There were 10 whole time equivalent healthcare assistants in post; however four healthcare staff were on sick leave and one was on maternity leave at the time of the inspection.

- The ward manager and senior outpatients nurse told us staff shortfalls were covered through the use of bank staff. The outpatient services had four nurses and five healthcare assistants that worked as bank staff and they received the same level of training of permanent staff in the department. The service reported no agency staff had been used in the last 12 months.
- The outpatients service used a 'Spire Healthcare' staffing tool that was based on clinics rooms running, chaperone requirements and procedures taking place. Staff rotas were prepared four weeks in advance. Staffing levels were monitored on a daily basis and staffing requirements were discussed at daily huddle meetings.
- Outpatients staff worked across a number of shifts between 7.30am and 9pm. Shift handovers occurred on a daily basis and staff worked across the outpatient areas depending on the clinics and activity taking place. We found the department was sufficiently staffed during the inspection and there were at least three nurses and two healthcare assistants in the department.
- The service used a 'red flag' system to identify and escalate when staffing levels fell below the minimum requirement of two qualified nurses on shift. The ward manager told us there had been one instance in the past 12 months where a red flag was raised due to insufficient nurse staffing. This was escalated and an additional nurse was promptly made available from the ward to provide cover and ensure there was no impact to patient safety.

**Physiotherapy staffing**

- **The service had enough physiotherapy staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The physiotherapy manager oversaw the running of the department. There were four whole time equivalent physiotherapists supporting the outpatients department. Physiotherapy cover was provided on evenings and on Saturdays.
- The physiotherapy manager told us they were sufficiently resourced but were interviewing for two additional physiotherapy posts to cover for staff that were due to leave the department in the near future.

**Medical staffing**

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- All consultants working in the outpatients service were under practicing privileges.
- There were 83 consultants that worked across both surgery and outpatients at the hospital. There were also 61 consultants (such as cardiologists, dermatologists and audiologists) that only worked in the outpatients department.
- As part of their practising privileges consultants were responsible for the care and treatment of their patients at all times. Consultants were available for advice by telephone if they were not on-site.
- There was a system for consultants to arrange appropriate alternative named cover by another consultant if they were unavailable (for example, due to sickness or leave).
- The outpatients staff were also supported by a resident medical officer with on-site cover available 24 hours per day.
- For our detailed findings on medical staffing please see the Safe section in the surgery report.

**Records**

- **Staff kept detailed records of patients' care and treatment.**
- Staff used paper based patient records and these were securely stored in each area we inspected. Information such as scan results, referral records, consent forms, consultation summaries and discharge letters were also available electronically.
- We looked at the outpatients records for 10 patients and physiotherapy records for four patients. These were structured, legible, complete and up to date with few omissions and errors.
- The patient records we looked at included information such as medical histories, referral letters, booking records, risk assessments, consultation notes, nursing assessments and observations and safety checklist records and these were completed correctly.

- Patient records were not permitted to be taken off site by staff except for photocopies in the event of a patient transfer to the local NHS trust.
- A limited number of patient records were kept on site, with most completed records kept at a separate archive facility. Staff told us most records from the off-site archive facility could be retrieved within 24-48 hours. There was an electronic notes location system which allowed staff to see where notes were located so they could be retrieved.
- Patient notes were requested by the administration staff and prepared in advance of outpatient clinics. If an original set of records was not available for the clinic then a duplicate patient record was created using available information, such as copies of last clinic letters, referral letters, diagnostic scan reports and pathology results. The duplicate patient notes were clearly marked with a red label to ensure they were not mixed up with the original notes. The duplicate records were kept to one side within the medical records office and merged with the original patient record when located.
- A monthly audit of missing notes was carried out in the outpatients department. Audit results showed that between February 2018 and February 2019, patient notes were available on 98.97% of occasions. There was an action plan in place to improve compliance and this had led to a reduction of missing notes from over 1% during 2018 to 0.7% in January 2019 and 0.63% in February 2019.

### Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines.**
- The outpatient services did not store any controlled drugs. The medicines kept in the department were used for routine outpatient clinics and procedures. Only medicines prescribed by medical staff were kept in stock.
- Medicines were securely stored in locked cabinets in the areas we inspected. Staff carried out routine checks on medicine stocks and expiry dates. We looked at a sample of medicines and found these were kept within their expiry dates.
- We found that medicines were ordered, stored and discarded safely and appropriately. Records for ordering, return and disposal of medicines were maintained by outpatients staff. Medicines were ordered through the on-site pharmacy.
- Staff carried out routine medicines security and prescribing audits. Audits showed good levels of compliance and action plans were in place to improve areas of non-compliance.
- We saw that medicines that required storage in medicine fridges (such as eye drops) were appropriately stored. Fridge temperature logs showed that these were checked daily and the medicines we checked were stored at the correct temperatures. Staff understood what steps to take if storage temperatures exceeded the recommended temperature ranges.
- We looked at the medicine records for three patients. Patients were given their medicines in a timely way, as prescribed, and records were completed appropriately. The records we looked at also showed patient allergy status had been documented.

### Incidents

- **The service managed patient safety incidents well.**
- There had been no 'never events' reported in relation to the outpatients services between October 2017 and April 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There had been no serious patient safety incidents reported by the outpatient services and diagnostic imaging services between October 2017 and September 2018. There had been 177 clinical incidents and 12 non-clinical incidents reported by the services during this period. These were all rated as no or low harm.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on an electronic incident reporting system.
- Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the matron or ward manager.
- Staff told us they received feedback about incidents reported and that this was used to improve practice and the service to patients. Learning from incidents was

shared through hospital-wide alerts, bulletins and newsletters. Meeting minutes showed that incidents were also discussed during routine site management team, clinical governance and departmental meetings so shared learning could take place.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There had been no patient deaths reported by the services during the past 12 months. There was a process in place for patient deaths to be reviewed and investigated through the hospital's clinical governance team, and the Clinical Governance Committee.

**Safety Thermometer (or equivalent)**

- **The service used safety monitoring results well.**
- The outpatient services collated information on patient safety and this was reported on a clinical scorecard every three months. The clinical scorecard included incidents of venous thromboembolism (VTE – blood clots), patient falls, pressure ulcers and patient readmission rates.
- The clinical scorecard showed the incident rates for VTE, pressure ulcers and patient falls were within the hospital's targets between January 2018 and December 2018.
- The outpatient services reported one patient fall incident during 2018. This had resulted in no patient harm. There were no cases of VTE or pressure ulcers reported by the outpatient services during this period.
- The pre-operative assessment process involved VTE screening assessments of patients prior to admission for treatment at the hospital. The hospital reported VTE screening compliance was 100% during 2018.

## Are outpatients services effective?

We inspect but do not rate effective for outpatient services.

**Evidence-based care and treatment**

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- Patients received care according to national guidelines such as National Institute for Health and Care Excellence (NICE) guidelines, such as for infection prevention and control (QS 61) and patient experience (QS 15).
- Care pathways and clinical policies were benchmarked against national guidelines and developed through the corporate provider.
- Standardised care pathways were in use and being developed for certain procedures and these were used as part of initial patient assessments and during the pre-operative assessment process by outpatient staff.
- Changes to clinical practice and policies were cascaded by the corporate provider with summary briefs. Changes to practice were discussed at routine Medical Advisory Committee, clinical effectiveness and clinical governance meetings.
- Updated policies and changes to practice were shared with outpatients staff during monthly departmental meetings and staff were required to sign a log sheet to confirm they had read and understood these.
- Outpatients staff used a modified pathway for certain treatments (such as injections) based on the World Health Organization (WHO) safety checklist.

**Nutrition and hydration**

- **Patient's nutrition and hydration needs were managed well.**
- Patients were given advice on starve times for certain procedures as part of their pre-operative assessments.
- Patients with specific nutritional needs were also identified as part of the pre-operative assessment process through the use of the MalnutritionUniversal Screening Tool (MUST).

**Pain relief**

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- Patients were assessed for pain symptoms during pre-operative and post-operative outpatient appointments and supported in managing pain through prescriptions with the appropriate pain-relief medicines.
- Patients that underwent certain treatments (such as injections) within the outpatient services were assessed and monitored by staff as part of their routine observations to identify and manage pain symptoms.

- Patients were prescribed pain relief medicines to take home and given advice on how to manage pain symptoms following discharge after certain procedures and during post-operative outpatient appointments.
- The outpatients' patients we spoke with did not highlight any concerns in relation to pain management.

**Patient outcomes**

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- The outpatient services did not participate in any national clinical audits. However, patients outcomes were benchmarked against the provider's other hospitals nationally using a clinical scorecard. This included standard indicators relating to incidents, infections, patient readmissions and patient satisfaction surveys.
- The clinical dashboard for April 2019 showed the hospital scored 'green' for most quality indicators demonstrating that compliance against performance indicators had been achieved.

**Competent staff**

- **The service made sure staff were competent for their roles.**
- Newly appointed staff underwent an induction process for up to six weeks and their competency was assessed using an induction checklist prior to working unsupervised.
- Staff told us they received an annual appraisal including a mid-year review. The hospital reported that 100% of outpatient staff had completed their appraisals during 2018.
- Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital or clinic). There were no consultants working in the outpatient services with any outstanding queries relating to their practising privileges.
- Practicing privileges were reviewed every two years by the hospital director, matron and Medical Advisory Committee chair.
- All eligible staff were up to date with their Nursing and Midwifery Council (NMC) and General Medical Council (GMC) revalidation dates.
- Records showed that 100% of outpatient staff had received basic life support (BLS) and immediate life support (ILS) training. Records showed 67% of outpatient staff had completed the paediatric basic life support (PBLS) training and 75% had completed paediatric immediate life support (PILS) training.
- There were also two nurses trained to advanced life support (ALS) and one nurse trained to European Paediatric Advanced Life Support (EPALS) within the outpatient services.
- There was a resident medical officer (RMO) on site who covered the outpatient services as well as the ward and theatre areas. The RMO had completed advanced life support (ALS) and European Paediatric AdvancedLife Support(EPALS) training.
- Staff across the outpatient services received competency based training specific to their role. Competencies were signed off by authorised person (such as the manager or approved trainer) prior to staff carrying out certain activities, such as taking bloods, cannulation and undertaking venous thromboembolism (VTE – blood clots) assessments.
- We looked at six outpatient and physiotherapy staff files and these showed evidence of up to date competency-based training as well as additional on-the-job and mandatory training.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by the management team.

**Multidisciplinary working**

- **Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- There was effective daily communication between multidisciplinary teams across the outpatient services. Outpatient staff told us they had a good relationship with consultants, physiotherapy, pharmacy and ward and theatre teams.
- A daily hospital huddle of staff from various disciplines was held and attended by senior representatives from each hospital department. Outpatient staff also carried out 'safety huddles' on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- Physiotherapy services were available six days per week to coincide with outpatient clinic times.
- Collaborative working with the surgical department meant each area knew the number and type of patient that would be receiving treatments and may need interventions.

Good

# Outpatients

- There were a number of service level agreements in place with nearby organisations (such as the local NHS Trust) which involved teamwork to ensure continuity of care for patients.

**Seven-day services**

- **Outpatient services were available six days per week.**
- The outpatient services operated from 7:30am until 9pm during weekdays and from 9:30am to 3:30pm on Saturdays.
- The One Penny Lane clinic opened during weekdays and one Saturday per month for an ophthalmology specialty outpatient clinic.
- The physiotherapy services and diagnostic imaging services also operated six days per week to coincide with outpatient clinics.

**Health promotion**

- **Staff discussed health promotion and lifestyle choices with patients.**
- Staff told us they routinely discussed health promotion and lifestyle choices with patients as these could impact on their ability to receive treatment at the hospital. For example, patients identified as being overweight, patients at high risk due to high alcohol consumption or patients that were smokers were given advice and support (including referral to external services, such as 'Smoke Free Liverpool').
- Nursing staff on the ward, pre-operative assessment and outpatient departments had completed e-learning training on 'Making Every Contact Counts' to give them the knowledge to give brief advice to patients who are identified as being smokers, increased levels of alcohol intake and overweight.
- Staff from 'Smoke Free Liverpool' attended to give outpatient staff training on the advice to give to patients to encourage them to give up smoking. Written advice materials on giving up smoking were also available in the department.
- A calendar was available in the outpatient services to highlight health awareness campaigns such as Mental Health and Sun Awareness month.

**Consent and Mental Capacity Act**

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**
- Staff had the appropriate skills and knowledge to seek verbal informed consent and written consent before providing care and treatment to patients.
- Patient records showed that written and verbal consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to treatment.
- Records showed 100% of outpatient staff had completed mandatory training in the Mental Capacity Act (MCA) 2005.
- Where patients lacked the capacity to provide informed consent, staff made decisions about whether treatment could be provided and sought input from other healthcare professionals, such as a psychiatrist or the patient's general practitioner (GP).
- Staff told us that patients that lacked capacity (such as those living with dementia) would be accompanied be a carer.
- Patients aged 16 and 17 years could be admitted for outpatient services. There was a trained paediatric nurse that carried out competency assessments based on the Gillick competence guidelines. Patients that were deemed as unable to consent to treatment were referred for treatment at one of the provider's other hospitals in the local area. We looked at the records for three patients aged 16 and 17 years and saw that Gillick competence assessments had been completed appropriately by the paediatric nurse.

## Are outpatients services caring?

Good

This is the first time we have rated this service. We rated caring as good.

**Compassionate care**

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner across the outpatient areas. Staff spoke with patients in a friendly and polite way.
- Patients were seen in individual consultation rooms and staff spoke with patients in private to maintain

confidentiality. We saw that reception staff in the main waiting area spoke with patients discreetly. There were a number of small waiting rooms across the department that could be used for patients if they required further privacy.

- Staff told us a small room in the physiotherapy area was occasionally used as a treatment room for individual patients where privacy and dignity may be required. We saw the room could not be locked and the door had clear glass that could impact patients' privacy and dignity. We raised this during the inspection and saw evidence that immediate remedial actions were taken, including signage put in place to show if the room was occupied and a roller-blind for the glass section of the door so privacy could be maintained.
- We spoke with five patients and they were all complimentary towards the staff and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included "the staff were kind, friendly", "staff were helpful and "over the moon with the care received".
- The physiotherapy department carried out a satisfaction survey to seek feedback from patients referred from outpatients during January 2019. The survey was based on 37 responses and showed 100% of patients that responded would recommend the physiotherapist and the physiotherapy department.
- The Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Test data for outpatient services specifically was not available; however the test data for all patients across the hospital between July 2018 and December 2018 showed the hospital had consistently high monthly scores (between 95% and 99%) with a response rate of 17% during this period. This indicated that most patients were positive about recommending the hospital's services to friends and family.

**Emotional support**

- **Staff provided emotional support to patients to minimise their distress.**
- Patients told us the staff were calm, reassuring and supportive and helped them to relax prior to undergoing treatment. We saw staff spending appropriate time talking to patients and responding to their questions in an appropriate manner.
- During consultations patients were offered a chaperone or patients could be accompanied by a friend or relative present.
- Staff reviewed patients' emotional state as part of the initial assessment process. Where patients were identified as needing counselling support, they were referred for psychiatric support or to their general practitioner (GP) so they could access the appropriate support or treatment needed.

**Understanding and involvement of patients and those close to them**

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patient records included initial outpatient consultations and pre-operative assessments that took into account individual patient preferences.
- Patients we spoke with told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. They told us the risks and benefits of their procedure or treatments were clearly explained to them so they could make an informed decision.
- Patients also spoke positively about the verbal information and support they received from staff before, during and after their treatment.

## Are outpatients services responsive?

Good

This is the first time we have rated this service. We rated responsive as good.

**Service delivery to meet the needs of local people**

- **The service planned and provided services in a way that met the needs of local people.**
- The outpatient services had sufficient capacity to meet the needs of patients attending the department. There were a number of waiting areas and sufficient numbers of treatment and consultation rooms. A range of clinics and treatments were available six days per week, with capacity for additional clinics on evenings and weekends if required.

- Patients underwent an initial booking and consultation process that allowed staff to plan for the patient's care and treatment in advance so that patients did not experience delays in their treatment. Patient records were prepared and staff allocated in advance of clinics.
- There was daily communication between staff across the hospital and daily safety huddles that allowed for any patient flow or staffing concerns to be escalated and managed.
- The hospital had limited car parking facilities and planned to expand the number of car parking spaces available for patients following patient feedback through engagement and satisfaction surveys.

**Meeting people's individual needs**

- **The service took account of patients' individual needs.**
- Information leaflets about the services were readily available in all the areas we visited. Information leaflets in different languages or other formats (such as braille, large print or 'easy read' format) were also available or could be printed upon request.
- Staff could access a language interpreter service if needed.
- Patients with certain conditions were excluded from undergoing treatment at the hospital. For example, patients with complex pre-existing medical conditions. These patients were offered services at another of the provider's hospitals.
- Patients under 16 years of age could attend outpatient consultation appointments only. If these patients required any further care or treatment they were referred to another of the provider's hospitals.
- Patients aged 16 and 17 years of age could receive treatment (such as physiotherapy services) following Gillick competency assessment by a paediatric nurse. There was a tracker system that identified when a patient under 18 years of age attended the department and staff ensured that at least one member of staff with safeguarding level 3 was on duty at the time.
- We saw that children's toys and activity sets (such as colouring books) were available in the outpatient waiting areas. These were routinely cleaned and maintained by staff and were available for children and young people that attended the department as patients or for adult patients that were accompanied by their children.
- Records showed 100% of outpatient staff had completed dementia awareness training during 2018. The department also had dementia link nurses in place to provide support and advice if needed.
- The initial and pre-operative assessments identified patients living with dementia or a learning disability and this allowed the staff to decide whether they could treat these patients or refer them to another healthcare provider that could meet their needs.
- Staff told us patients living with dementia or a learning disability would normally be accompanied by a carer. Staff we spoke with were able to give examples of reasonable adjustments made when carrying out procedures for patients with specific needs (such as appointments at the beginning or end of the day).
- Staff also completed a passport document for patients admitted for treatment with dementia or a learning disability as part of their initial assessment. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes, alerts (such as allergies) and their discharge arrangements.
- The services were accessible for patients with a wheelchair and other facilities were available for patients with a disability (such as hearing loops).
- The outpatient department had a designated, multi-functional room for use by patients, relatives and staff to promote the needs and preferences of different groups of people. This room served as a prayer room, quiet room, breastfeeding room and space for breaking bad news.
- The physiotherapy team arranged follow-up treatments to coincide with other outpatient appointments (such as wound checks, staple removal or consultant appointments) so patients did not have to make multiple visits to the hospital.
- All patients and visitors had access to free hot and cold drinks and refreshments and these were available in the waiting areas across the outpatient services.

**Access and flow**

- **People could access the service when they needed it.**
- Patients were referred to the outpatient department through NHS referral or through a GP or self-referral for private funded and insured patients.
- Patients were given appointments based on their preferences. Outpatient and physiotherapy patients

were normally allocated 30 minute appointments but this could vary depending on the type of treatment. Appointment times were staggered during the day to avoid long patient waiting times.

- The outpatient services consistently exceeded the 92% national standard for the incomplete pathway referral to treatment time (less than 18 weeks) between April 2018 and March 2019.
- We did not observe any issues relating to patient access and flow during the inspection. There was a relaxed atmosphere in the outpatient department and patients were being seen promptly with minimal waits. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patient records showed staff had completed an early discharge planning checklist that covered areas such as medicines and communication to the patient and other healthcare professionals, such as GP's, to ensure patients were discharged in a planned and organised manner.
- The physiotherapy department carried out a patient wait time audit in September 2018 to monitor wait times for physiotherapy services. The audit covered 71 patients and found that the average wait time was 2.6 minutes with the longest wait time of 9 minutes. A re-audit was planned every six months to monitor wait times and identify areas for improvement.
- The service regularly monitored patients that did not attend (DNA) their appointments. The average DNA rate for patients across outpatients and diagnostic imaging services was 4.9% between June 2018 and March 2019.
- Actions had been taken to ensure all the patients attended their appointments at the right time and patients were contacted to rearrange if they did not attend their appointments. The service sent letters at least a week in advance of appointment and then followed up by sending a text message 24 hours prior to the appointment. This had led to a significant drop in the number of DNA's for the outpatient service.
- All new and follow up patients received a text reminder 48 hours prior to their appointment. New patients that did not attend their appointment were contacted by phone or in writing and offered a new appointment. If the patient failed to attend the second appointment then they were discharged back to their GP.
- If a patient failed to attend their follow up appointment a further SMS message or email was sent asking the patient to contact the hospital. Patients that did not respond were contacted by telephone. If the patient did not respond and there was no urgent clinical reason for them to attend then they were discharged back to their GP.
- The hospital was reviewing whether patients could respond to the SMS appointment reminder stating whether they would be attending or not in order to further improve the DNA rates.

**Learning from complaints and concerns**

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- Information leaflets describing how to raise complaints about the service were visibly displayed in the reception and waiting areas. Staff we spoke with understood the process for receiving and handling complaints. Complaints were managed by the complaints coordinator.
- The complaints policy stated that complaints would be acknowledged within three working days and investigated and responded to within 20 working days for routine complaints.
- Where the complaint investigation had not been completed within 20 working days, staff were required to notify the complainant in writing explaining the reasons for the delay.
- Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns within the organisation (to the corporate provider) or to external organisations such as the Parliamentary and Health Service Ombudsman (for NHS patients) and the Independent Sector Complaints Adjudication Service (ISCAS) for private funded patients.
- The outpatient services received 32 complaints between April 2018 and March 2019. The most frequent reasons for complaints were lack of communication (13 complaints) and delayed / cancelled appointments (11 complaints).
- Remedial actions taken to improve services following these complaints included a review of pre-operative assessment staffing and processes and additional training for pre-operative staff in the hospital's updated admissions policy.
- We looked at the records for five complaints during the inspection. These showed that complaint investigations

and response letters were completed appropriately. We saw evidence that duty of candour principles were applied verbally and in writing following complaints to the services.

- Staff told us that information about complaints was discussed during daily huddles and monthly departmental meetings to raise staff awareness and aid future learning. Complaints were also reviewed for trends / learning as part of routine senior management team (SMT), clinical governance and medical advisory committee meetings. We saw evidence of this in the meeting minutes we looked at.
- For our detailed findings on complaints please see the responsive section in the surgery report.

## Are outpatients services well-led?

Good

This is the first time we have rated this service. We rated well-led as good.

### Leadership

- **The service was temporarily overseen by the ward manager whilst a new outpatients manager was being recruited; however the ward manager had the right skills and abilities to run a service providing high-quality sustainable care.**
- The existing outpatient manager was in the process of leaving the organisation and was on sick leave at the time of the inspection. The role had been advertised and the hospital was in the process of recruiting a new outpatient manager.
- In the interim, the outpatient services were being overseen by the ward manager (also deputy matron). The ward manager was also supported by the senior outpatients nurse (also resuscitation lead) who oversaw staff rotas and was involved in the day to day running of the service.
- The physiotherapy department was managed by the physiotherapy manager. The ward manager and the physiotherapy manager reported to the matron (also head of clinical services) who reported to the hospital director (who was the registered manager with the Care Quality Commission).
- Staff in the outpatient services were aware of the current interim arrangements and told us they received good support from the ward manager and senior outpatients nurse. Outpatient staff were also positive about the visibility and support they received from senior managers, such as the matron and hospital director.
- For our detailed findings on leadership please see the well-led section in the surgery report.

### Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- The hospital vision was 'to be recognised as a world class healthcare business'. This was underpinned by a set of values and promises around achieving patient, staff and consultant satisfaction.
- There was an overarching 2019 strategy for the hospital, which included four specific objectives relating to outpatient services and four objectives relating to physiotherapy services.
- The outpatient service objectives were based around providing safe, effective and well-led care for patients, ensure patients requiring surgery attend pre-operative assessments, ensure patients and carers are fully informed and maintain a well led department by employing highly skilled staff and retaining them through training and professional development.
- The physiotherapy department objectives were based around offering a patient centred physiotherapy service, to enhance the profile of department through web, social media and marketing, to launch pre-operative "Joint School" for total hip and knee replacement and to achieve 'outstanding' in future CQC reviews.
- The vision, values and objectives were clearly displayed had been cascaded to staff across the outpatient services and staff had a good understanding of these. Objectives were incorporated into individual staff appraisals.

### Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- All the staff we spoke with were highly motivated and spoke positively about the care they delivered. They described the outpatient services and the hospital had a warm, friendly and family-like culture where staff were supported well and worked as a team.

- The overall staff sickness rate for outpatient staff ranged between 0% and 5% between March 2018 and December 2018.
- The outpatient staff turnover rate between January 2018 and December 2018 was of 9% for nursing staff and 25% for healthcare assistants. At the time of the inspection, there was one nurse on long-term sick leave. There were four healthcare assistants on sick leave and one on maternity leave (out of 10 whole time equivalent healthcare assistants). The shortfalls were being managed through the use of bank staff (that had received the same level of training as permanent staff).
- We spoke with two healthcare assistants and they described how they were undergoing a period of difficulty as a result of the sickness rates but they were well supported by the management team and also received good emotional / supervision support during this period.
- The staff we spoke with told us they received regular feedback to aid future learning and that they received good training and learning opportunities.
- Most staff felt confident to raise issues with their managers and felt the management team responded positively when concerns were shared. Staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.
- For our detailed findings on culture please see the well-led section in the surgery report.

**Governance**

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- There were clear governance structures in place that provided assurance of oversight and performance against safety measures. There were a number of groups and committees (such as the Infection Control Committee, Medical Advisory Committee, Clinical Governance Committee and Clinical Effictiveness Committee) in place that held meetings either monthly or every three months and reported to senior management team.
- There were daily huddles held in the outpatient services and a hospital-wide huddle held daily to manage patient risks and cascade governance information to staff. The outpatients and physiotherapy teams held monthly clinical staff meetings in place. Meeting minutes showed that discussions around workforce, performance and governance issues and key risks took place during these meetings.
- We looked at a selection of consultant files and these contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks. We spoke with one consultant in the bone and joint centre who told us they were required to submit this information to the hospital on an annual basis.
- We looked at a selection of staff files and these showed evidence that appropriate recruitment pre-employment checks had been carried out. This included identification checks, qualifications, Hepatitis B inoculation certificates, at least two employment references and Disclosure and Barring Service (DBS) checks.
- For our detailed findings on governance please see the well-led section in the surgery report.

**Managing risks, issues and performance**

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- There was a risk management policy in place that outlined the process for identifying, assessing and mitigating risks to the services.
- We saw that up to date risk assessments were in place in relation to health and safety risks and Control of Substances Hazardous to Health (COSHH) assessments.
- The key risks relating to the outpatient services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member (such as the ward manager or matron) responsible for managing that risk.
- Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the hospital risk register.
- Staff were supported by the hospital governance lead and governance assistant to review open risks and identify mitigations / controls to reduce or eliminate risks. Key risks were reviewed at monthly departmental meetings and clinical governance meetings.

- Routine staff meetings took place to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as infection control, patient records and medicines management. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and CREWS newsletters.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.
- For our detailed findings on managing risks, issues and performance please see the well-led section in the surgery report.

**Managing information**

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as performance reports, audit records and meeting minutes.
- Staff completed information governance training as part of their annual mandatory training. Records showed 100% of staff in the outpatient services had completed this training.
- The hospital reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO).
- Staff used paper based and electronic patient records that contained detailed patient information from admission through to discharge. This meant that staff could access all the information needed about the patient at any time.
- Electronic systems (such as to store records and manage patient appointments) required password access.
- Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates. Policies and procedures included log sheets to confirm staff in the outpatient services had read the policies.

**Engagement**

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.**
- Staff across the outpatient services told us they received good support and regular communication from the management team. Staff routinely participated in daily safety huddles and routine departmental team meetings to cascade information.
- The hospital also engaged with staff through bulletins and newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The service sought formal feedback from staff through staff engagement surveys and these were benchmarked nationally against the provider's other hospitals. The 2019 staff engagement survey showed the hospital performed similar to or slightly below the provider's average for the key indicators from the survey. There was an action plan in place to improve staff engagement following the survey.
- Staff were supported with development opportunities and were offered additional support such as fitness and Pilates classes at discounted rates.
- We spoke with a member of staff who had experienced difficult personal circumstances and they told us their emotional needs were really well supported by their colleagues and the management team.
- Staff across the outpatient services told us they routinely engaged with patients and their relatives to gain feedback from them. This was done formally through participation in patient experience surveys and through patient focus groups and events. We looked at the findings from a selection of patient surveys and focus groups and the feedback was very positive. There were actions in place to improve areas highlighted through patient feedback, such as patient car parking facilities.
- The physiotherapy department conducted out a range of surveys to gain feedback from patients and staff groups across the hospital. The feedback was mostly positive and the department used this information to look for ways to improve services.

Good

# Outpatients

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

**Learning, continuous improvement and innovation**

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- A pre-operative assessment to pharmacy direct referral process had been introduced so patients identified with certain health conditions are assessed and given medicines and support in a timely manner.
- The hospital was in the process of launching an updated pre-operative assessment pathway to allow staff to record all relevant risk assessments and test results in one document.
- For our detailed findings on learning, continuous improvement and innovation please see the well-led section in the surgery report.

Good

# Diagnostic imaging

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

## Are diagnostic imaging services safe?

Good

This is the first time we have rated this service. We rated safe as good.

**Mandatory training**

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory training was delivered through a structured programme with face to face sessions and e-learning modules. Staff we spoke with told us they were allowed sufficient time to complete their training when required.
- Staff received equality and diversity, compassion in practice and anti-bribery training once as part of their induction. Staff completed annual mandatory training in fire safety, information governance, infection control, health and safety and safeguarding adults and children. Moving and handling training took place every two years.
- Records showed that 100% of staff across the diagnostic imaging services had completed their mandatory training during 2018. Training was delivered on an on-going annual programme and the completion rate for diagnostic imaging staff during the current year was 92% at the time of our inspection.
- Local rules for radiation were available in files within the treatment rooms and all relevant staff had signed a log sheet to confirm they had read and understood these.

**Safeguarding**

- **Staff had training on how to recognise and report abuse and they knew how to apply it.**
- There were policies in place for safeguarding vulnerable adults and safeguarding children and young people that provided guidance for staff on how to identify and report safeguarding concerns.
- Staff received mandatory training in safeguarding adults and children. Records showed 100% of diagnostic imaging staff had completed level one and level two safeguarding training (adults and children) during 2018.
- Records showed eight out of 10 diagnostic imaging staff (80%) had completed level three safeguarding training. The hospital reported that from March 2019 onwards a new level three safeguarding training module had been developed and all staff were required to complete level three safeguarding training during 2019.
- Records showed 100% of diagnostic imaging staff had completed training in 'Prevent' (anti-radicalisation) and female genital mutilation (FGM).
- The diagnostic imaging staff we spoke with were aware of how to identify abuse and report safeguarding concerns. Staff told us they would notify the imaging manager and the safeguarding lead if they identified any safeguarding concerns, in accordance with the hospital's safeguarding policies.
- The hospital reported one safeguarding incident relating to diagnostic imaging services between April 2018 and March 2019. The alleged abuse was identified in July 2018 by a member of staff in the diagnostic imaging department and related to matters outside of the hospital. We found that staff in the diagnostic imaging service had taken appropriate actions to protect the patient from potential abuse.
- For our detailed findings on safeguarding please see the safe section in the surgery report.

**Cleanliness, infection control and hygiene**

- **The service controlled infection risk well.**

Good

# Diagnostic imaging

- The hospital's 'control of infection manual' outlined the processes for infection prevention and control. Records showed 100% of diagnostic staff had completed mandatory training in infection control during 2018.
- There had been no cases of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) reported by the hospital between January 2018 and April 2019.
- The diagnostic procedure rooms, clinical areas and waiting areas were visibly clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules and daily checklists were in place and up to date, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Sharps bins were appropriately stored and labelled correctly. Staff used chlorine-based disinfectant to clean and decontaminate surfaces and equipment.
- Personal protective equipment, such as gloves and aprons, were readily available across all the areas we inspected. There were enough hand wash sinks and hand gels. Staff we saw were compliant with hand hygiene and 'bare below the elbow' guidance.
- We found that clean linen was stored on a trolley in the ultrasound unit. This was not covered which meant there was a potential risk of contamination from air-borne particulates. The hospital's policy for storage of linen stated clean linen should be covered to minimise the risk of contamination. We raised this with staff at the time of the inspection and the operations manager confirmed new linen trolleys with covers had been ordered to address this issue and interim measures such as temporary covers would be used until the delivery of the new linen trollies.
- A hand hygiene audit was carried out at least every three months to monitor staff compliance with hand washing guidelines. Audit results from October 2018 to March 2019 showed overall compliance in the diagnostic imaging department was 95%. There was an action plan in place to improve areas where poor hand hygiene compliance was identified and this was discussed with staff to improve compliance.
- Infection control audits were routinely carried out to check compliance against national infection prevention and control guidelines and to monitor the cleanliness of the general environment and equipment. The April 2019 audit of the outpatients and diagnostic imaging department showed high levels of compliance. There was an action plan in place to improve concerns identified during the audit, such as consistency in the completion of cleaning checklists and the use of 'I am clean' labels to show equipment has been cleaned.

**Environment and equipment**

- **The service had suitable premises and equipment and looked after them well.**
- We found the environment across the diagnostic imaging department was well maintained, free from clutter and suitable for providing safe care and treatment for patients.
- The diagnostic scan rooms, treatment rooms and waiting areas were well maintained and free from clutter. All the equipment we saw was visibly clean and well maintained.
- There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing was managed by the hospital's engineering manager who arranged for equipment to be serviced by external contractors. All the equipment we saw was clean, well maintained and within the service, calibration and electrical safety test due dates.
- We found that single use sterile instruments were stored appropriately and kept within their expiry dates. Medical gas cylinders (such as oxygen) were stored securely in most areas. An oxygen cylinder was located on the floor in the mobile computerised tomography (CT) unit. Staff told us they were awaiting delivery of fixings to secure this.
- Staff told us that all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- Emergency resuscitation equipment was available for adults and children. The log sheets we looked at were complete and up to date, demonstrating that staff carried out daily and weekly checks on emergency equipment.
- There was an emergency back-up power system in case of power failure and this was serviced on an annual basis.
- There were signs and warning lights outside controlled areas were radiation was used to make it clear when it was safe to enter.

- Staff wore dosimeters so that managers knew how much radiation the staff had been exposed to. These were changed every two months and dosimeter readings were checked by the radiation protection supervisor(s) and results were shared with staff during routine departmental meetings.
- There were no staff exposure related incidents reported by the services in the last 12 months. If any abnormal dosimeter readings were identified advice was sought from the radiation protection advisor.
- Diagnostic imaging staff were provided with personal protective equipment such as lead aprons and thyroid protection to protect them against radiation exposure, in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Consultants performing complex procedures also wore lead radiation protection goggles. The equipment was checked visually every three months and screened every six months to check if it was fit for purpose.

**Assessing and responding to patient risk**

- **There were systems and processes in place to reduce the risks to patients and staff.**
- Staff carried out risk assessments on patients attending the imaging department. The service had safety questionnaires that patients completed prior to undergoing radiological procedures. The service had a magnetic resonance imaging (MRI) safety questionnaire and a computerised tomography (CT) questionnaire. These were used to identify patients such as pregnant patients, those that had undergone surgery recently and those with implants, so staff could assess whether patients were suitable to undergo procedures.
- Risk assessments had been completed for all the levels of radiation and the risk assessments addressed occupational safety to radiographers and also to patients. Local rules for radiation were available in files within the treatment rooms for each level of radiation. Risk assessments and processes were reviewed every two years or sooner if any change in practice was identified.
- The radiation protection advisor carried out a review of radiation protection local rules and IR(ME)R employers procedures to assess compliance against IR(ME)R guidelines. The last review was carried out in September 2017 and was next due in 2021.
- The service had two radiation protection supervisors (RPS) appointed to ensure there was at least one available in the imaging department at all times. Their duties included maintaining and monitoring compliance with local rules and risk assessment records, providing training and support to staff and overseeing the management of staff dosimeters.
- There was a contractual arrangement in place for the services to receive support from an external radiation protection advisor (RPA) and medical physics expert. The radiation protection advisor carried out a review at least every three years and was responsible for issues such as calibration of equipment, risk assessments and dose assessment and recording. The last review was carried out in September 2017 and was next due in 2020.
- The diagnostic imaging services at the hospital did not have any radioactive substances as they did not provide secondary care (such as radiotherapy or nuclear medicine).
- The patient dose audit (2018) consisted of a random sample of approximately 100 X-ray procedures including plain radiography, fluoroscopy procedures and theatre screening to check that patient doses were recorded accurately. The audit found there was 98% degree of compliance of imaging staff recording doses accurately. The next audit was scheduled for May 2019.
- The service had processes to confirm the right person got the right radiological scan at the right time. The diagnostic imaging department had implemented the Ionising Radiation ( Medical Exposure) Regulations. IR(ME)R 'pause and check' process before every patient examination to confirm the delivery of safe and effective patient care. This included a six point check. The six point check included examination justification, patient's recent imaging, patient's identity (name, date of birth, postcode), pregnancy status, confirmation that the patient expected the diagnostic testing procedure and a check as to whether the patient had had a similar procedure recently. This enabled staff to check patient understanding about the radiological procedure and to reduce duplication and possibly over exposure to radiation.
- The service conducted an audit of IR(ME)R 2017 requirements in relation to patient identification in January 2019, based on a random sample of 50 patient records. The audit showed there was 96% compliance with pause and check processes. There was an action plan in place to improve compliance and a re-audit was scheduled for August 2019.

- The diagnostic imaging manager also carried out an observational audit (consisting of 10 patient observations) to check that staff carried out identification checks for patients undergoing x-ray procedures. The audits for June 2018 and January 2019 showed there was 100% compliance in staff checking of patients' details, anatomy and laterality.
- An audit was conducted to check compliance that radiographers asked female patients between the ages of 12 and 55 years old the date of the first day of their Last Menstrual Period (LMP) before they had any computerised tomography (CT), X-ray and fluoroscopy procedures in the department between the areas of the diaphragm and knees. The audit covered the period between September 2018 and February 2019 and showed there was 96% compliance for X-ray & fluoroscopy patients (based on 316 patients) and 94% compliance for CT patients (based on 121 patients). A further audit was scheduled for September 2019.
- There were policies and procedures in place for the management of patients whose health deteriorated during treatment. Where a patient's health deteriorated, diagnostic imaging staff were able to contact the resident medical officer, who was on site 24 hours per day.
- There was a hospital wide resuscitation team (consisting of the resident medical officer and trained nursing and care staff). There had been no instances where patients required resuscitation in the imaging department during the past 12 months.
- The service reported that annual magnetic resonance imaging (MRI) safety training was provided for the hospital wide resuscitation team underwent and any staff who would need to access the department.
- The hospital had an arrangement with the NHS trust and the local critical care network for transferring patients out if their health deteriorated and they required emergency treatment. There had been no instances where patients required transfer to acute hospital from the imaging department during the past 12 months.
- The diagnostic imaging manager told us they had recently carried out a simulation exercise in the magnetic resonance imaging (MRI) area to test the responsiveness of the resuscitation team. The simulation involved a scenario with a live person that required resuscitation support and the exercise was successful with a rapid response from the resuscitation team.
- Staff monitored patients by carrying out routine observations after certain procedures and patients were discharged when fit to do so.
- Staff used a modified safety checklist, based on the World Health Organization (WHO) checklist for certain diagnostic procedures (such as fluoroscopy). Staff completed safety checks before (Sign in), during (time out) and after (sign out) procedures and documented this on a standardised form, which was kept in the patient's records.
- An audit to monitor adherence to the WHO checklist was carried out every three months by observing at least 10 procedures and reviewing the completed checklist records. The audit for January – March 2019 showed there was 100% compliance with the sign in step and 93% compliance with the time out and sign out steps. The diagnostic imaging manager discussed areas of non-compliance with individual staff members to improve compliance.

**Diagnostic Imaging Staffing**

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The diagnostic imaging staff use predictors from the outpatient clinics and theatre lists to determine how many patients would require support and flexible working patterns were in place to provide timely treatment for patients.
- There was a diagnostic imaging manager that oversaw the day to day running of the service.
- There were 10 whole time equivalent staff in the imaging department. There were two radiographer vacancies at the time of the inspection. The vacant posts had been recruited to and were awaiting start dates. The shortfall in radiographer staff was managed through the use of agency staff. The diagnostic imaging manager told us they used regular agency staff that had undergone local induction and were familiar with the department's policies and procedures.
- The mobile computerised tomography (CT) scan service was available one Wednesday per week and was operated by two staff. These staff were managed

centrally by the provider and the hospital director was responsible for the staff when on site. The hospital director conducted engagement meetings with the central computerised tomography (CT) team at least every three months to gain assurance that the staff were trained and competent.

### Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- There were 15 consultant radiologists working in the diagnostic imaging department under practicing privileges.
- For our detailed findings on medical staffing please see the Safe section in the surgery report.

### Records

- **Staff kept detailed records of patients' care and treatment.**
- Records such as consent forms and patient assessments were in paper format and these were scanned electronically on to the provider's IT system. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff in other parts of the hospital, such as during routine outpatient consultations.
- We looked at the diagnostic imaging records for four patients. These were structured, legible, complete and up to date with few omissions and errors.
- The patient records we looked at included information such as consent forms, diagnostic scan reports, images, patient assessments and safety checklist records and these were completed correctly.

### Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines.**
- The diagnostic imaging services did not store any controlled drugs. The medicines kept in the department were used for routine scans and procedures (such as contrast materials used for scans).
- Staff in the diagnostic imaging department used patient specific directions for six medicines; gastrografin, omnipaque, dotarem, buscopan, multihance and klean prep. These had been developed in line with NHS England guidance by the diagnostic imaging manager in conjunction with a consultant radiologist and approved by a pharmacist.
- Radiographers that used patient specific directions had competency assessments in place and competencies were periodically reviewed and assessed by a trained person (such as the diagnostic imaging manager or a radiologist). We looked at the patient specific directions used for one patient and the competencies for two staff in the mobile computerised tomography (CT) unit and these were complete and up to date.
- Medicines and contrast materials were securely stored in locked cabinets in the areas we inspected. Staff carried out routine checks on medicine stocks and expiry dates. We looked at a sample of medicines and found these were kept within their expiry dates.
- We found that medicines were ordered, stored and discarded safely and appropriately. Records for ordering, return and disposal of medicines were maintained by diagnostic imaging staff.
- Staff carried out routine medicines security and prescribing audits. Audits showed good levels of compliance and action plans were in place to improve areas of non-compliance.

### Incidents

- **The service managed patient safety incidents well.**
- There had been no 'never events' or serious patient safety incidents reported in relation to the diagnostic imaging services between October 2017 and April 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on an electronic incident reporting system.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (2017) IR(ME)R. The service had procedures in place to report incidents to the appropriate regulators, for example the Care Quality Commission (CQC).

- There had been five incidents involving radiation reported by the services between March 2018 and April 2019. One of these was reportable and had been reported to the radiation protection advisor and the Care Quality Commission.
- The reportable incident related to a patient that incorrectly underwent a second computerised tomography (CT) scan. The incident was reported to the CQC and the radiation protection advisor, who carried out a risk assessment. The incident was investigated and root cause identified as the consultant recorded the wrong patient details. Learning from the incident was shared with staff, relevant consultants and the Medical Advisory Committee (MAC) to reduce reoccurrence.
- The remaining four incidents related to errors during X-rays (such as x-ray taken on incorrect part of body). None of these incidents were IR(ME)R reportable. These incidents had been referred to the radiation protection advisor and investigated to improve the services. Remedial actions taken included staff training and raising staff awareness of 'pause and check' guidelines.
- Staff told us they received feedback about incidents reported and that this was used to improve practice and the service to patients. Information about incidents was shared through hospital-wide alerts, newsletters, safety huddles and routine departmental meetings so shared learning could take place.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. We saw evidence that duty of candour principles were applied verbally and in writing following the radiation incidents reported by the services.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- For our detailed findings on incidents please see the Safe section in the outpatient services report.

**Safety Thermometer (or equivalent)**

- **The service used safety monitoring results well.**
- Information on patient safety was reported on a clinical scorecard every three months. This included incidents of venous thromboembolism (VTE – blood clots), patient falls, pressure ulcers and patient readmission rates.
- The clinical scorecard showed the incident rates for VTE, pressure ulcers and patient falls were within the hospital's targets between January 2018 and December 2018.
- There were no cases of patient falls, VTE or pressure ulcers reported by the diagnostic imaging services during this period.

## Are diagnostic imaging services effective?

We inspect but do not rate effective for diagnostic imaging services.

**Evidence-based care and treatment**

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- Patients received care according to national guidelines such as National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists and the Royal College of Radiographers.
- Care pathways and clinical policies were benchmarked against national guidelines and developed through the corporate provider. The imaging manager was involved in a peer group of imaging managers across the provider's hospitals nationally and regularly attended meetings to discuss changes in practice and share learning.
- Updated policies and changes to practice were shared with diagnostic imaging staff during monthly departmental meetings and staff were required to sign a log sheet to confirm they had read and understood these.
- Diagnostic imaging staff used a modified pathway for certain treatments (such as injections) based on the World Health Organization (WHO) safety checklist.

**Nutrition and hydration**

- All patients had access to free hot and cold drinks and refreshments and these were available in the waiting areas across the outpatient services.

**Pain relief**

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

Good

# Diagnostic imaging

- Patients that underwent diagnostic imaging procedures were assessed and monitored by staff as part of their routine observations to identify and manage pain symptoms.
- Patients were given advice on how to manage pain symptoms following discharge after certain procedures.

### Patient outcomes

- **Managers and staff monitored the effectiveness of diagnostic services and compared the outcomes of their services both internally and externally.**
- Diagnostic imaging staff carried out a range of routine audit of key processes as part of a planned audit schedule. These included equipment, infection control, safety checklists, referral audits, consent, World Health organisation checklists and Ionising Radiation (Medical Exposure) Regulations. The audit frequency ranged from monthly to annually depending on the type of audit.
- Patient outcomes were benchmarked against the provider's other hospitals nationally using a clinical dashboard and scorecard. This included standard indicators relating to incidents, infections, patient readmissions and patient satisfaction surveys.
- The clinical dashboard for April 2019 showed the hospital scored 'green' for most quality indicators demonstrating that compliance against performance indicators had been achieved.

### Competent staff

- **The service made sure staff were competent for their roles.**
- Newly appointed staff underwent an induction process for up to six weeks and their competency was assessed using an induction checklist prior to working unsupervised.
- Staff told us they received an annual appraisal including a mid-year review. The hospital reported that 100% of diagnostic imaging staff had completed their appraisals during 2018.
- Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital or clinic).
- There were 15 consultant radiologists working under practicing privileges at the hospital. There were no consultants working in the diagnostic imaging services with any outstanding queries relating to their practising privileges.
- Practicing privileges were reviewed every two years by the hospital director, matron and Medical Advisory Committee chair.
- All eligible staff were up to date with their Health and Care Professional Council (HCPC) and General Medical Council (GMC) revalidation dates.
- Records showed that 100% of diagnostic imaging staff had received basic life support (BLS) and 89% had completed paediatric basic life support (PBLS) training.
- The hospital reported that the imaging department had started to roll out immediate life support (ILS) training for radiographers during 2019. At the time of the inspection two radiographers (22%) had completed ILS training.
- There was a resident medical officer (RMO) on site who covered the diagnostic imaging department as well as the outpatients, ward and theatre areas. The RMO had completed advanced life support (ALS) and European Paediatric AdvancedLife Support(EPALS) training.
- Staff in the diagnostic imaging department received competency based training specific to their role and by diagnostic procedure. Competencies were signed off by an authorised person (such as the manager or approved trainer) prior to staff carrying out certain activities, such as operating diagnostic scanning equipment.
- We looked at five staff files and these showed evidence of up to date competency-based training as well as additional on-the-job and mandatory training.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by the management team.

### Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- There was effective daily communication between multidisciplinary teams across the diagnostic imaging services. Diagnostic imaging staff told us they had a good relationship and daily communication with other teams across the hospital.
- A daily hospital huddle of staff from various disciplines was held and attended by senior representatives from each hospital department. Diagnostic imaging staff also carried out 'safety huddles' on a daily basis to ensure all staff had up-to-date information about risks and concerns.

Good

# Diagnostic imaging

- There was collaborative working with the mobile computerised tomography (CT) scan team that were on site once day per week.

**Seven-day services**

- **Diagnostic services were available six days per week.**
- The diagnostic imaging department offered services for general X-ray from 8am to 8.30pm on weekdays and from 8am to 1pm on Saturdays. An on-call service operates outside these hours.
- Fluoroscopy procedures were also available from Monday to Saturday. The ultrasound services were available from 9am to 5pm during Monday to Friday.
- The magnetic resonance imaging(MRI) service operated during weekdays with an on-call service at weekends. Computerised tomography (CT) scan services were available one day each week.

**Health promotion**

- **Staff discussed health promotion and lifestyle choices with patients.**
- Staff gave advice and support to patients identified as being overweight, patients at high risk due to high alcohol consumption or patients that were smokers (including referral to external services, such as 'Smoke Free Liverpool').

**Consent and Mental Capacity Act**

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**
- Staff had the appropriate skills and knowledge to seek verbal informed consent and written consent before providing care and treatment to patients.
- Patient records showed that written and verbal consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out diagnostic procedures.
- Records showed 100% of diagnostic imaging staff had completed mandatory training in the Mental Capacity Act (MCA) 2005.
- Where patients lacked the capacity to provide informed consent, staff made decisions about whether treatment could be provided and sought input from other healthcare professionals, such as the patient's general practitioner (GP).
- Staff told us that patients that lacked capacity (such as those living with dementia) would be accompanied be a carer or person that can legally make decisions on their behalf.

## Are diagnostic imaging services caring?

Good

This is the first time we have rated this service. We rated caring as good.

**Compassionate care**

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We saw that staff were professional, friendly and polite. We observed staff speaking to patients and providing care in a respectful manner across the diagnostic imaging areas.
- Patients' privacy and dignity was maintained. Each treatment room had changing areas where patients could change in privacy. Discussions with patients were also held in private to maintain confidentiality.
- We spoke with three patients and they were all complimentary towards the staff and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included "staff are friendly and helpful" and "the care provided is impressive".
- The imaging department carried out an annual patient satisfaction survey to seek feedback during June 2018. The survey was based on 150 responses from patients that had received MRI, X-ray and ultrasound treatments and patients were asked nine questions relating to timeliness of appointments, staff conduct and privacy and dignity. The survey results showed 100% positive responses and all patients either 'strongly agreed' or 'agreed' in response to the nine questions covered in the survey.

**Emotional support**

- **Staff provided emotional support to patients to minimise their distress.**

Good

# Diagnostic imaging

- The staff we spoke with understood the importance of providing patients with emotional support. They gave examples of how they took time to support distressed or anxious patients.
- Patients we spoke told us the staff were supportive and reassuring. We saw staff spending appropriate time talking to patients and responding to their questions in an appropriate manner.
- During consultations patients were offered a chaperone or patients could be accompanied by a friend or relative present.

**Understanding and involvement of patients and those close to them**

- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient records included initial assessments that took into account individual patient preferences.
- Patients we spoke with told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand.

## Are diagnostic imaging services responsive?

Good

This is the first time we have rated this service. We rated responsive as good.

**Service delivery to meet the needs of local people**

- **The service planned and provided services in a way that met the needs of local people.**
- The imaging department had sufficient capacity to meet the needs of patients attending the department. A range of imaging services and diagnostic procedures were available six days per week, with on-call arrangements in place if out-of-hours services were required. Computerised tomography (CT) scan services were available on site one day each week.
- The hospital did not provide oncology services. However, for incidental findings of cancer during diagnostic procedures patients were offered appropriate referral pathways to cancer multidisciplinary (MDT) services.
- All patients were booked in advance so services and appropriate staffing could be planned prior to patients attending the department.
- The environment for patients was comfortable with sufficient waiting areas. The imaging department waiting area was shared with the physiotherapy waiting area. All areas we saw were furnished to a good standard.

**Meeting people's individual needs**

- **The service took account of patients' individual needs.**
- Information leaflets about the services were readily available in all the areas we visited. Patients were supplied with leaflets and there were information posters in the waiting areas to explain the risks of radiation and equivalent doses. Information leaflets in different languages or other formats (such as braille, large print or 'easy read' format) were also available or could be printed upon request.
- Staff could access a language interpreter service if needed.
- The imaging department was based on the ground floor and was easily accessible, including for disabled or wheelchair users.
- Diagnostic imaging interventional procedures were not available to patients under 16 years of age. However, 16 and 17 year old patients could undergo treatment if they were assessed as competent following Gillick competency assessment by a paediatric nurse. There was a tracker system that identified when a patient under 18 years of age attended the department and staff ensured that at least one member of staff with safeguarding level 3 was on duty at the time.
- Records showed 100% of diagnostic imaging staff had completed dementia awareness training during 2018. The department also had a number of staff signed up as Dementia Friends to provide support and advice if needed.

- Staff told us patients living with dementia or a learning disability would normally be accompanied by a carer. Staff we spoke with were able to give examples of reasonable adjustments made when carrying out procedures for these patients.

**Access and flow**

- **People could access the service when they needed it.**
- Patients were referred to the imaging department through consultants at the hospital or directly through their GP.
- Patients could book an appointment at the time and date of their choice. Most patients we spoke with told us they did not experience any delays in getting an appointment.
- Records showed that between April 2018 and March 2019, 100% of patients referred for diagnostic tests were seen within six weeks. The national standard is at least 99% of patients should wait less than six weeks from referral to diagnostic test.
- There was daily communication between diagnostic imaging staff to manage patient flow. Daily huddles took place involving outpatient, ward and theatre staff and these included discussions about admissions for the forthcoming day and to identify patients with specific needs.
- We did not identify any delays in clinic times during the inspection. Patients were seen promptly and did not experience extended wait times following their arrival.
- The imaging department carried out an annual wait times audit during August 2018 involving 302 patients that attended the department over a two-week period. The audit results showed the majority of patients did not experience significant delays: -
  - 93% of magnetic resonance imaging(MRI) patients had their examination started within 10 minutes of their appointment time.
  - 77% of X-ray patients were called for their examination within 10 minutes of the referrals being available.
  - 66% of ultrasound patients were scanned within 10 minutes of their appointment time and 75% had their examination completed within 30 minutes.
  - Six out of the 10 (60%) patients attending for fluoroscopy examinations were called in within 10 minutes of the referral being available. One patient waited over 30 minutes past their appointment time for their examination to start and this was due to the double-booking of previous patients.
- The imaging department carried out an audit of turnaround times for X-rays, computerised tomography (CT) scans and magnetic resonance imaging(MRI) scans. The target turnaround time for scan results was five days or below. Audit results for January to March 2019 demonstrated the service exceeded the five day turnaround time target and average turnaround times ranged between 0.1 and 2.9 days.

**Learning from complaints and concerns**

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- Information leaflets describing how to raise complaints about the service were visibly displayed in the main reception and waiting area. Staff we spoke with understood the process for receiving and handling complaints. Complaints were managed by the complaints coordinator.
- The complaints policy stated that complaints would be acknowledged within three working days and investigated and responded to within 20 working days for routine complaints.
- Where the complaint investigation had not been completed within 20 working days, staff were required to notify the complainant in writing explaining the reasons for the delay.
- Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns within the organisation (to the corporate provider) or to external organisations such as the Parliamentary and Health Service Ombudsman (for NHS patients) and the Independent Sector Complaints Adjudication Service (ISCAS) for private funded patients.
- The diagnostic imaging services received 13 complaints between April 2018 and March 2019. The most frequent reasons for complaints were; lack of communication (5 complaints) and long wait (two complaints).
- We saw evidence to show these complaints were investigated appropriately and responded to in a timely manner. Remedial actions taken to improve services included additional training for new staff and an

improved communication process between the imaging and main reception staff. We saw evidence that duty of candour principles were applied verbally and in writing following complaints to the services.
- Staff told us that information about complaints was discussed during daily huddles and monthly departmental meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes we looked at.

For our detailed findings on complaints please see the responsive section in the surgery report

## Are diagnostic imaging services well-led?

Good

This is the first time we have rated this service. We rated well-led as good.

### Leadership

- **The diagnostic imaging manager had the right skills and abilities to run a service providing high-quality sustainable care.**
- The overall lead for the service was the diagnostic imaging manager, who oversaw the day to day running of the service. The diagnostic imaging manager reported to the matron (also head of clinical services) who reported to the hospital director (who was the registered manager with the Care Quality Commission).
- Staff told us they understood their reporting structures clearly and described the diagnostic imaging manager as approachable, visible and as providing them with good support.
- Diagnostic imaging staff we spoke with were also positive about the visibility and support they received from senior managers, such as the matron and hospital director.
- For our detailed findings on leadership please see the well-led section in the surgery report.

### Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- The hospital vision was 'to be recognised as a world class healthcare business'. This was underpinned by a set of values and promises around achieving patient, staff and consultant satisfaction.
- There was an overarching 2019 strategy for the hospital, which included four specific objectives relating to the diagnostic imaging services. These were based around delivering services that prioritise safety and are patient-focussed, and the development of new services and facilities.
- The vision, values and objectives were clearly displayed had been cascaded to staff across the imaging department and staff had a good understanding of these. Objectives were incorporated into individual staff appraisals.

### Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- All the staff we spoke with were highly motivated and positive about their work. They told us there was a friendly and open culture and that they received good support from the their colleagues and the diagnostic imaging manager.
- The staff we spoke with told us they received regular feedback to aid future learning and that they received good training and learning opportunities.
- For our detailed findings on culture please see the well-led section in the surgery report.

### Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- There were daily discussions and handover meetings in the imaging department and a hospital-wide huddle was held daily to manage patient risks and cascade governance information to staff. The diagnostic imaging department held monthly clinical staff meetings and discussions around workforce, performance and governance issues and key risks took place during these meetings.

# Diagnostic imaging

- Annual Radiation Protection Committee meetings were established and attended by the radiation protection advisor, hospital director, radiation protection supervisors, diagnostic imaging manager, clinical governance lead and matron.
- For our detailed findings on governance please see the well-led section in the surgery report.

**Managing risks, issues and performance**

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- There was a risk management policy in place that outlined the process for identifying, assessing and mitigating risks to the services.
- We saw that up to date risk assessments were in place in relation to laser protection risks, radiation protection risks, health and safety risks and Control of Substances Hazardous to Health (COSHH) assessments.
- The key risks relating to the diagnostic imaging services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member responsible for managing that risk. A risk scoring system was used to identify and escalate key risks to the hospital risk register.
- Key risks were reviewed at monthly departmental meetings and clinical governance meetings. Routine staff meetings took place to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as infection control, patient records and diagnostic equipment quality and safety checks. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and CREWS newsletters.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.
- For our detailed findings on managing risks, issues and performance please see the well-led section in the surgery report.

**Managing information**

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as patient records, performance reports, audit records and meeting minutes.
- Staff completed information governance training as part of their annual mandatory training. Records showed 100% of staff in the diagnostic imaging services had completed this training.
- The hospital reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO).
- Electronic systems (such as to store records and manage patient appointments) required password access. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff in other parts of the hospital, such as during routine outpatient consultations.
- Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates. Policies and procedures included log sheets to confirm staff in the diagnostic imaging services had read the policies.

**Engagement**

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.**
- Staff in the diagnostic imaging service told us they received good support and regular communication from the diagnostic imaging manager and the senior management team. Staff routinely participated in daily safety huddles and routine departmental team meetings to cascade information.
- The hospital also engaged with staff through bulletins and newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

Good

# Diagnostic imaging

- Diagnostic imaging staff told us they routinely engaged with patients and their relatives to gain feedback from them. This was done formally through participation in patient experience surveys and through patient focus groups and events. We looked at the findings from a selection of patient surveys and focus groups and the feedback was very positive.
- For our detailed findings on engagement, please see the well-led section in the surgery report.

**Learning, continuous improvement and innovation**

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- Spinal injection clinics had recently been moved from theatres to the diagnostic imaging department to improve patient access and flow. The diagnostic imaging manager told us the move was received positively by consultants and a dedicated time slot had been given for this clinic.
- The diagnostic imaging manager described the diagnostic imaging department as stable and effective with a good team of staff. The manager identified radiographer staffing as one of the key risks for the department but was confident this was being addressed through the recruitment of new staff.
- For our detailed findings on learning, continuous improvement and innovation please see the well-led section in the surgery report.

# Outstanding practice and areas for improvement

## Outstanding practice

- In surgery, staff identified ways to providing integrated person-centred pathways of care for patients who required additional support. Staff identified and managed opportunities to reduce patients' anxieties and improve communication at all stages of their treatment.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should improve the arrangements for incident reporting so that all staff (including consultants) directly report incidents in a timely manner.
- The provider should consider appropriate actions so that all safeguarding concerns are reported and managed in a timely manner.
- The provider should improve records to maintain them up to date, accurate and where translation services are utilised they appropriately sign the consent form.
- The provider should make improvements so that all staff consistently take appropriate actions in response to early warning scores for monitoring the deteriorating patient.
- The provider should consider how it will manage absences of key staff (such as the complaints lead) in a manner that does not affect service performance.
- The provider should take appropriate actions so that all staff understand the early warning score processes for monitoring the deteriorating patient.
- The provider should take actions so that clean linen is suitably stored to minimise the risk of exposure from the open environment.