Spire Fylde Coast Hospital

Quality Report

St. Walburgas Road
Blackpool
Lancashire
FY3 8BP
Tel: 01253 394 188
Website: www.spirehealthcare.com/spire-fylde-coast-hospital/

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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 Fylde Coast Hospital is operated by Spire Healthcare Ltd. It is a private hospital in Blackpool, Lancashire. The hospital has been operating for over 35 years (opening in 1983). It is located 400 yards from a local NHS trust main acute site. It is on the outskirts of the town of Blackpool and about one mile from the seaside promenade. Blackpool and the wider Fylde Coast have a population of around 350,000. The hospital primarily serves the communities of Blackpool and the Fylde Coast, however it also accepts patient referrals from outside this area.

The hospital is registered to provide diagnostic and screening procedures, surgical procedures and treatment of disease, disorder and injury. The hospital has 26 single rooms and 11 day-care beds which are provided in two single sex bays. Facilities include three operating theatres, 10 consulting rooms, physiotherapy treatment rooms, medical imaging services and outpatient and diagnostic facilities.

The hospital has a registered manager who has worked in a managerial post at the hospital since September 2015, working alongside the previous registered manager. The registered manager was appointed in August 2016.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on the 8 and 9 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 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 surgical service level.

Services we rate

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

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

We found areas of outstanding practice in outpatients:

- In the physiotherapy department the technical instructor was working with self-funding patients who were coming into the hospital for joint replacements as they were unable to access NHS occupational therapy services post operatively. They were working with patients when they attended the pre-assessment clinic for their surgery to help people to access any necessary equipment e.g. chair raises, raised toilet seats, shoe horns etc. For patients who accessed this face to face services there was a slight reduction in length of stay.

We found areas of practice that required improvement in surgery:

- The provider should consider providing refresher training to staff around emergency resuscitation equipment so that they are able to carry out checks on equipment effectively.
- The provider should regularly check expiry dates on consumables stored as part of emergency resuscitation equipment.
- The provider should consider how to better evidence that staff employed as surgical first assistants have the appropriate qualifications and professional requirements in place.
- The provider should keep online and paper records relating to staff competencies and policies up to date if paper records are to be used.

We found areas of practice that require improvement in outpatients:

- The service should ensure that all records are legible.

We found areas of practice that required improvement in diagnostic imaging:

- The service should ensure that there is a documented audit trail for safeguarding concerns that have been raised with the safeguarding lead and acted upon internally.
- The service should make sure that there is documented evidence of all actions staff have taken to safeguard patients or investigate complaints and incidents. So that there is a clear audit trail.
- The service should ensure that staff are aware of their roles and responsibilities under the duty of candour.
- The service should ensure that there is documented evidence of all complaints received in line with the hospitals policy.
- The service should ensure that the new leadership structure provides defined roles and lines of responsibility.
- The service should consider the involvement of staff and other stakeholders in the development of the vision and strategy.
- The service should consider a review of the strategy to provide a documented plan of workable actions, to make sure that they achieve what they have set out to do.
- The service should consider a review of its engagement with staff, patients and service users to capture their views to improve the quality of services provided.

Following this inspection, we told the provider that it should make some improvements to help the service improve. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North West)

Summary of findings

Overall summary

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The hospital is registered to provide diagnostic and screening procedures, surgical procedures and treatment of disease, disorder and injury. The hospital has 26 single rooms and 11 day-care beds which are provided in two single sex bays. Facilities include three operating theatres, 10 consulting rooms, physiotherapy treatment rooms, medical imaging services and outpatient and diagnostic facilities. Outpatient clinics are also provided from a small clinic in Lytham, approximately 20 minutes away. Facilities for plain x-ray diagnostic tests are also available in this clinic.

The hospital has a registered manager who has worked in a managerial post at the hospital since September 2015, working alongside the previous registered manager. The registered manager was appointed in August 2016.

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. We rated this service as good because it was safe, effective, caring, responsive and well-led. The service had made improvements to safety processes and governance systems since our last inspection. Staff had the right skills and qualifications to carry out their roles safely and effectively. A staffing tool was used to calculate staffing needs based on the acuity of patients listed for surgery. Managers monitored service performance using feedback from patients, key performance indicators and patient outcome data. This information was compared with similar providers where possible. Patient feedback was largely positive. We observed staff taking the time to interact with patients and staff spoke about patients and their relatives with respect and compassion. Care was provided taking into account the needs of individuals and people could access care and treatment when they needed it. There were effective leaders employed within the service. Staff spoke positively about the senior leadership team. Senior managers had made efforts to encourage continuous learning and there had been positive changes to the culture within the service.
Outpatients	Good	We rated this service as good because it was safe, caring, responsive and well-led. We inspected but did not rate effective. The service saw only adults and was available six days a week with clinics available in the evenings. Staff had received mandatory training and safeguarding training. There had been no infections in the department and all areas were visibly clean and tidy. Staff worked to national guidelines and there was evidence of multi-disciplinary team working amongst different staff groups. Staff were caring towards patients and there was positive feedback from patients about the staff.

Summary of findings

Adjustments were made for patients as necessary and there were few complaints about the service. Staff worked to improve outcomes for patients and monitored these. Leadership was positive and staff said that they liked working at the hospital.

Diagnostic imaging

Good

We rated this service as good because it was safe, caring, responsive and well-led. We inspected but did not rate effective.
There were onsite X-ray, mammography and ultrasound facilities. Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans were provided by Spires Mobile Unit. The service was available six days a week, and evening appointments were available. Outside of normal working hours there was an on-call service provided.
Staff had received mandatory training and were aware of their responsibilities to safeguard patients from abuse. The environment was visibly clean and tidy, and equipment was well maintained.
Care and treatment was based on national guidance and they monitored the effectiveness of this. The service made sure that staff were competent to undertake their roles and there was evidence of multidisciplinary team working.
Feedback from patients was positive about their care and we observed caring interactions between staff and patients.
The service met the needs of patients and took into account their individual needs. Patients could access the service when they needed it and complaints were low.
There was a positive culture and staff felt that the leadership team was approachable. Risks were managed well and staff were encouraged to learn and develop.

Summary of findings

Contents

Good

Spire Fylde Coast Hospital

Services we looked at

Surgery; Outpatients and Diagnostic imaging.

Summary of this inspection

Background to Spire Fylde Coast Hospital

Spire Fylde Coast hospital is a purpose-built private hospital that opened in 1983. The hospital provides outpatient consultation and diagnostics including imaging along with inpatient and day case admitted treatment for adults 18 years and over. Services are provided to insured, self-funding and NHS patients under contract agreements with Clinical Commissioning Groups and Trust hospitals. The hospital's primary catchment area is Blackpool and Fylde Coast along with North Lancashire, Cumbria and Preston.

The hospital has a registered manager who has worked in a managerial post at the hospital since September 2015, working alongside the previous registered manager. The registered manager was appointed in August 2016.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, other CQC inspectors, and specialist advisors with expertise in surgery, diagnostic imaging and outpatient services. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Why we carried out this inspection

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital/service has been inspected four times, and the most recent inspection took place in September 2016 and was rated as requires improvement. There had also been a responsive inspection in December 2017 to review surgery, although this was not rated. which found that the hospital/service was meeting all standards of quality and safety it was inspected against.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on the 8 and 9 April 2019.

During the inspection, we visited we visited the ward, surgical theatres, X-ray, ultrasound and outpatient areas. We spoke with 49 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 14 patients and one relative. We also received seven 'tell us about your care' comment cards which patients had completed during our inspection. During our inspection, we reviewed 20 sets of patient records, as well as reviewing 10 competencies and 43 policies.

Information about Spire Fylde Coast Hospital

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Summary of this inspection

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In the reporting period March 2018 to February 2019 there were 1194 inpatient and 5335 day-case episodes of care recorded at the hospital; of these 5152 were NHS-funded and 1377 were non-NHS funded.

- 17 percent of all NHS-funded patients and 25 of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 43,865 outpatient total attendances in the reporting period; of these 26,388 were NHS funded and 17,477 were private patients..
- 139 doctors were employed or practising under rules or privileges in February 2019.
- Two regular resident medical officers (RMO) worked on a one week on and one week off rota.
- Spire Fylde Coast Hospital employed 35.2 whole time equivalent registered nurses, with 26.3 whole time equivalent health care assistants and operating department practitioners and 62.5 whole time equivalent other hospital staff, as well as having its own bank staff.
- The accountable officer for controlled drugs was the hospital director.

Track record on safety

- No never events.
- Clinical incidents (between January 2018-December 2018) – 736 in total, of which 533 were no harm, 187 were low harm, 20 were moderate harm.
- Four incidents were categorised as a serious injuries.
- 0 incidences of hospital acquired Methicillin-sensitive Staphylococcus aureus (MSSA)
- 0 incidences of hospital acquired Clostridium difficile (c.diff)
- 0 incidences of hospital acquired E-Coli
- Between March 2018 and February 2019 85 complaints were received.

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department
- Bupa Accreditation for cataract surgery

Services provided at the hospital under service level agreement:

- Provision of Infection Prevention and Control Services
- Vascular Ultrasound Diagnostic Investigations
- Provision of Blood and Blood Components
- Provision of Cardiology Services
- Occupational Health & Wellbeing Services
- Translation and Interpreter Services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

- Staff had training in key skills and this was provided through a mixture of face to face and electronic training sessions, which were to be completed annually or biennially.
- Staff understood how to protect patients from abuse and had training on how to recognise and report abuse.
- The service controlled infection risk well. There was a patient and visitor information board that included information about infection prevention and control.
- The service had suitable premises and equipment and looked after them well.
- They managed medicines well. The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had enough staff to care for patients and keep them safe.
- Staff collected safety information and used it to improve the service.

However:

- We found that safeguarding concerns were not always documented in line with the hospital policy.
- We were given an example of a safeguarding concern which had been raised in the imaging department by a member of staff. Radiography staff followed the hospitals policy in respect of escalation to the safeguarding lead for the hospital. Appropriate action was taken internally to follow up the concern. However, we did not see documented evidence of this and an incident report form had not been completed in accordance with the hospital policy. This meant that if there were future concerns there was no documented evidence of the concerns and action that had been taken on that occasion.

Summary of this inspection

- The provider should consider providing refresher training to staff around emergency resuscitation equipment so that they are able to carry out checks on equipment effectively.
- Not all staff were aware of their roles and responsibilities under duty of candour which is the process of being open and honest when things go wrong.
- We found that although the provider had a process for regularly checking expiry dates on consumables, stored as part of emergency resuscitation equipment, we found one item on an emergency resuscitation trolley to be out of date, which had been highlighted but not removed.

Are services effective?

Good

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Managers used the Spire Healthcare scorecards to benchmark performance against other hospitals within the provider group. The scorecard monitored key performance indicators such as returns to theatre, surgical site infections, transfers to hospital, readmission rates and incidence of blood clots.
- Staff ensured that patients received enough food and drink to meet their needs and improve their health. The patient waiting area contained a water cooler and there were cups available for patients and their carers or relatives to use. Patients could also use hot drinking making facilities which were available in the main entrance.
- Staff regularly assessed patient's pain using pain scores and we saw that this was documented in patient records at each assessment.
- Intentional rounding was also used as a tool to prompt staff to ask about patient's levels of pain and ask if they needed any pain relief.
- Patient outcome performance was monitored by the clinical audit and effectiveness committee, clinical governance committee and medical advisory committee. There were action plans in place for any measure which fell below Spire targets.
- Staff received appraisals which took into account their individual performance, training needs and career aspirations. These were referred to as 'enabling excellence' meetings.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. The service worked closely with surrounding hospitals.

Summary of this inspection

- The hospital provided some seven-day services.
- Staff understood the consent process and they followed the service policy and procedures when a patient could not give consent. They understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- We found that the provider needed to consider how to improve access to evidence that staff employed as surgical first assistants have the appropriate qualifications and professional requirements in place when required. The provider should keep online and paper records relating to policies up to date if paper records are to be used.

Are services caring?

Good

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

- Staff provided emotional support to patients when they needed it and provided reassurance.
- We observed that patients were treated with privacy and dignity.
- Patient feedback about their care and treatment was very positive.
- Staff involved patients and those close to them in decisions about their care and treatment.
- We observed that patients and their carers were involved in discussions about the patient's treatment.

Are services responsive?

Good

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

- The service planned and provided services in a way that met the needs of people who used the service.
- The service took account of patients' individual needs. Systems were in place to support those people with additional requirements.
- 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.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of this inspection

- The hospital provides free of charge Echo cardiograms for all patients who require this test as part of a surgical care pathway. This ensures patients have access to timely treatment as required

However:

- We found that within the diagnostic imaging service, documented evidence of complaints were not always in line with the hospitals policy.

Are services well-led?

Good

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

- The hospital had gone through recent changes within the senior management team which included the recruitment of a theatre manager and deputy matron who had the right skills and experience to provide strong leadership.
- There was a vision and strategy for the hospital which focussed around patient safety and commercial viability.
- At the time of our inspection, the hospital strategy was to; 'deliver high quality care to our patients, demonstrating that we are the provider of choice for the Fylde Coast, growing our relationships with our partners to increase our market share by promoting our clinical services to the local population, continue to improve the hospital's survey scores by promoting the benefits of teamwork, improving communication between us all and continuing to build on what we do well and work together to deliver on our promises'.
- Staff we spoke to throughout the service reported a supportive and open culture. We were told by staff working in theatres that there was no divide between staff members of different roles such as nurses and operating department practitioners.
- There were effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services.
- The Spire Healthcare governance framework was implemented at Spire Fylde Coast Hospital to support oversight and management of risk and performance issues.
- There was a risk register in place for the hospital which included risks for each department. . For surgical services, the highest rated risk was that the operating table in theatre three needed replacing. There were appropriate actions in place to mitigate this risk until a new table was resourced.
- The service collected, analysed, managed and used information well to support all its activities, using secure

electronic systems with security safeguards. The information used in reporting performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant.
- Senior leaders engaged well with staff and patients to shape and improve service provision.
- The service was committed to learning from when things went wrong and strived for continuous improvement.
- 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.

However:

- The new leadership structure did not provide defined roles and lines of responsibility.
- The hospital strategy was published annually and although managers and staff we spoke to were aware of the strategy, some told us that they had not always been consulted on it.
- The diagnostic imaging service should consider a review of its engagement with staff, patients and service users to capture their views to improve the quality of services provided.

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

Our rating of safe improved.We rated it as **good.**

Mandatory training

- There was a mandatory training guide in place for all hospital staff which detailed the mandatory training modules for all staff (including bank staff) and additional, role specific modules.
- Mandatory training included; fire safety, infection control, information governance, manual handling and compassion in practice. At the time of our inspection, compliance with mandatory training was 93% across all staff against a hospital year-end target of 95%.This was an improvement from our last inspection.
- Basic life support training was provided to all staff. Anaesthetic and recovery staff were trained in intermediate life support and there were eight staff across anaesthetics and recovery who were trained in advanced life support. We verified training compliance through reviewing staff training records. This ensured that there was always someone available with the right level of training in the event of an emergency.
- Staff told us that they completed regular scenario-based simulation training which helped to prepare in case of life-threatening emergencies within the hospital. For example, two weeks prior to our inspection, staff had completed a simulation of a major haemorrhage in recovery. Staff could put forward suggestions for any scenarios they would like to cover.

Safeguarding

- All staff were provided training in level two safeguarding for children and adults. This was completed as two e-learning modules and compliance at the time of our inspection was 95% for safeguarding children and 96% for safeguarding adults across all staff.
- Level three safeguarding training was part of role-specific training for clinical staff.
- There was a safeguarding policy in place which was readily accessible to staff should they need to refer to it. All staff we spoke to were able to articulate how they would handle any safeguarding concerns, and this was in line with the hospital policy. In the first instance, staff would report concerns to their line manager who would escalate to the safeguarding lead as required. Any incidences of safeguarding concerns were reported through the online incident reporting form.
- There was a named safeguarding lead at the hospital and staff we spoke with were aware of who this was and how they could be contacted.

Cleanliness, infection control and hygiene

- We observed that staff used personal protective equipment such as gowns, gloves and aprons as appropriate to minimise the risk of spread of infection. We noted that staff were observing the hospital uniform policy and adhered to ‘bare below elbows’
- There was alcohol gel readily available in public areas and hand washing facilities in each clinical area. However, we observed that during cannulation of a patient prior to surgery, the member of staff did not wear gloves and used only alcohol gel instead.

- We reviewed cleaning schedules during our inspection. These records were kept up to date and checklists were displayed in public areas.
- Regular infection prevention compliance audits were carried out. We were provided with copies of the infection prevention trackers for 2018 which monitored results for each area of the hospital. Overall, compliance with clinical equipment cleaning schedules had improved across surgical services with results of 100% in theatres and 83% for the ward across quarter four.
- Hand hygiene, uniform compliance, surgical scrub and environmental infection prevention audits were carried out each quarter and compliance was good overall across surgical services. Room for improvement had been recognised in relation to insertion of peripheral cannulas resulting in an exercise to identify individuals who were non-compliant. This action resulted in improvement across 2018 with 90% compliance in quarter four.
- We were provided with copies of the associated action plans for infection prevention audit recommendations and found that recommendations were being acted on.
- There were sterilisation services on site and this department was accredited by SGS.
- Endoscopes were decontaminated on site. There was a separate room for clean and dirty scopes. The scopes were stored in vacuum packs with clear expiry dates. There were none stored in cabinets as they were used and recycled as required. A traceability log was kept per endoscopy list.
- There were no instances of hospital acquired MRSA, MSSA, C.difficile or E.Coli infections reported between January and December 2018.
- The incidence of surgical site infections between January and December 2018 was 0.5% across all surgical procedures.
- There was a Spire group guideline for antibiotic prescribing which was based on national guidelines and evidence-based practice. A local guideline for Spire Fylde Coast Hospital had been adapted from this and taking into account the prescribing guidelines of the local acute provider.

Environment and equipment

- All clinical and public areas of the hospital we visited appeared clean and free from clutter.
- Clinical and general waste was disposed of separately, there were spillage kits available for the clean up of bodily fluids or hazardous substances.
- There was resuscitation and difficult airway management equipment available for each of the three theatres and surgical ward. We checked the contents of each trolley during our inspection and found that daily checks had been signed for however there were two items which required attention. The manujet (equipment used for airway resuscitation) for theatre three was not suitable for use and some staff were not clear on how to use this equipment which is used for difficult airway resuscitation. This was escalated at the time of our inspection and the item was immediately removed from use.We were subsequently provided with evidence that a replacement manujet had been ordered. In theatre three there was an intubation catheter which had passed its expiration date. We escalated this to the theatre manager at the time who assured us that each trolley would be reviewed and the out of date equipment replaced.
- Electrical equipment such as suction and defibrillators had been tested in line with the servicing schedule ensuring that it was suitable for use with the exception of manujets which were on each emergency trolley in theatres. This was escalated and resolved at the time of our inspection.
- There was a process for the reporting of faulty equipment. There were engineers on site and there was a service level agreement in place for the maintenance and servicing of equipment.
- There was appropriate equipment for the safe moving and handling of patients. We observed staff using slide sheets and patslides to transfer patients safely to and from the operating table.
- Theatres, recovery and endoscopy were laid out in a way which supported patient flow through from surgery to recovery.
- There were 24 beds on the ward and all of these were single ensuite rooms. There was an emergency buzzer and nurse call bell in each room as well as piped oxygen.

- There was a physiotherapy room on the ward where a hoist was stored and there was an emergency buzzer in this room as well.
- Bariatric equipment was available when needed.
- There were carbon dioxide and foam fire extinguishers located throughout the hospital and these were stored in holders fixed to the wall. The date of service was also displayed on each fire extinguisher and these were in date.

Assessing and responding to patient risk

- Staff assessed patient's individual risk appropriately and acted on identified risks. Comprehensive risk assessments were carried out as part of the preoperative assessment and on admission. Patients were monitored post operatively to identify any deterioration in their condition.
- There was a clear acceptance and exception criteria for admission to the hospital which was outlined in the elective adult surgical admission policy.
- The hospital accepted patients assessed as ASA (American Society of Anaesthesiologists grading system) one or two due to there being no critical or intensive care facilities on site. Elective patients assessed as ASA three were referred for multidisciplinary review before taking a decision whether to proceed.
- There was a standard operating procedure for the transfer out of patients whose condition deteriorated and required acute care. Each incidence of transfer out was reported as a serious incident and each case was reviewed for any lessons learned. There had not been any notable themes or trends in cases of transfers out at the time of our inspection.
- We were told of an example when a patient's operation had been cancelled on the day as they were deemed not fit for surgery. This patient had been listed at the weekend and the case was discussed at the team brief. The surgeon had been happy to go ahead with the procedure however concerns were escalated by theatre staff and the decision was taken to cancel the procedure.
- The service had adapted the World Health Organisation Five Steps to Safer Surgery to form their safety checklist and sign in and sign out process for surgical procedures. This was an improvement from our last inspection. We observed the sign in and sign out on two occasions during our inspection and found that staff carried out the five steps as per hospital policy. The sign in was completed with the surgeon present in the anaesthetic room. There was a prosthetic pause as needed to ensure that the correct prosthesis was in place for the correct patient.
- We observed that a thorough count of swabs and equipment check was completed as part of the sign out. This count was recorded within patient records as part of the care pathway.
- During each step, the full team was engaged, there was good communication between staff and each step was documented on a separate board within theatres and then within the patients records.
- Compliance against the surgical safety checklist was audited each quarter through observation and review of records for ten surgical procedures. Compliance rates were above 95% across each quarter in 2017/18. For quarter four 2018/19, compliance was 100% for the observation and 99% for the documentation review.
- We observed the handover of patients from ward to theatre staff. We were told that the handover always took place between two qualified members of staff. The patients' identity, consent form and allergies were checked, and the patient was asked to confirm the procedure they were attending for. This preoperative checklist was completed by a member of ward and theatre staff.
- There were two recovery staff to a two-bedded recovery bay. During our inspection, we observed that the theatre list was delayed when the recovery bays were full to ensure that patients were cared for safely.
- Staff recorded national early warning scores for patients in line with hospital policy for recording of observations following surgical procedures. National early warning scores help to identify when a patient's condition may be deteriorating based on their observations. We reviewed ten sets of patient records and found that national early warning scores were calculated correctly and escalated for medical review when indicated.
- There was a major blood loss policy in place which was within review date and easily accessible in the case of

an emergency. Staff completed major blood loss training every two years which was facilitated by the local acute provider. Staff also completed a yearly online update.

- There were two units of O negative blood available on site in the case of a major blood loss. This was kept in the blood fridge which was located on the ward near to theatres. Staff had recently carried out a timed major blood loss practice scenario in which the stages of the major blood policy had been completed within 11 minutes.
- A group and save blood sample was collected for all patients prior to surgery and the results were clarified the day before their procedure.
- Transfer out and safe critically ill transfer out training was delivered to staff by an external provider. This was completed every two years by theatre and ward staff.
- An emergency test was carried out daily following the morning safety huddle which included a test of the crash bleep and the response from bleep holders was timed.
- Patients determined to be at low risk with no co morbidities could undertake a preoperative assessment over the telephone but any patients with newly diagnosed conditions were asked to attend for a face to face assessment.
- We observed two preoperative assessments as part of our inspection. Each patient was asked about their understanding of the procedure and the details were confirmed within their consent form. A medical history was taken for each patient and a set of baseline observations was recorded. The assessment included screening to determine whether a test for MRSA was needed.
- The service used British Medical Journal recommended tests for elective surgery based on ASA grade.
- Acute illness management training was delivered by the resuscitation lead within the Spire group on a rolling basis so that it was accessible to all staff as needed.
- There was always a member of staff with advanced life support training allocated to theatres as well as a member of staff on call and the resident medical officer was trained in advanced life support.
- Bed sensors had been introduced for use within the ward for patients who were deemed at high risk of falls. This helped to reduce the risk of patients being cared for in single bedrooms.
- During our inspection, we observed that the decision to cancel a surgical procedure was taken due to the patient having been treated for an underlying infection. Staff followed the process for escalating concerns and the clinical decision to delay surgery was supported by the Head of Clinical Services. We witnessed good communication between theatre staff and the multidisciplinary team in relation to this and the patient and family were kept informed throughout.

Nursing and support staffing

- Since our last inspection there had been a push to recruit to establishment across surgical services.
- Staffing levels across surgery services was in line with the Association for Perioperative Practice guidelines.
- All staff received a full induction before they started working within the service. Newly qualified staff were also allocated a period of time as a supernumerary member of staff until they felt confident to work autonomously.
- Registered nursing staff were assigned a mentor when they started working at the hospital. We spoke with a member of staff who had found this to be beneficial.
- The hospital used agency staff to cover nursing and support staff shifts when needed. Managers told us that they used regular agency staff to improve continuity of care and so that staff were familiar with the hospital processes and procedures.
- The use of bank and agency staff had reduced over the year prior to our inspection as the service had successfully recruited more substantive staff. Registered nurse shifts for theatres were consistently the highest proportion of shifts filled by bank and agency staff and this had reduced to 39% in February 2019 from 64% in March 2018. This was also the staff group with the highest vacancy rates; managers told us that they were working to recruit to establishment levels.

- We spoke with agency staff members who confirmed that they regularly worked at the hospital and had a full induction when they first started. Agency staff completed further inductions if they had not worked in an area for a long time as a refresher.
- Sickness rates were higher among operating department practitioner and healthcare assistant working in theatres (15% as of February 2019) and registered nurse staff in theatres had the lowest sickness rates (3.9% as of February 2019).
- There were always two members of theatre staff in recovery.
- Staff working as surgical first assistants were required to have the relevant qualifications to carry out this role. There was a risk assessment in place for the use of surgical first assistants during spinal surgery which had been updated in March 2019.
- There were two contracted staff working in a surgical first assistant role at the time of our inspection with regular agency staff also used in this role. There were plans for additional staff to also be trained to fulfil this role, to reduce the use of agency staff. We reviewed the personnel checks recorded for each surgical first assistant. There were gaps against the occupational health history for six surgical first assistants and two had yet to provide proof of professional indemnity. For three surgical first assistants there was no record of a disclosure and barring services check however managers told us that this information was collated by the agency. Following our inspection, we were informed that such information was held electronically and that these online records were complete and up to date for all staff who worked as surgical first assistants although this was not highlighted by managers during our on-site review.
- There was an on-call theatre team to facilitate any returns to theatre.
- A staffing tool was used to determine safe staffing levels for the ward. Each day the staffing allocation was matched to the staffing tool. We observed that safe staffing notice boards were completed with the numbers of staff on shift and name of the nurse in charge.
- On the ward, nurses were allocated a maximum of five patients who had a general anaesthetic or seven who had received local anaesthetic. The nursing staff we spoke with told us that this worked well and that the workload was manageable.
- There was a nurse in charge allocated to each shift on the ward and they were usually supernumerary for the morning shift.
- A nursing handover took place between each shift at 7am, 2pm and 9pm. These handovers were audio recorded which meant that staff did not need to leave their patients to provide a handover. Staff we spoke to felt that this worked well.
- There was a daily huddle in theatres which took place before the whole hospital safety huddle. This included representation from staff allocated to each theatre and any issues of concern relating to patient safety or staffing were recorded and escalated.

Medical staffing

- There were 139 doctors employed or with practising privileges and had been employed for more than six months at the time of our inspection. 73 had completed 100 or more procedures over the past year.
- In the 12 months prior to our inspection, ten consultants had their practising privileges removed; the majority due to resignation.
- In the 12 months prior to our inspection, 13 consultants had been temporarily suspended. Most of these suspensions were due to non-compliance with mandatory documentation, and the consultants had been reinstated once documentation was received.
- Patients were admitted under the care of a named Consultant who was responsible for the patient throughout their pathway of care. Consultants were required to live within 45 minutes travel time from the hospital in case they were required out of hours to assist. A resident medical officer (RMO) was also on duty to provide 24 hour medical assistance.
- There were two resident medical officers employed at the hospital. They were on site during the day and available on call out of hours. Their working hours were split so that they each worked one week and then had a week gap before working again.

- Any incidences of out of hours calls to the resident medical officer were discussed at the morning safety huddle and were recorded as an incident using the online reporting system. This was so the resident medical officer's sleep disturbances could be monitored and if required, alternative cover could be arranged whilst the resident medical officer was given adequate rest time.
- The resident medical officer completed a daily ward round and attended the handover to night staff.
- There was a daily RMO tasks board so that nursing staff could list patients for review or test results. that needed to be reviewed. This had helped communication between staff and it was clear to see when tasks had been completed.

Records

- Records were paper-based. We reviewed ten sets of patient records relating to patients who had undergone surgical procedures. We found that entries were legible, dated and signed. Records were not always filed chronologically but it was easy enough to follow and determine the plan of care for each patient.
- Each set of records included a comprehensive medical history, referral information and test results necessary to carry out an assessment for surgery.
- Preoperative assessments were completed and recorded fully. A new care record was being developed for the preoperative assessment.
- There was evidence in patient records of daily reviews by the resident medical officer during inpatient stays.
- Test results were filed in patient records and there was evidence that these results had been appropriately reviewed and acted on as needed.
- There was a care pathway specific to the surgical procedure for each patient. This included risk assessments completed on admission for nutrition, falls and venous thromboembolism (blood clot). There was also a section for discharge planning and the five steps to safer surgery checks were also included within the pathways. Finally, the pathway included space for recording postoperative care and discharge assessment.
- Copies of communications with patients' GPs were filed within their records. A discharge summary was sent to the patient's GP, referring clinician and the patient also received a copy.
- We observed that records were stored securely and appropriately. Paper records were kept in locked cupboards or in areas which could only be accessed by staff members.

Medicines

- Medicines were stored securely and in line with manufacturers' guidelines. We reviewed the fridge and room temperatures and checklists where medicines were stored and found that these were completed in line with hospital policy.
- Controlled drugs were stored securely and appropriately. The use and disposal of wasted controlled drugs was recorded in line with hospital policy. This was an improvement from our last inspection.
- Emergency drugs such as those used for cases of anaphylaxis were stored in boxes with resuscitation trolleys and secured with tamper evident seals.
- Patients own medicines were stored in lockable cupboards by each bed.
- A new medicines administration record had been implemented which was more detailed and included space for patients to acknowledge they had received information around how to take their take home medications.
- We reviewed the medicines administration record for ten patients and found that these were completed as per hospital policy. Any patient allergies were clearly documented.
- A clinical pharmacy service was in place at the hospital with pharmacist presence Monday to Friday 8:30-16:30. There was also pharmacist advice available via telephone out of hours.
- Pharmacists carried out regular patient interventions and found that their advice had made a difference to patient care. The team was looking at how they could record and audit these interventions.

Good

Surgery

- The pharmacy team carried out regular audits with the aim of improving medicines management across the hospital. At our last inspection, we found concerns with the management of controlled drugs, but a recent audit demonstrated compliance of over 90% across all areas with hospital policy.
- Actions from medicines management incidents or themes identified through audit were shared via team meetings and a monthly medicines management communication which was displayed on staff notice boards throughout the hospital. Staff we spoke to felt that these communications were well received as they detailed why each action was important as well as advising staff of best practice.

Incidents

- Throughout our inspection we saw evidence of learning from incidents. Each member of staff we spoke to could give an example where lessons had been learned following a reported incident. We saw that lessons learned were discussed as part of team meetings, daily safety huddle and shared via email and staff notice boards.
- Four incidents resulting in serious injury were reported between January and December 2018. There were no incidents which were categorised as never events. The most commonly reported serious injury was venous thromboembolism or pulmonary embolism (blood clots). Following review of these incidents, staff told us that information leaflets were now given to all patients about the risks and symptoms of blood clots.
- There was a process in place to ensure appropriate review of patient deaths which occurred within 31 days following surgery and staff were able to give examples of learning following a patient death. There had been no inpatient deaths between January and December 2018.
- Staff told us that 48-hour flash alerts were issued as a means of communicating urgent lessons learned following never events or serious untoward incidents which had occurred within the hospital or at other locations within the Spire group.
- There was a 'quality street' display on the wall outside of theatres which shared lessons learned following incidents. For instance, there was a focus on wrong side anaesthetic block and staff told us that team briefings included reference to the quality street display.
- The service also used safety crosses (visual tool which uses calendar days to mark progress against a goal) to monitor progress against actions from incidents such as missed doses of medications or compliance with temperature checks.
- Staff we spoke to demonstrated understanding of their responsibilities with regards to Duty of Candour. From a review of recent incident investigation reports we found evidence that the statutory requirements of Duty of Candour were met when patient harm had occurred.

Safety Thermometer (or equivalent)

- The hospital submitted data to the Safety Thermometer. This showed that over the past year there had been no incidences of urinary tract infections acquired in patients with a catheter in situ. There had also been no reports of patient falls in this time.
- The proportion of patients experiencing harm free care had fluctuated but apart from three instances across the year, this figure was consistently above the national average of 94%.
- In the year prior to our inspection, the hospital reported 100% of patients were assessed for risk of venous thromboembolism (blood clot) and 100% received prophylaxis when indicated.
- The hospital updated a scorecard each quarter that showed the outcomes for various clinical measures.

Are surgery services effective?

Good

Our rating of effective improved.We rated it as **good.**

Evidence-based care and treatment

- We reviewed 43 hospital policies, standard operating procedures and local work instructions as part of our inspection. All policies were within review date and referenced national standards and best practice guidelines where applicable.
- All policies and procedures were accessible to staff online and a folder with hard copies of all policies was kept in a staff area within the hospital. This folder was kept up to date by the governance team at the hospital however, where folders were kept in theatres and on the ward not all policies were the most recent version.
- Policies were updated in line with changes to national guidelines and standards and there were trackers in place to monitor compliance with national guidelines and local policies.
- The policy for cosmetic surgery was compliant with the Royal College of Surgeons Professional Standards for Cosmetic Surgery 2016.
- Services were compliant with National Institute for Health and Care Excellence pathways for obsessive compulsive disorder and body dysmorphic disorder.
- Patients could be referred for counselling or psychotherapy with a consultant psychologist if there was cause for concern with regards to patients referred for cosmetic or bariatric surgery. An audit to review the proportion of patients referred for bariatric or cosmetic surgeries and the reasons for referral was part of the 2019 audit schedule.
- The hospital 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 hospital took account of the Association for Peri-operative Practice's position statement on the perioperative care collaborative recommendations for surgical first assistants. 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. This had been an improvement since our last inspection.
- The hospital carried out checks that venous thromboembolism assessments had been conducted on each patient. Across 2018, 100% of patients were assessed for risk of venous thromboembolism.
- Two medical practitioners at the hospital held practising privileges for cosmetic surgery and both were on the General Medical Council specialist register.
- For patients undergoing breast implantation, breast registry patient information leaflets were given at the outpatient preoperative assessment appointment. On the day of surgery, breast registry data collection forms were completed by the surgeon so that this data could be input into the breast register.
- Managers used the Spire Healthcare scorecards to benchmark performance against other hospitals within the provider group. The scorecard monitored key performance indicators such as returns to theatre, surgical site infections, transfers to hospital, readmission rates and incidence of blood clots.
- Where indicators fell below the set targets, safety crosses were used as a means of monitoring improvement and engaging staff.
- The hospital held accreditation with SGS for its sterilisation services and with Bupa in relation to cataract surgery. To gain accreditation, the service was required to meet a several performance standards set by the accrediting bodies. Endoscopy services were working towards JAG accreditation at the time of our inspection.

Nutrition and hydration

- Staff ensured that patients received enough food and drink to meet their needs and improve their health.
- The service used a malnutrition screening tool to assess patients' nutritional requirements.
- Fasting times were confirmed with patients during the preoperative assessment. We observed that staff stressed the importance of keeping hydrated during fasting periods.

- Patients who attended for bariatric surgery were referred to a dietician and received a telephone consultation prior to their procedure.
- From our review of inpatient records, we found that fluid balance was monitored and totalled at the end of each day for patients as required. We also noted that following surgery patients were prescribed medicines to prevent nausea and vomiting as needed.
- Patient satisfaction with food and drink was captured through patient friends and family test survey results. Spire Fylde Coast scores for food quality were consistently above the Spire Healthcare average for 2018.
- A taster menu was given to a patient focus group as part of a patient forum in 2018 following which attendees were asked to provide feedback.
- Spire Fylde Coast hospital participated in the patient led assessment of the care environment audit in which the hospital received positive feedback around nutrition and hydration.

Pain relief

- Staff regularly assessed patient's pain using pain scores and we saw that this was documented in patient records at each assessment.
- Intentional rounding was also used as a tool to prompt staff to ask about patient's levels of pain and ask if they needed any pain relief.
- Staff used pictorial pain charts for those patients that had communication difficulties. 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, nurses told us they would look for signs of distress, for example sweating and a fast heart rate, to assess pain levels.
- Pain scores were audited to ensure that if patients triggered a high score this was acted on appropriately and promptly.
- Pain management was discussed with patients as part of the preoperative assessment.
- A recent patient survey results showed that 96% of patients were 'extremely satisfied' or 'satisfied' with the way that their pain was managed during their stay.

Patient outcomes

- Hospital managers used a variety of means to measure and monitor patient outcomes. A scorecard was used across Spire Healthcare locations as a means of benchmarking performance.
- Across 2018, the hospital met the targets set for; surgical site infections for hip and knee arthroplasty (less than 0.6%), unplanned returns to theatre (less than 0.2%) and inpatient falls (less than two per 1000 bed days). There were no incidences of transfer to critical care or hospital acquired pressure ulcers.
- The readmission rate was slightly above the target set (less than 0.3%).
- The incidence of venous thromboembolism (blood clot) was also higher than the target (less than 0.5%) at 0.95%. However, the hospital did meet the targets for venous thromboembolism risk assessment and prophylaxis.
- Patient outcome performance was monitored by the clinical audit and effectiveness committee, clinical governance committee and medical advisory committee. There were action plans in place for any measure which fell below Spire targets.
- The hospital had joined the North West Advancing Quality Alliance to promote, measure and benchmark best practice standards in primary hip and knee replacements with other local providers.
- The hospital submitted data to national data sets where applicable to allow results to be benchmarked and monitored across long term. For example, the hospital supplied data to the British Spinal Registry and National Joint Registry.
- The National Joint Registry consent rate for Spire Fylde Coast Hospital was in line with the national average for independent healthcare.
- Participation rates for patient reported outcome measures for hip procedures and knee procedures was 71% and 69% respectively for 2018.
- The hospital submitted data to The Commissioning for Quality and Innovation framework which supported improvements in the quality of services and the creation of new, improved patterns of care.

- Managers used safety crosses to monitor progress against safety improvement measures. For example, at the time of our inspection there were safety crosses in use in relation to medicines prescribing to reduce errors.

Competent staff

- Staff received appraisals which took into account their individual performance, training needs and career aspirations. These were referred to as 'enabling excellent' meetings. Information supplied in the provider information return stated that 100% of staff had and appraisal completed within the last year.
- We reviewed the training and competency records of ten staff across the service. We found that staff were up to date with the mandatory and role-specific training required. Competencies were recorded, and peer assessed where applicable. All staff had undergone the relevant competency assessments relating to use of equipment, point of care testing and clinical competencies specific to their roles.
- There was a clinical competencies booklet for all staff to complete. This included a self-assessment, sign-off by assessor and any supporting evidence such as observation or training modules for a comprehensive list of skills including; safeguarding awareness, management of pain, medicines management and administration and consent.
- Staff working with preoperative assessment had completed a three-day external course in preoperative assessment.
- Staff were supported to access continued professional development opportunities. For example, we spoke with a member of staff who was completing the care certificate and had been given time in working hours for course work.
- We were given examples of when staff members had felt able to challenge the practice or behaviours of their peers. Staff told us that when they had raised concerns this was dealt with by managers promptly and professionally.

Multidisciplinary working

- There was a whole hospital safety huddle held at 9am each day. We observed a huddle during our inspection and noted that there was representation from each area of the hospital. Staff were able to share issues which could impact on other departments and escalate any incidents which had occurred the day before so that immediate learning was shared effectively.
- Each consultant had overall responsibility for their patient. When the consultant was not on site, staff were able to contact them on the home number or mobile which was stored on a centralised system.
- Plans for discharge were included as part of the preoperative assessment and re-visited following surgery. When necessary, staff involved patients' relatives and carers in discharge planning.
- Information was shared with patients' GPs on discharge, giving details of the surgery and any additional information relevant to the patient's care.

Seven-day services

- The hospital provided some seven-day services.
- Operations were conducted Monday to Saturday between 8am and 9pm (6pm on Saturdays).
- Emergency surgery could also be conducted out of hours if necessary. The on-call theatre team was called out for returns to theatre only and not in the event of a late-running theatre list.
- 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 physiotherapy team provided a 24-hours a day, seven days a week service.

Health promotion

- The ward areas contained leaflets for patients and families regarding health promotion. This included information about caring for surgical wounds, having general anaesthetic, and ten steps to a more active life.
- The physiotherapy contained a set of practice steps (with rails) that patients could use to practice walking again after surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in mental capacity and consent. This was provided as an e-learning module and was mandatory for all clinical staff.

Good

Surgery

- Staff we spoke to could articulate when and how to gain consent for care and treatment and when they might consider that someone lacked the capacity to consent to care and treatment.
- Consent to surgery was gained during the initial consultation and confirmed at preoperative assessment and prior to the procedure.
- For patients who attended for cosmetic surgery, the hospital policy for cosmetic surgery stated that there must be at least a minimum of two weeks between the first consultation and the surgical procedure. This was in line with the Royal College of Surgeons 'Professional Standards for Cosmetic Surgery' 2016.
- Staff told us that if any concerns regarding a patient's capacity to consent to care and treatment were identified during the preoperative assessment, a further meeting would be arranged with the patient, relatives, consultant and Head of Clinical Services as required. A two stage mental capacity assessment would then be completed.

Are surgery services caring?

Good

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

Compassionate care

- During our inspection, we directly observed care provided to four patients and gathered feedback from a further six patients who had accessed the services.
- We observed staff providing compassionate care to patients and their families. In recovery, we witnessed staff speaking with patients to provide them reassurance and support.
- Staff spoke to patients with respect and in a polite, sensitive manner.
- Patient feedback was consistently positive and especially in relation to attitudes of staff and the hospital environment.
- Patients told us that 'staff were very caring and answered all questions asked', 'staff took a genuine interest in my recovery' and they were 'treated with dignity and respect'.
- Patients privacy and dignity was always maintained. Due to the layout of theatres, it was possible for a patient entering theatre to pass a patient in recovery however there were curtains around each recovery bay to maintain patient's privacy.
- On the ward, we observed that patient call bells were responded to promptly and staff took the time to interact with patients and their families.
- One of the hospitals values was to 'put patients at the centre of everything we do' and candidates were assessed against the hospital values when recruited to work at the hospital. Staff were also asked to evidence how they demonstrated hospital values through their appraisal process.
- Patient feedback was routinely gathered and acted on to improve services. There was an established patient forum who were asked to input into decisions such as those around refurbishment plans. Any patient feedback was also shared at the daily hospital safety huddles.
- Patient friends and family test results were consistently high for the hospital. Between September 2018 and February 2019, more than 90% of respondents said that they would recommend the hospital as a place to receive care. In February this figure was 100%. Response rates were consistently above 20%.

Emotional support

- Staff provided emotional support to patients and their relatives as required.
- Staff we spoke with described experiences caring for patients who were nervous or anxious about surgery and explained how they took the time to comfort patients.
- We observed that staff interactions with patients were not rushed and staff gave people time to talk through any concerns they might have.
- We observed recovery staff speaking calmly and supportively to patients following surgery.

Good

Surgery

- There was a quiet room within the outpatient's department which could be used for more sensitive discussions with patients and their relatives.

Understanding and involvement of patients and those close to them

- There were support groups available for patients who underwent life-changing procedures such as cosmetic and bariatric procedures.
- There was a chaperone policy in place and patients could be provided with a chaperone if they wanted. Information about chaperone arrangements was displayed in public waiting areas.
- We observed that staff communicated with people in a way that they could understand. During preoperative assessments we noted that staff explained surgical procedures to patients and those close to them clearly and asked for confirmation that this information had been understood.
- Patients we spoke to told us that they felt fully informed about their care and treatment and had received an 'excellent' service.
- Patients told us that they had 'always been listened to' by staff caring for them.
- Staff gave examples of times when they had involved patient's relatives or carers more closely in their care in order to meet their individual needs.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- We found that the facilities and premises were appropriate for the services delivered. The needs of the local population had been considered in making decisions around refurbishment.
- The hospital and departments were accessible to people with physical disabilities.
- The service adhered to 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.
- The hospital's pre-assessment team identified those patients that required interpreter services and would pre-book support for appointments.
- The hospital offered patients a choice and flexibility of appointment times which included evenings and weekends.
- Visiting times were flexible to allow family members to stay as long as they wished. Carers were permitted to stay overnight if required.

Meeting people's individual needs

- Written information was provided to patients to support them through their procedure such as information about fasting, what to do if you become unwell prior to the procedure and information specific to their procedure.
- Staff confirmed during the preoperative assessment whether patients had arrangements for transport home and if they had support at home from their relatives or those close to them.
- There was a room on the inpatient ward which staff told us was reserved for patients with dementia. This was because the bathroom was set out in a way which was adapted for people with dementia and this room was closest to the nurses' station.
- All staff had completed online dementia awareness training, with some having completed additional courses. There were link nurses for dementia care who could provide additional support and advice to staff caring for people with dementia.
- Patients with dementia or identified as having more complex needs were placed first in theatre lists to minimise their anxiety.
- We were told of an example of a patient who was profoundly deaf whose case study had been shared as an example of best practice. The patient and their relative had been closely involved with the multidisciplinary team in planning their care and

treatment. Staff had put a robust care plan in place and an interpreter was hired to attend and provide translation in sign language. The result had been a positive experience for the patient and their relative.

Access and flow

- There were processes in place to manage access and flow through the hospital. Monthly capacity meetings took place where theatre lists were reviewed and reduced if necessary.
- There was a weekly 'to come in' list which was collated and disseminated on Friday of each week. This allowed theatre staff to finalise the order of theatre lists dependent on the complexity of procedures and equipment needed.
- Admission times were staggered where possible to reduce waiting times between admission to the hospital and being taken to theatre.
- An online calendar was used to schedule patients for surgery. Any patients deemed not fit for surgery at this time were added to the calendar entry for 25th December that year as no surgeries were scheduled for this date. This meant that staff could easily keep track of patients requiring preoperative assessment.
- Urgent patients could be identified at a number of stages including their first consultation, pre-assessment clinic, or through multidisciplinary reviews. Complex patients were discussed at theatre briefings and morning huddles.
- Between January to December 2018 there had been 6625 visits to the operating theatres and 5459 day case attendances. In the same period, 21 procedures were cancelled due to non-clinical reasons and all of these were rescheduled within 28 days of the cancelled appointment.
- There was one unplanned return to theatre between January and December 2018 and 12 unplanned transfers to another hospital. This was for services not provided at the hospital, for example, CT scanning when the mobile service was not available. None of these were emergency critical care transfers.
- There were 19 unplanned readmissions within 28 days of discharge between January and December 2018.
- There were two of three theatres which could be used out of hours for any returns to theatre and there was an on-call theatre team to facilitate such instances.
- Staff were familiar with the hospital policy for the transfer of patients to a local acute hospital or intensive care unit and gave examples when patients had been transferred appropriately. There had been 10 instances of unplanned transfer of inpatients between January and December 2018.

Learning from complaints and concerns

- Complaints could be raised through the hospital's website, via telephone or in writing (letter or email) through the hospital complaints handler, patient feedback forms or verbally to members of staff.
- 'Please talk to us leaflets' explaining the complaints process were available throughout the hospital as well as posters in different languages explaining the complaints process.
- There was a policy in place for handling and responding to complaints and managers monitored compliance with this policy.
- The hospital had a clear complaints process, with escalation processes for both NHS and privately funded patients governed by the Independent Healthcare Sector Complaints code and the NHS complaints procedure respectively.
- The complaints procedure set out the three-stage process for the review of complaints, and appropriately referenced the adjudication services: The Independent Healthcare Sector Complaints Adjudication Service and the Parliamentary and Health Service Ombudsman.
- 85 complaints had been received between March 2018 and February 2019, none had been referred to the Independent Healthcare Sector Complaints Adjudications Service or Parliamentary and Health Service Ombudsman.
- Complaints were acknowledged within two days of receipt and the service aimed to resolve complaints within 20 days as per hospital policy.
- Staff told us about learning which had been implemented following complaints. For example,

patients who attended for day case surgery had complained that there was nothing to keep them occupied in the day case bays. To resolve this, a television had been installed in the day case unit.

Are surgery services well-led?

Good

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

Leadership

- The hospital had gone through recent changes within the senior management team which included the recruitment of a theatre manager and deputy matron who had the right skills and experience to provide strong leadership.
- The theatre manager was part of the senior management team at the hospital which meant they were involved in discussions around plans which would directly affect surgical services.
- Staff we spoke to told us that they felt their managers were approachable. Staff told us that they would feel comfortable raising any issues or concerns to managers and were confident that these issues would be resolved.
- At the time of our inspection, the role of ward manager was being covered by two ward sisters who were acting up into this role.
- There were three coordinators working in theatres who were responsible for different areas.
- A new chair of the medical advisory committee had recently been appointed. This had come following a challenging time for the hospital's senior leadership team as there had been concerns raised by staff. This had led to an external review being commissioned by Spire Healthcare to review the hospital's management and governance arrangements. Recommendations of the external review had been taken on board by the senior management team and at the time of our inspection, staff reported having seen improvements in leadership and governance.
- Staff told us that the senior leadership team was approachable and visible. The head of clinical services regularly visited clinical areas and attended the daily safety huddle along with the hospital manager.
- 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.

Vision and strategy

- There was a vision and strategy for the hospital which focussed around patient safety and commercial viability.
- At the time of our inspection, the hospital strategy was to; 'deliver high quality care to our patients, demonstrating that we are the provider of choice for the Fylde Coast, growing our relationships with our partners to increase our market share by promoting our clinical services to the local population, continue to improve the hospital's survey scores by promoting the benefits of teamwork, improving communication between us all and continuing to build on what we do well and work together to deliver on our promises'.
- The hospital strategy was published annually and although managers and staff we spoke to were aware of the strategy, some told us that they had not always been consulted on it.
- Each department had created a local strategy which fed into the aims and objectives of the hospital strategy.
- There was also a clinical governance strategy which was based on continuous service improvement.

Culture

- Staff we spoke to throughout the service reported a supportive and open culture. We were told by staff working in theatres that there was no divide between staff members of different roles such as nurses and operating department practitioners.
- Staff we spoke to told us of an open-door policy by hospital managers and reported that they felt listened to and supported by managers.

- There was a Freedom to Speak Up guardian within the hospital and staff we spoke with were aware of who this was and how to contact them should they wish to raise any concerns. We were told that the hospital had also recently appointed three additional freedom to speak up ambassadors and had plans to add a consultant freedom to speak up ambassador as an additional way to raise concerns.
- Any incidents raised to the Freedom to Speak Up guardian were reported through the online incident reporting system. There had been no themes or trends identified over the previous 12 months, but two incidents had been reported as 'behavioural issues' and were dealt with following HR processes. In that time there had been a total of five incidents reported.
- Staff told us that they were encouraged to report any incidents which did or could result in patient harm. There was a culture throughout the service of learning from when things went wrong as opposed to apportioning blame.
- Managers we spoke to felt that staff were open to improvement and changes to practice within the hospital. We were told of an example where certain staff groups had been more reluctant to change but a compromise was found where possible.
- Theatre staff we spoke to told us that they never felt pressure to continue with a theatre list if it was not safe to do so. They were supported to escalate concerns with regards to patient safety.
- We were provided with the hospital group data against the workforce race equality standards for 2017. This showed that results for black and minority ethnic staff was comparable with white staff. A slightly higher proportion of black and minority ethnic staff reported experiencing discrimination from patients, the public or other staff members. This data covered the whole of Spire Healthcare and could not be broken down by location.
- The service provided evidence of compliance with the Competitions and Marketing Authority Private Healthcare Market Investigation Order 2014.
- We saw an improvement in the culture of the theatre team since our previous inspection, with staff feeling more empowered and supported to speak up and be listened to. This was evident from an example we were given when staff concerns had been heard and acted on.

Governance

- There were effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services.
- The Spire Healthcare governance framework was implemented at Spire Fylde Coast Hospital to support oversight and management of risk and performance issues.
- There was a clear governance structure which demonstrated links to and from external committees which were part of the wider Spire Healthcare group. There were clear lines of accountability from the ward to the board of directors.
- The medical advisory committee met quarterly. We reviewed the minutes from the four most recent meetings and found that these showed there was some appropriate challenge from committee members and that the committee held senior managers to account for hospital performance and assurances. We met with the chair for the medical advisory committee who confirmed that there had been improvements to the effectiveness of committee meetings.
- There were processes in place for granting practising privileges for consultants who wanted to work at the hospital. Firstly, their CV would be reviewed by the hospital director and head of clinical services who determined whether to proceed with the application. An application pack would then be sent to the consultant and, if satisfactory, reviewed by the hospital director, head of clinical services and the medical advisory committee chairman and speciality representative. This would then be ratified at the next medical advisory committee meeting.
- Practising privileges were then reviewed once every two years or sooner if concerns were raised regarding the consultant's practice.
- 17 members of staff had their professional registration revalidated in the 12 months prior to our inspection.

- There was a clinical governance committee in place which was chaired by the head of clinical services and attended by the hospital director and medical advisory committee chair. The minutes of these meetings were reviewed during the medical advisory committee meetings.
- Morbidity and mortality was a standard agenda item at clinical governance committee meetings and the case review process was intended to provide opportunity for lessons learned and to drive improvement.
- There was senior management team representation at departmental meetings and safety huddles.
- Team meetings took place monthly and the minutes from each were kept in a folder on the ward so that staff who had been unable to attend could review the information.
- During our previous inspection of this service, we found that the provider did not hold evidence that staff acting as surgical first assistants had the relevant checks and qualifications to carry out this role. At our most recent inspection, this information could not be provided to us when asked, but following our inspection, we were informed that such information was held electronically and that these online records were complete and up to date for all staff who worked as surgical first assistants, although this was not highlighted by managers during our on-site review.

Managing risks, issues and performance

- There was a risk register in place for the hospital which included risks for each department . For surgical services, the highest rated risk was that the operating table in theatre three needed replacing. There were appropriate actions in place to mitigate this risk until a new table was resourced.
- The Spire Healthcare governance framework outlined the process for escalation of risk through the hospital and to head office if the risk could not be managed locally.
- There was a health and safety and risk committee which was chaired by the hospital director and included representatives from all departments.
- There was also a clinical governance committee chaired by the head of clinical services and attended by the hospital director and chair of the medical advisory committee.
- Risks could be added to the hospital risk register via either of these committees.
- Risks were identified through risk assessments, patient and staff feedback, incident reporting, external accreditation assessments, audit and national recommendations.
- The hospital conducted several 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.
- There was a business continuity plan in place for the hospital. This detailed the roles of the initial and local emergency response team as well as contingency plans in the case of a variety of circumstances such as loss of power or contaminated water.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The information used in reporting performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant.
- Senior managers used information effectively to monitor and improve performance. This information was collated into the hospital scorecard which was reviewed at managers meetings, clinical governance committee and medical advisory committee meetings.
- The service reported data to the Private Healthcare Information Network which is a not-for-profit organisation that publishes data to help patients make informed decisions regarding their treatment options, and to help providers improve standards.

- In the three months prior to our inspection, no patients were seen without all relevant medical records being available.

Engagement

- Senior leaders engaged well with staff and patients to shape and improve service provision.
- Staff received an email each month from the hospital manager which celebrated any achievements and outlined goals moving forward.
- A Spire-wide survey found that staff working in theatres at Spire Fylde Coast Hospital were the joint seventh happiest out of 39 locations.
- The annual staff survey January 2019 found Spire Fylde Coast Hospital had the best overall engagement results across the Spire group.
- Managers used patient forums to engage with patients to assess the services provided and make improvements based on their experiences.
- Social media pages and review sites were also used as a means for gathering patient and public feedback.
- There was a patient experience group which was attended by representatives from across the hospital to review feedback and complaints to identify themes and areas for improvement. This information was then discussed at team meetings and was a standard agenda item.

Learning, continuous improvement and innovation

- The service was committed to learning from when things went wrong and strived for continuous improvement.
- 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.
- We saw examples of lessons learned following incidences of mortality and morbidity following surgery. Even when changes would not have impacted the outcome, where improvements were identified this was shared with staff across the hospital.
- Examples of best practice were shared with staff through team meetings and recorded in the minutes so that they could be viewed by staff who were not able to attend.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

This service was previously rated with diagnostic services and so we have no previous rating for the outpatient department (OPD). We rated it as **good.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Mandatory training included fire safety, health and safety awareness, equality and diversity, infection control, information governance, manual handling, compassion in practice, managing violence and aggression and anti-bribery. All staff completed this training.
- Additional training was provided to appropriate staff which included the mental capacity act, incident reporting and controlled drugs.
- The OPD manager could access the mandatory training records for the staff in their department. When staff had completed all the training, this showed as green and if they had only completed half of their training, this showed as red. All the OPD staff and the physiotherapy staff were up to date with their mandatory training.
- There had recently been face to face study days for basic life support training and paediatric basic life support training. The two qualified OPD nurses had attended a face to face intermediate life support training course.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to use it.
- There was a hospital safeguarding policy which was in date.
- Safeguarding training included safeguarding vulnerable adults, combined levels one and two and safeguarding children and young people combined levels one and two. Everyone did this safeguarding training.
- Safeguarding level three training was available for staff that needed it as part of their role.
- Staff told us that there had been no incidents of safeguarding that had arisen in the OPD, they said that they knew what to do and if they had any concerns they would go to the safeguarding lead for the hospital.
- There was an identified lead for female genital mutilation who was the out-patient lead.
- There was a patient and visitor information board that included information about safeguarding, female genital mutilation and Prevent. (Prevention of radicalisation and extremism).

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept equipment and premises clean. They used control measures to prevent the spread of infection.
- All the areas in the OPD and physiotherapy department were visibly clean and tidy. Cleaning

schedules were displayed in all treatment rooms and rooms were cleaned at the end of each clinic, not all had been completed but this was an oversight on completing the documentation and not in the cleaning of the rooms.

- There had been no infections in the OPD. Patient information was available for caring for surgical wounds, screening for MRSA and infection control.
- The hospital undertook hand hygiene audits every three months across a number of departments as part of the provider's national audit programme which across 2018 showed 96% compliance. In 2018, a department specific audit was added for outpatients and the latest results for the last three months of 2018 showed 100% compliance.
- The cleaning schedule for clinical equipment was audited every three months. For the year 2018 to 2019, results showed 71%, 57%, 53% and 75%. Due to the poor results for the audit additional audits had been scheduled to try to improve results.
- There were hand washing sinks in all the treatment rooms and hand sanitiser was available around the OPD and physiotherapy department.
- The hospital had its own housekeeping staff.
- Personal protective equipment was readily available in each treatment room and in the physiotherapy treatment area. We saw that staff used it. There was appropriate waste disposal which was well signed for clinical and general waste.
- Naso-endoscopes were cleaned with appropriate wipes which was in line with current decontamination guidance. There were additional plans for scopes to be processed at the end of each clinic through the hospital's onsite sterile washers once staff training and additional equipment were in place.
- In the dirty utility room there was information about management of blood spillage and blood-stained body fluids.
- There was a patient and visitor information board that included information about infection prevention and control. There were posters about infection control and bare below the elbow around the OPD and physiotherapy areas.
- There was a hospital infection prevention and control team newsletter. This had information about audits, mandatory training targets, different infections and how to address them and some information on the monkey pox outbreak from Public Health England. This was because a patient had been diagnosed with the virus at a nearby hospital trust.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The service did audits of the environment every three months. In the year 2018 to 2019 the audit had scored 84%, 94%, 91% and 93%.
- Treatment rooms were spacious and well equipped with storage cupboards and forms, patient leaflets and paperwork necessary for the clinics. All treatment rooms were air-conditioned.
- The OPD shared a resuscitation trolley with the diagnostic department which was next door. The trolley was checked daily by the OPD staff and this was recorded. We saw the completed schedules for the trolley.
- In the OPD there was a resuscitation trolley, sepsis bag and adult and paediatric anaphylaxis boxes so that staff had the equipment to deal with any emergencies that could arise during clinic. All the equipment was checked and in date.
- The treatment trolleys were appropriately stocked for the clinics depending on the speciality of the clinic.
- There was a process for the reporting of faulty equipment. There were engineers on site and there was a service level agreement in place for the maintenance and servicing of equipment.
- Equipment we saw in the treatment rooms was cleaned and had been checked appropriately. These checks had been recorded. There was enough equipment for the clinics. There were weighing scales in each of the treatment rooms which had been checked and calibrated.
- The hospital had invested in new equipment for the department including treatment beds, a bipolar

machine for electrosurgery in the dermatology clinics, a microscope for ear, nose and throat patients and more sphygmomanometer's for blood pressure testing.

- The department did sharps handling audits every three months. In the year 2018 to 2019 the department had scored 83%, 98%, 80% and 93%. The sharps bin audit was done every year and was at 100%.
- All sharps boxes' we saw on the inspection were dated and signed and were not overfilled.
- The department audited disposal of waste including clinical waste every three months. In the year 2018 to 2019 the department scored 93%, 90%, 80% and 94%. The department scheduled additional audits when the results were poor.
- The department completed mattress audits and these were between 98% and 100% for the year.
- Although the service did not treat children and young people there was paediatric resuscitation equipment available for children who were visitors. Some trained staff had received training in paediatric life support in case of emergency assistance being required for a visiting child.
- The dirty utility room did not have a lock on the door though all cupboards in the room were locked. Flammable liquids were stored in a locked cupboard in this room. We raised this with the hospital and a keypad was fitted shortly after the inspection.
- The physiotherapy gym was spacious with two treatment couches with curtains for privacy and dignity.

Assessing and responding to patient risk

- The service responded to patient risk and there were processes in place to respond to a deteriorating patient.
- There was a daily huddle at 8.45 am in the OPD for staff. Any issues for the day were raised at this meeting and any feedback from incidents, complaints or changes to hospital processes. This was sent out to staff who were unable to attend the meeting.
- We observed a huddle during the inspection which was attended by two qualified staff and four health care assistants. The OPD lead discussed the days clinics, a reminder about sharps bins and cleaning schedules, dementia training, the infection and prevention control link team minutes and updated policies and guidelines. There was a reminder to staff taking patients to other departments to ensure that all documentation was correctly labelled.
- In an emergency, staff could call the on-call team to support a deteriorating patient. Staff told us most emergencies involved people fainting due to low blood sugars or a drop-in blood pressure. There were buttons around the hospital to summon the team.
- The OPD lead said that they wanted to do some scenarios of a deteriorating patient for the OPD to support staff development.
- The two staff nurses in the OPD had up to date intermediate life support training and the health care assistants had basic life support training.
- All consultants had a chaperone with them at all times to assist with the clinics and to support the patients. Depending on the clinic this was a qualified nurse or a health care assistant. Some clinics had two members of staff to support.
- Each treatment room had an alarm that could be used to call for help if necessary.
- Reception staff checked patients names, addresses and phone numbers when they arrived at the hospital.

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 department used a staffing tool based on how many clinics were running, procedures taking place and chaperone requirements.
- There were eight staff contracted to work in the OPD, two qualified staff and six health care assistants (HCA's). They also used bank staff from Spire to cover any staffing gaps, annual leave and sickness.

- Staff told us that the workload in the department had significantly increased over the last year. The department would be recruiting additional bank staff in the future with some staff given more responsibility in the department.
- There were six physiotherapy staff at the hospital and a technical instructor who also had an administration role. Some were full time, some were part time, and some were permanent bank staff who worked flexibly to meet the needs of the service.
- The physiotherapy manager would look at the theatre schedule three to four weeks ahead to plan the in-patient activity for the staff. Staff could take time in lieu if necessary and staff we spoke with said that this worked well meeting the needs of patients and supporting work life balance.

Medical staffing

- There were no medical staff assigned to the OPD.

Records

- Staff kept detailed records of patients' care and treatment. Most records were clear up to date and easily available to all staff providing care.
- The records were paper records and were stored securely in trolleys in the OPD.
- If a record could not be found for a clinic a temporary record was created which contained a front sheet of the patient's details and the outcome letter from their last appointment. Scan and blood test results were available on the hospital computer system. Staff told us that there could be one or two missing records every day which equated to 2% of all patient records. Temporary files were a different colour and could be identified easily and were married up with the permanent record as soon as it was located.
- We looked at three patient records in the OPD. In one record the consultant entry was illegible, however the letter to the patients GP was clear and concise and had been written on the same day as the patient's visit. The second record had clear clinical notes and the GP letter was also clear and concise. The patient's allergy to penicillin was noted in the record. In the third record there was a clear entry and comprehensive letter to the patients GP. In all records the entry was signed and dated.
- We looked at two records from a gynaecology clinic, both were fully completed and signed and dated. All allergies were noted. The chaperones who were present at the time of the examination had signed and dated the record.
- The physiotherapy service audited its patient records against the Chartered Society for Physiotherapy standards. This was done three times a year and at the last audit all scores were over 90%.

Medicines

- Medicines were stored safely in the OPD.
- Medicines were stored in a locked cupboard in the office area which was secured with a keypad, though very few medicines were kept in the OPD. Room temperatures were recorded daily and if the room became too hot staff contacted the onsite pharmacy. We saw that medicines were within their expiry dates. Eye drops requiring refrigeration were kept in the hospital pharmacy until needed.
- We checked several different dressings in the storage cupboards in the treatment rooms in the OPD and all were within the expiry date.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff were aware of the duty of candour and knew when it was appropriate to use it.
- Any issues could be raised at the morning huddle in the OPD and staff and managers said that the huddle was useful for communication.

- The service had an electronic incident reporting system. Staff completed their own incident forms and the HCA's would go to the OPD lead if they needed any help with reporting the incident.
- All the incidents in the OPD were no harm or low harm. The main incidents were post-operative wound infection in the dressing clinics, missing patient records and communication issues. Staff told us that there were not as many missing records as there used to be.
- We were given an example of an incident in the OPD where the wrong patient sticker had been put on a referral form for diagnostic testing. Staff told us what changes had been put in place to try to prevent this happening again and we observed that these were communicated to staff at the huddle.
- The service had "feedback Friday" when there was a rapid review of any incidents that had occurred during the week and shared learning was fed back to staff.

Are outpatients services effective?

We do not rate this domain in the out-patient department.

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.
- There was a process for reviewing national guidelines. This was through the clinical audit and effectiveness committee where guidance was reviewed as a multi-disciplinary team and then fed back to the appropriate team through the team meetings. Implementation of the guidance was monitored by the clinical audit and effectiveness committee.
- The hospital used evidence-based pathways based on clinical guidelines from appropriate recognised bodies including the National Institute of Health and Care Excellence and the Royal Colleges.
- The physiotherapy team described how they had implemented new guidance to the service.

Nutrition and hydration

- Free refreshments were available to all patients in the waiting areas of the OPD.

Pain management

- The physiotherapists used a visual analogue pain scale as one of their patient's outcome measures.

Patient outcomes

- The department audited infection control, sharps bins, departmental waste and the environment.
- The physiotherapists used the Chartered Society of Physiotherapy quality standards and peer reviewed patient records against the standards. They looked at 10 patient records and produced a report with agreed suggestions for further learning and development for each staff member. The outcome of the review determined the frequency of the reviews. This was done twice a year.
- The patient outcome measures were reviewed as part of the process including meeting the specific needs of the patient, meeting the expectations of the patient and the evaluation of each episode of care.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- All staff were involved in "enabling excellence" which was an appraisal system where staff met with their manager three times every year. Managers said that staff could request a 1:1 at any time. All OPD staff had completed their appraisals.
- Training was provided for the health care assistants by the hospital group.
- Representatives from equipment companies were coming into the hospital to do training for staff.
- Staff could access training at the nearby hospital trust and one of the nurses was currently having training on antiseptic non-touch technique.
- A member of staff had attended training at a specialist eye hospital to support the eye clinics.
- Different specialities had a lead nurse for example, ear, nose and throat and ophthalmology, the OPD lead

said that this was developing as more clinics were set up at the hospital. There were plans to expand gynaecology, wound care and urology. All would require additional skills and competencies.

- Each physiotherapist had a competency folder which contained their progress for all clinical and core competencies. All the physiotherapy staff had completed their appraisals.
- One of the physiotherapists had been to look at procedures undertaken at other Spire hospitals so that they could prepare for changes to spinal surgery at the hospital.

Multidisciplinary working

- Different staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- All staff in the OPD said that they worked well with the consultants.
- The physiotherapists said that they worked closely with the nurses on the ward in helping to mobilise patients and supporting their post-operative recovery.

Seven-day services

- The OPD service was six days a week with some evening clinics.
- The physiotherapy service was available seven days a week for in-patients and six days a week for the OPD patients.

Health promotion

- There was patient information around the OPD about a number of conditions. One of the health care assistants was concerned that patients did not always receive enough information about their condition following diagnosis and had contacted the local hospital to obtain patient information which was available around the department.
- There were information leaflets about smoking cessation.

Consent and Mental Capacity Act

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- There were best interests' meetings for all patients who would be having any type of procedure who had dementia or cognitive impairment. These were held in the OPD clinics.
- There was a patient and visitor information board that included information about mental capacity and Deprivation of Liberty Safeguards.

Are outpatients services caring?

Good

This service was previously rated with diagnostic services and so we have no previous rating for the outpatient department. We rated it as **good.**

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We observed that patients were treated with privacy and dignity. The hospital dignity and respect standards were displayed on notice boards in patient areas.
- We saw patient feedback cards one said "thank-you for your kind care and attention when I was in hospital" and the other said "all the staff looked after me with great care and made my hospital visit a very pleasant one, many thanks."
- Cards from patients stated, "excellent care, warm welcome, friendly staff." "I was blown away with the care" and "I feel like my care was excellent, I would highly recommend".
- We spoke to a patient with restricted mobility and their relative, they told us they really liked the hospital because it was smaller and more personal, they liked

the staff coming for them to the waiting area and taking them to the treatment room. The patients relative had received treatment at the hospital which they described as beautiful.

- Another patient was returning to the OPD following surgery. They had been a day case but due to complications had needed to remain in hospital overnight. They told us that the recovery staff had visited them in the morning to check that they were alright.
- Another patient was full of praise for the care that they had received at the hospital and described it as "second to none." They were returning to the hospital for further treatment following surgery.
- Reception staff welcomed patients to the hospital, they were polite and courteous and knew some of the patient's names as they had been attending the hospital for a number of years. They asked patients how they were.
- The physiotherapists had their own patient satisfaction survey. Of the 11 patients involved in the survey, ten patients described the service as excellent and one patient described it as good. Nine patients described privacy and dignity as excellent and two patients described it as good.

Emotional support

- Staff provided emotional support to patients when they needed it and provided reassurance.
- There was always a nurse present in the consulting room when a consultant was going to have a difficult discussion with a patient. Patients could be moved to the quiet room from the treatment room until they were ready to leave the hospital.
- We spoke to a patient who was very nervous, and we saw that staff reassured them about their treatment and gave them options to consider about their treatment.

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.
- We observed that patients and their carers were involved in discussions about the patient's treatment.

Are outpatients services responsive?

Good

This service was previously rated with diagnostic services and so we have no previous rating for the out-patient department. We rated it as **good.**

Service delivery to meet the needs of people who used the service.

- The service planned and provided services in a way that met the needs of people who used the service.
- There were 10 consulting rooms in the OPD. There were two waiting areas and a pre-operative waiting area. Clinic times were from 8.00am to 21.00pm Monday to Friday and 8.30am to 18.00pm on Saturdays.
- Hot and cold drinks were available in the waiting areas for all patients. There was a range of seating available for patients in the waiting areas.
- There was an OPD office which contained medicine storage cupboards, medical records, staff lockers and computers for staff. It was very small, and staff said that it got very hot in summer. We were told that the hospital had plans to install new air conditioning system by the end of August 2019, and had a process in place to ensure medicines were moved to pharmacy if temperatures were too warm to keep them safely stored.
- Patients attending the service were approximately 60% NHS and 40% self-funding. The service treated only adult patients. The majority of OPD attendances were orthopaedic (25.1%) followed by ophthalmology, ear, nose and throat and gynaecology.
- Each of the consulting rooms was spacious and well equipped. There were treatment couches that had curtains for privacy and some of the rooms were equipped for specialities for example, ophthalmology and ear, nose and throat. A nurse or health care assistant was allocated to each room to act as a chaperone for the consultant. The chaperones

collected the patients from the waiting areas to take them to the appropriate clinics. There were signs outside the rooms indicating which consultant was in the consulting room and who the chaperone was.

- There was a quiet room in the OPD which was comfortably furnished and had blinds for privacy. The room was used by patients who had received bad news and by staff who needed to speak with patients and their relatives.
- Consultants set their protocols for their clinics allocating times for new and follow up clinics. Appointment times varied between 10 and 30 minutes dependant on whether the appointment is new or follow-up and the clinical specialty.
- There was a physiotherapy department with a spacious treatment area/gym and a large staff area. The physiotherapy manager told us that there was funding from the hospital to improve the gym and facilities.
- Patients were collected from the OPD waiting rooms by the physiotherapists. The physiotherapists decided on treatment length dependant on what procedure they had had done.
- Physiotherapy was mainly musculoskeletal with treatment of mild neurological symptoms and basic chest clearance. There was also physiotherapy advice for post-operative gynaecological patients. Patients were seen on the ward post-operatively or in the OPD and self-funding patients could attend the hospital as out-patients.
- The physiotherapists were unable to request diagnostic tests for their patients but one of the physiotherapists had recently completed a post graduate degree and with this qualification the service hoped that this member of staff would be able to request diagnostic tests. Currently for NHS patients the physiotherapists had to write to the patients GP and for self-funding patients the physiotherapists referred to the patient's consultant.

Meeting people's individual needs

- The service took account of patients' individual needs.
- Staff told us that patients with a learning disability would normally attend the department with a relative or carer. They would try to put them at the beginning of a clinic list and relatives and carers could stay with patients.
- The hospital was introducing patient passports for patients with a learning disability or cognitive impairment and were using "this is me" from the Alzheimer's society. On the day of the inspection there was training on dementia taking place at the hospital.
- There was a patient and visitor information board that included information about dementia and cognitive impairment.
- There was dementia signage on the toilet doors in the OPD and a dementia friendly clock in the reception area.
- The service usually only treated patients with a body mass index of 40 or less but could consider patients with a higher body mass index (BMI) following a multi-disciplinary team review in line with the admission policy. Patients with more complex needs, or a higher BMI, could be offered treatment at other Spire hospital with critical care facilities on-site. The hospital had a bariatric lead nurse.
- There was a designated treatment room for bariatric patients with appropriate furniture and equipment.
- Interpreting services were available for patients at the hospital. Letters were sent out in the appropriate language when translators were booked.
- There were toilets for those patients who were less mobile, and an assisted patient bathroom was available in the OPD.
- The service was providing extra-corporeal shock wave therapy for tendon problems.

Access and flow

- 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.
- The service was exceeding the 92% target for the 18 weeks referral to treatment time. This was achieved by evening and weekend clinics if necessary.

Good

Outpatients

- The service was meeting the 18-week target for cataract surgery for the first eye with patients waiting two to three months for surgery on the other eye if required.
- Patients were checked in by the reception staff. Some patients were given an appointment as they left the hospital, and some were sent a further appointment by the pathways team at the hospital. Staff tried to accommodate patient requests for appointment times.
- Reception staff informed patients if clinics were running late, the department was looking at having a board with any delays on it to keep patients updated. If a consultant was more than 15 minutes late for a clinic the hospital would contact them and inform patients about any delays.
- If patients did not attend for their clinic appointment the reception staff checked with the consultant if a further appointment needed to be sent out. Most patients who did not attend were NHS patients and some cosmetic follow up patients.
- Some medical records were kept on site while others were kept at a national distribution centre. All patient records were being reviewed and if patients were not due to be seen for four weeks their records were sent off site. This had cleared a substantial number of patient records and had made other records easier to find. Records could be retrieved from the national distribution centre within 24 hours. Staff told us that there were hardly any missing records and that the ones in use were easier to find.
- The review of the patient records, although time consuming, was showing positive results and was supported by the senior management team who were paying staff overtime to continue the review of all records.
- When a record was completed in the OPD it was sent to the Pathways team where it was tidied up and the outcome letters were added. Those going off site had their barcodes scanned and the others were scanned. Letters were typed by secretaries both on and off site from the consultant's recordings. Outcomes were checked to ensure that patients who needed a further appointment had received one.
- Patients with severe back pain could be seen urgently as self-funding patients by the physiotherapists.

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.
- There was information around the hospital about the complaint's procedures on notice boards and in leaflet format. The deputy matron told us that there were no outstanding complaints in the department.
- Staff told us that they had few complaints in the department and that they tried to address them while the patient was on site. They would take the patients into the quiet room and listen to their concerns. Most complaints were delays to appointments, lack of information, delays to a service and poor patient care.
- The OPD manager told us about a complaint around a diagnostic test and a delay in the results. They told us what had been put in place to try to prevent a similar incident happening again.

Are outpatients services well-led?

Good

This service was previously rated with diagnostic services and so we have no previous rating for the OPD. We rated it as **good.**

Leadership

- Staff we spoke with said that they were more connected with senior clinical staff than they used to be and that senior managers were more visible in the organisation. The deputy matron told us that they visited the OPD every day.
- Staff told us that leadership had stabilised in the department.
- Managers were trying to give staff more ownership by getting them more involved in the department and developing more roles such as link nurses.

- Some of the senior staff had been on a preceptorship course and staff were encouraged to come from other departments to speak with the preceptors if they had any issues or concerns.

Vision and strategy

- The hospital values and mission statement were displayed round the hospital.
- The deputy matron told us that the OPD had started to develop a vision for the OPD for the future development of the service.

Culture

- The hospital had "freedom to speak up guardians" and there were posters around the hospital so that staff knew who they were.
- The physiotherapists described an open culture at the hospital where staff were happy to speak up about incidents and that the lessons learned were disseminated to all staff.

Governance

- For further information please refer to the surgery report.

Managing risks, issues and performance

- For further information please refer to the surgery report.

Managing information

- We saw that there was information for staff about data protection and what information could be sent by encrypted and unencrypted email. There was also information about not providing information relating to patients to someone calling on a patient's behalf.
- Patients waited behind a line at the reception desk in the OPD to give privacy to the people who were at the desk.
- There was an information security poster displayed in the OPD.

Engagement

- There was a support group that had been set up for head and neck cancer patients.

Learning, continuous improvement and innovation

- For further information please refer to the surgery report.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

The service has not previously been rated. 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 provided through a mixture of face to face and electronic training sessions, which were to be completed annually or bi-annually.
- The lead for the department was responsible for monitoring staff's mandatory training compliance and they received regular reports detailing staffs progress. Mandatory training compliance was recorded electronically on staffs individual learning hub records.
- Staff were given a twelve-month period to complete the relevant mandatory training modules. We were told that staff were given time to complete it within their working day.
- We reviewed the mandatory training records for three members of staff and saw that the average completion rate was 87.6% this was close to the hospital compliance target of 95% completion by the end of December.

Safeguarding

- Staff understood how to protect patients from abuse and had training on how to recognise and report abuse. However, we found that concerns were not always documented in line with the hospital policy.
- The hospital provided services for adults and we were told that there were no patients accepted under the age of 18. The safeguarding lead for the hospital was the clinical service lead who was trained to safeguarding level four. There were 15 senior members of senior staff in the hospital who had undertaken safeguarding level three training.
- There was a safeguarding policy in place and staff had access to a safeguarding flow chart which was displayed in staff areas. Staff described the safeguarding policy in which safeguarding referrals were made directly to the Head of Clinical Services.
- Staff received safeguarding level two training for adults. The safeguarding lead for the hospital confirmed that the diagnostic imaging team were 100% compliant with safeguarding training.
- We were given an example of a safeguarding concern which had been raised in the imaging department by a member of staff. Radiography staff followed the hospitals policy in respect of escalation to the safeguarding lead for the hospital. Appropriate action was taken internally to follow up the concern and it was identified that there was no action required. However, we did not see documented evidence of this and an incident report form had not been completed in accordance with the hospital policy. This meant that if there were future concerns there was no documented evidence of the concerns and action that had been taken on that occasion.
- The service used a 'pause and check' process which met with the society and college of radiographer's guidelines. We saw that there were posters in place to remind staff of the pause and check procedure. Staff had also created their own pause and check poster to

mirror the official poster which was updated monthly and had different font and picture each month. We were told this had been as a result of an incident to prevent sign blindness. We observed a patient receiving an X-ray and saw that the 'pause and check' process was followed, and three points of identification were checked.

Cleanliness, infection control and hygiene

- The service-controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- The areas we visited within the department were visibly clean and tidy. Hand sanitiser was available upon the entrance to the department and in public areas. Inside treatment rooms there were hand washing facilities. The service used disposable curtains to maintain the dignity of patients in rooms and within the waiting area. We saw that these were within date and had been recently changed.
- We observed disinfectant wipes were available for staff to use in imaging rooms and we saw staff cleaning equipment and beds between patients.
- Each clinical room within the department contained a cleaning schedule which was completed by diagnostic imaging staff. The completed sheets were sent to the infection prevention and control lead nurse for the hospital, where they were audited and stored. We reviewed the cleaning schedules for the clinical rooms within the department and we saw that they had been consistently completed.
- Monthly infection prevention and control audits were undertaken. The audit results were reviewed quarterly at the link nurse meeting. We saw that they covered hand hygiene, waste and sharps, equipment, environment and personal protective equipment. Results of the audits were discussed with staff as part of team meetings.
- We reviewed the audit results for January to December 2018 and saw that in the main the results were green and ranged between 90% to 100%. The audit results for January to April 2019 demonstrated that for five of the indicators the department was between 90% and 100% compliant. However, we saw that the patient led hand hygiene result was 20%. We were told that this had been discussed as part of the daily safety huddles to raise staff awareness and that an action plan would be developed for improvement.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The department was small and was made up of a waiting area for outpatients, a changing room and toilet which were unisex. One large x-ray room, an ultrasound room, a mammography room and an image reporting room. There were separate entrances and exits for inpatients and outpatients.
- The outpatient waiting area was pleasant and provided comfortable seating for three people. There was a number of posters displayed around the room which provided information for patients; these included a comparison of radiation doses from different types of diagnostic imaging, how to share feedback with the hospital and a reminder to patients if they think they may be pregnant to inform staff prior to their scan or x-ray. The waiting area contained a dignity curtain to section off access from the changing rooms to the ultra sound room.
- We observed patient call bells and emergency pull cords in public areas. Diagnostic rooms contained panic buttons in case of a medical or security emergency.
- Stock of sundries were kept in drawers and cupboards within the rooms. We checked a range of stock which was held in the department and found that these within the manufacturer's expiry dates.
- The service had a rolling equipment replacement programme in place. We were told that the service was currently looking into replacing the x-ray equipment with a digitalised system. We were told that there were no issues obtaining funding for equipment. Staff felt that they had access to appropriate equipment to undertake their roles.
- Equipment was serviced through an external company and we saw that the current service plan was in place until 2021. We were told that faulty equipment was replaced as part of the contract. There was a file in the service leads office which contained information in

relation to the maintenance of equipment and this contained a flow chart to assist staff with actions if there was a machine fault. Contact details for the maintenance team were present and we saw that the operating hours were Monday to Friday 8.00 am until 6.00 pm excluding bank holidays. Faults or issues with the equipment were logged with the company and recorded in a local fault book.

- We reviewed the maintenance records for equipment held in the department and we saw that all equipment had been serviced within the last 12 months and radiation protection checks were up to date. We observed equipment and rooms displayed the local rules as required by the Ionising Radiations Regulations 2017 and these were within date. Access to imaging rooms was restricted by keypad and lock and key entry. There were illuminated warning signs in place for when imaging equipment was in use.
- There were a variety of lead aprons and gloves of different weights available for staff in the x-ray room. There was a protective screen for staff to stand behind during the x-ray procedure. Protective equipment such as lead aprons and protective screens were monitored on an annual basis to ensure they provided adequate protection. We observed the last screen audit for lead protective equipment had been completed in July 2018.
- Waste was appropriately segregated into clinical, domestic and sharps waste. There were appropriately labelled waste containers available in each room.
- The service had access to a resuscitation trolley which was shared with the outpatient department. The trolley was located on the main corridor outside of the department. We saw that daily checks on the trolley were undertaken consistently and we reviewed the equipment kept on the trolley and found that it was intact and within the manufacturer's expiry dates.
- The service used a picture archiving communication system. The record system was managed centrally by a dedicated information technology team. The service reported faults or issues with the system to the central team. Contact details were available in staff areas and on the hospital intranet. The was 24 hours a day seven days a week support for raising faults or issues with the information technology systems.

Assessing and responding to patient risk

- Staff used appropriate methods and documentation to identify potential risks to patients and respond appropriately to the changing risks to patients.
- Staff had access to a panic button within the main x-ray room behind the screen. Staff we spoke with explained that they had had to use it recently for crash calls and the team responded quickly.
- There were emergency medication and anaphylaxis emergency medication boxes kept inside the x-ray rooms in case of a patient emergency. Staff received anaphylaxis training as part of their departmental competencies and were trained in recognising deteriorating patients using the 'situation, background, assessment, recommendations' (SBAR) communication tool and national early warning scores (NEWS2).
- Radiographers reviewed referral details for patients to make sure that they had been completed appropriately and in accordance with the Ionising Radiation Regulations. Staff provided examples of errors they had identified during this process and explained the procedure to refer back to the medical staff member who had referred the patient. Referrals were only accepted from doctors registered with the GMC.
- The unit undertook ultrasound guided biopsies for neck and thigh investigations and injections in the imaging department and in theatres. We saw that World Health Organisation checklists were in use for these procedures. We observed two procedures and saw that staff carried out the appropriate checks and completed the accompanying documentation. The service monitored compliance of the completion of the checklists, these were reported quarterly. We reviewed the audit results for September to December 2018 (quarter four 2018) which showed 100% compliance.
- Images which required radiologist review and reporting were prioritised by the clerical staff using a risk assessment system. If an image required urgent review and there was not the appropriate radiologist

available onsite the service had access to a radiologist at a local NHS hospital for the reporting of images. Images were easily shared across the electronic picture archiving and communication system.

- Staff asked female patients between the ages of 18 and 55 the date of their last menstrual period which was documented on referral forms and uploaded to the electronic system. Staff were aware of the organisation policy which stated female patients between the ages of 15 and 55 should be asked, however the service did not treat patients under the age of 18. This was in line with the Ionising Radiation (Medical Exposure) Regulations 2017. We observed posters in waiting areas which provided patients with information about pregnancy and diagnostic imaging. We reviewed the records for five patients and saw that the last menstrual period checks had been documented for four of the patients.
- The service had access to a radiation protection advisor and medical physics expert through the organisations central team. There was also a member of staff within the team who provided a radiation protection supervisor role. This meant that they had additional knowledge and provided support where necessary.
- We saw that the service had a policy in place which detailed how the service would meet with the requirements of the Ionising Radiation (Medical Exposure) Regulations 2017. The policy was inside its review date and detailed how they would monitor adherence to the regulations to make sure they provided safe radiation care.

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.
- Staffing requirements were assessed using predictors which looked at the number of inpatients, theatre lists, outpatient clinics and booked imaging appointments. The service had a flexible approach to staffing to support the demands of the hospital.
- The service employed three permanent contracted staff, three regular bank staff and two whole-time equivalent administration staff. At the time of our inspection the service reported one vacancy for a whole-time equivalent radiographer, which we were told had been recruited to.
- The service had minimum staffing requirements which made sure that bank staff were always supported by a permanent contracted member of staff. We were told that in the last 12 months there had been one occasion where there were only members of bank staff rostered to work in the department. We reviewed the radiographer rotas for February and March 2019 and saw that there were no shifts where only bank staff were working. Staff said there were no issues with staffing for rotas. However, they did tell us that the rotas did not allow for unexpected circumstances such as sickness and staff had cancelled training and annual leave to support.
- We were told that the turnover of staff was low. The majority of the staff who we spoke with had worked in the service for a number of years. The service reported that there had been one member of staff who had left the service in the last year.
- The service used an external company for the recruitment of staff and bank staff were recruited internally to the department . The bank staff used by the service were regular long-term bank staff who had worked in the department for a number of years. The service used bank staff to meet the demands of the service, which meant that they did not use agency staff.
- Radiographer staff provided on call cover outside of working hours. We reviewed the on-call rotas for February and March 2019 and saw that cover was provided each day.

Medical staffing

- The service had enough radiologist staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Radiologists had specialist reporting areas. They worked according to their speciality lists which were

sent to them via email. Staff had access to radiologists in a local trust if they required urgent image reporting for a different speciality and the radiologists could access the images remotely.

- We reviewed the rotas for Radiologist staff for February and March 2019 and found that the rotas were covered. Staff reported no concerns with radiologist staffing. Radiologists could be contacted outside of working hours if required upon the decision of the consultant.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we found that there was an inconsistent approach to the wider record keeping system.
- The service used an electronic patient record system for the reporting and communication of diagnostic imaging results. The system was accessed by individual password entry. Staff in the neighbouring NHS trust could access images through the system and the service had access to images that had been taken by the trust. Results were shared with general practitioners through letters send in the post or via fax machine.
- World health organisation checklists were completed for invasive procedures and documented on paper forms. These were scanned onto the patient's electronic record.
- We reviewed five patients records on the electronic record system. We saw that all patients had documented procedure notes, scan reports, consent had been documented and completed and the world health organisation safety checklist was completed and present. For patients who required a last date of menstrual period check we saw that this had been undertaken and documented on the electronic record.
- We were provided an example of a safeguarding referral which the service had raised internally. We were told verbally about the action staff had taken. However, the service was unable to provide documented evidence of this and we were told it had not been incident reported in line with the safeguarding policy. There was therefore no clear audit trail of action taken by the hospital in case of future concerns.
- There was an incident raised in relation to a clinical trial which the service had participated in, that related to the documentation held within the department. When we reviewed the information held in the department in relation to the trial procedures and protocol we found that the information held did not meet the required checklist information. This meant staff did not have access to all of the required information to ensure adherence to the trial protocol.
- We were given an example of a complaint which was resolved at the informal stages. We identified that there was no documented evidence of this complaint held in the department or with the complaints department, who was not aware of the concern. This meant that there was no audit trail for future complaints related to this episode and no record of action staff had taken to resolve the complaint. There was a risk that themes and trends could not be identified if informal complaints were not always captured.

Medicines

- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right time.
- The service kept a range of medication to be used during procedures within the department. Medicines were stored in a locked cabinet inside the main x-ray room. The key for the medication was stored in a separate locked cabinet which authorised staff had access to.
- The monitoring of the temperature of stored medication was undertaken daily and there was a thermometer kept inside the cupboard with the medication. Staff recorded the temperature reading on a record sheet which was stored inside the cupboard. The completed documentation was sent to the pharmacy department for audit and storage. Staff told us the audit was discussed as part of the daily safety huddle and in team meetings. We reviewed the

medication temperature monitoring audit results for the service from January to December 2018 and saw that the department was consistently 100% compliant.

- We checked the medication stored within the cupboard and saw that they were intact and within the manufacturer's expiry dates. There were no controlled or refrigerated medication kept in the department.
- We observed the administration of medication during a diagnostic procedure and saw that second checks were undertaken prior to administration. We also observed a signed prescription and documented evidence from two members of staff that checks had been undertaken prior to administration.
- Emergency medicines were available in the event of a cardiac arrest or anaphylactic reactions (severe allergic reactions). They were kept inside the x-ray room and were in tamper evident containers.
- For our detailed findings on medicines please see the safe section in the surgery section of the report.

Incidents

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, not all staff were aware of their roles and responsibilities under duty of candour which is the process of being open and honest when things go wrong.
- Incidents were reported using an electronic incident report form and investigated internally by the service lead. Radiation incidents were reported centrally to the radiation protection team. Staff were aware of how to raise incidents and could give examples of incidents they had reported.
- Incidents were monitored and reviewed at the hospital management meetings. Lessons learnt from incidents were shared with staff through monthly team meetings, safety huddles and via email. We saw incidents were displayed on the governance notice board in the department office. However, we observed that the most recent incident displayed was from November 2018.
- Between April 2018 and March 2019, the service reported 31 incidents. There were 30 no harm incidents and one which had been categorised as low harm. The category with the highest number of incidents was unexpected events for which 10 had been reported and the lowest category was cancellation for which there had been one.
- We were given examples of recent incidents which had taken place and how learning was shared from these within the service and the wider hospital team. One example was that a member of hospital staff had walked into the x-ray room whilst it was in use despite the warning signs being illuminated. As a result, the service had installed a door bell and reminded staff to lock the door during imaging. The learning and new system was shared across the hospital with all staff. We were told that the new system worked well and there had been no further incidents or concerns.
- We were told that incidents requiring duty of candour (the process of being open and honest when things go wrong) were escalated to the hospitals Head of Clinical Services who would contact the patient. Not all staff could describe duty of candour and staff were not always clear about their roles and responsibilities under the duty of candour regulation.

Are diagnostic imaging services effective?

We do not provide a rating for effective when we inspect diagnostic services.

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.
- The majority of the policies and procedures followed by the service were system wide across the organisation. Policies referenced national guidance and were in-line with best practice. We saw that policies were accessible to staff online via the intranet.
- The service monitored and recorded the amount of radiation each patient received when undergoing

diagnostic imaging. Diagnostic reference levels and computed radiography were used through the department. We saw that diagnostic reference levels were displayed appropriately.

- The department utilised the knowledge and experience of staff who also worked in national health service organisations to keep up to date with evidence-based care and best practice.

Nutrition and hydration

- The service provided patients with access to drinks and they had access to the hospitals restaurant facilities to meet their needs.
- The patient waiting area contained a water cooler and there were cups available for patients and their carers or relatives to use.
- Patients could also use hot drinking making facilities which were available in the main entrance.
- Staff told us they had raised with the hospital leadership team that there was no access to de-caffeinated hot drinks for patients with cardiac problems or specific needs, this was as a result of verbal feedback from patients and relatives. We were told that this was changed quickly following their concerns.

Pain relief

- Staff assessed patients to see if they were in pain.
- Patients we spoke with told us that their pain needs were discussed and assessed in the outpatient clinic prior to attending the diagnostic imaging appointment.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service contributed to a number of internal audits. These were monitored through the quarterly audit and clinical effectiveness meetings and reported on the clinical effectiveness reports. We saw that these looked at waiting times, reporting times, World Health Organisation checklist documentation and consent.
- Staff had developed a departmental audit which looked at the techniques used for chest X-ray. The aim was to identify a standardised approach to chest x-rays to be used in the department to provide the best image quality with the least amount of radiation exposure for the patient. The audit was being conducted by a radiographer with the radiologists. We were told that the audit form which had been developed for this audit had been shared across the hospital as an example of good practice.
- The mammography results were read and reported from another hospital through a service level agreement.
- Radiologists attended monthly discrepancy meetings which were held in a local National Health Service hospital trust. The meeting identified learning from radiology discrepancies or errors to improve practice. The Information from the meetings was shared with staff in the service through the monthly team meeting.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- There was an organisation wide competency framework, which detailed what aspects of the diagnostic imaging role staff were required to complete as part of their induction. These were recorded on paper-based documents and stored in staff files on the unit. We were told that these were assessed and completed four to six weeks into the staff members employment. Staff did not provide on call cover until they had been signed off as competent.
- We saw that the competencies covered topics such as imaging general, consent, communication, anaphylaxis and safety in the imaging department. We reviewed the staff competencies for three members of the radiographer team and saw that all competencies were complete and signed off. However, we identified that one record did not contain the anaphylaxis competency assessment. We brought this to the attention of the service lead who took appropriate action.
- The department had a set of local competencies which were specific to the use of the equipment they used, these were completed annually. Initial training

for new equipment was provided through the manufacturer and subsequent training was provided in house by the service lead who also provided training for the electronic patient record system. We observed the equipment competency records for four members of staff and saw that they were complete and up to date.

- Bank staff received the same induction and competency training framework assessments as substantive staff members.
- Radiologist competencies were held and monitored by the hospital's governance team. We saw evidence that radiologist staff had up to date appraisals and had recent documented practicing privileges reviews.
- The hospital used a standardised template for appraisals which was called 'enabling excellence'. Staff received three appraisals annually these were known as initial, midterm and the final appraisal. Objectives were aligned to the hospital objectives and the strategy for the service. The service lead was responsible for appraising staff and monitoring compliance, which was reported monthly to the Head of Clinical Services for the hospital. We saw that staff appraisals were stored electronically on the service leads personal drive and that all permanent staff had received an initial appraisal for the year.
- Staff felt that the appraisal process was positive and a good way to monitor their progress and discuss any issues or concerns.
- The radiation protection advisor for the service provided radiation training for staff who did not work in the imaging department, as part of their induction. We observed the presentation which was used, and we saw that it met with radiation guidelines and was thorough and well informed.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service worked closely with surrounding hospitals. Staff asked patients when they had had their last scan or X-ray and would request diagnostic images from the appropriate hospital. This reduced the amount of radiation patients would receive to reduce risk.
- We were told that the service had a close working relationship with the theatre team. The service had access to the theatre diary in order to plan staffing and the service to meet requirements. Radiographers attended the weekly theatre staff meetings where they undertook service planning for the following week.
- A representative from each department attended a hospital wide safety huddle once a day. Where issues of concern, incidents, staffing and feedback was discussed. Information from the safety huddle was disseminated to staff verbally by the departmental representative and the notes were sent to all staff by email.

Seven-day services

- The service operated six days a week and the opening hours were Monday to Saturday 8.30am to 5.00pm. On a Wednesday and Thursday there were late clinics held until 8.00pm. Outside of working hours there was a radiographer who provided on call cover.

Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

- Staff understood the consent process and they followed the service policy and procedures when a patient could not give consent. They understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Consent was gained for all patients who were having an x-ray or scan. All patients undergoing an invasive procedure, were given information about the procedure beforehand and the risks were discussed, and written consent was documented. We reviewed the records of five patients who had undergone diagnostic procedures and we saw that there was recorded evidence of consent in the patient's electronic record. We reviewed the results of the

consent documentation audits for January to March 2019 and saw that the results ranged between 89% to 100%, the service had improvement action plans in place.

- We observed the consent process for two patients undergoing invasive diagnostic procedures. We observed a thorough discussion of the risks and we saw patients were able to make informed decisions about their care and treatment.
- Staff understood the consent process and could provide examples of action they had taken when a patient could not provide consent. We were told that patients who did not have capacity to consent were escalated to the Head of Clinical Services for the hospital. This would be documented on the 'patient agreement to investigation or treatment form'.
- There was a poster with information relating to the mental capacity act available for staff displayed on the governance board in the staff office.

Are diagnostic imaging services caring?

Good

The service had not previously been inspected, 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.
- During our inspection we spoke with four patients. The feedback we received about the service was always positive and patients were happy with the care they received. Examples of what patients told us were "I'm very happy with radiology service" and "I never felt rushed, great care".
- We observed three patient appointments. We observed that staff were friendly and kind to patients. Staff spoke to patients in a way that they could understand and gave them time for questions.
- Staff told us the length of appointment times meant that they have enough time to spend with patients and could explain what they were doing thoroughly. Staff felt they provided a "holistic" approach to patient care.
- We observed dignity curtains were in place in all treatment rooms. There was a privacy curtain which could be pulled across the outpatient waiting area so that the dignity of patients moving from the changing rooms to the ultrasound room was maintained. During our inspection we observed that this was used. There was a unisex changing area which provided two changing cubicles and patients were given gowns to wear if they needed to undress. Patients we spoke with felt that their privacy and dignity was maintained at all times.
- There was a chaperone policy in place and all patients could request a chaperone. We observed posters in patient areas which informed patients of their right to request a chaperone.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Staff recognised that the machinery and the procedures could be intimidating and frightening to patients. They said that they made sure that they provided patients with information on what to expect before the scan started and kept talking to the patient throughout to explain what they and the machines were doing.

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.
- Patients we spoke with felt they were involved in their care and treatment and understood what to expect. Patients told us that procedures were explained well, and that staff used language they could understand.
- We were given examples of how the service had made arrangements for a patient with additional needs to have the same team involved in each of their visits. It was identified that this was what the patient needed so that they felt comfortable.

Good

Diagnostic imaging

- Patients who were accompanied by relatives felt that they were involved in discussions about their care as they wanted them to be.
- The service was in the development stages of a patient feedback form which was specifically designed for the diagnostic imaging service.

Are diagnostic imaging services responsive?

Good

The service had not previously been inspected, 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 people.
- The service was open Monday to Saturday 8.30am to 5.00pm. There were late clinics held on a Wednesday and Thursday evening until 8.00pm so that patients who were unable to attend in working hours could be accommodated.
- Mobile scanning units provided magnetic resonance imaging (MRI) and computerised tomography (CT) scans at the hospital on set days of the week.
- The department was situated next to the outpatient department and was clearly signposted. The environment was appropriate and met patients' needs. The waiting area provided comfortable seating and a calm environment for patients and relatives. There was a water cooler, music and information leaflets for patients to read.
- The service had information in the waiting area about the accessible information standard. The information provided symbols and written text to direct patients on how to request information in a different format. This included large print, easy read, hearing loop and brail.
- We observed posters in the waiting area provided information for patients about how to share feedback and pregnancy and imaging information in 20 different languages
- It had been identified that there were more workstations needed for radiologists to report images. There was currently one workstation in place for reporting however there were days when the service would have two radiologists working. We were told this was an improvement that the hospital was working to implement.
- The hospital provides free of charge Echo cardiograms for all patients who require this test as part of a surgical care pathway. This ensures patients have access to timely treatment as required

Meeting people's individual needs

- The service took account of patients' individual needs.
- The hospital had a clear criteria for patients who could be treated safely in the hospital, and we were told that there were small numbers of patients who were treated who had complex or additional needs. However, we were told that staff from the referring area would communicate the patients' needs prior to them arriving on the unit, so that the service could make arrangements to meet these needs. Where this was not possible, they could refer patients to another hospital in the organisation who could accommodate patients with more complex needs.
- We were advised that the department sometimes provided services to patients who were living with dementia. The service had access to a dementia champion who was based in the outpatient department for support and advice. However, staff recognised that the department had not been adjusted to provide a dementia friendly environment and had plans to introduce some dementia friendly posters. Following our inspection, we were told that the service had dementia friendly clocks in place.
- The lead for the service had attended a dementia care course and there were two permanent members of staff who had been identified to attend the course. We were told it had made staff more aware of how they communicate with patients who were living with dementia.
- Staff had access to translation and interpreting services via the intranet and we were told it was hospital policy to use trained interpreters for the translation of clinical information and consent. We

were told that there was a number of staff who worked in the hospital who spoke a range of different languages. We were told staff had utilised their colleagues for translation for patients in the past. One of the members of the radiology team was sign language trained and could speak another language.

- Patients received letters for appointments which included information leaflets relating to the type of diagnostic imaging they were having. Patients we spoke with felt that the information they received prior to their appointment was informative and they were aware of what to expect.
- The service did not keep specialist moving and handling equipment within the department, however staff explained they could access it in the hospital if they needed it.

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice.
- The service did not receive referrals for patients who were acutely unwell. Referrals came from general practitioners, the outpatient department and the wards within the hospital. All referrals to the service were on paper and they had to be signed by a qualified doctor who had a general medical council registration number. All appointment bookings were overseen and booked through the clerical team. Clinic appointments for ultrasound scans and mammography were booked in advance to the appropriate speciality of radiographer. The service provided an X-ray drop-in session for outpatients and theatres.
- Images which required radiologist review and reporting were prioritised by the clerical staff using a risk assessment system. If an image required urgent review and there was not the appropriate speciality radiologist available onsite, the service had access to a radiologist at a local national health service hospital trust. Images were easily shared across the electronic picture archiving and communication system.
- The service monitored referral to imaging times quarterly. The results were discussed as part of the clinical audit and effectiveness meetings. We were told that the waiting times for private patients were a week and for national health service patients they were four to five weeks, this was in line with contractual arrangements. The service reported waiting times had not exceeded six weeks for diagnostic imaging.
- We reviewed the quarter one reporting audit published in March 2019 and saw that the majority of image reporting was within the five-day reporting time standard.
- Appointment waiting times and image reporting times were monitored and reported through weekly business meetings, where additional scanning days could be requested if needed.
- Patients we spoke with, said that appointments ran to time and those who had attended several times stated this was always the case. Patients described a flexible approach to appointment bookings to fit in with their work commitments.
- Patients who did not attend for their appointment were sent letters to request them to get in touch. The service had a policy whereby if a patient did not attend more than three times they would be referred back to the initial referrer. We were told that the service did not get many 'did not attend' appointments and this was not a concern, as a result there was no monitoring process in place for these.
- The Head of Clinical Services for the hospital told us that there had been no breaches for the diagnostic imaging department. We were told that reporting times were good and that across the hospital referral to treatment times and commissioning targets were met.

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. However, there was an inconsistent approach to the recording of informal complaints.
- There was a hospital complaints team where complaints were directed to. The procedure was for the complaint to be noted on an electronic and paper system held within the complaints department. We were told an incident form was completed for all

complaints and complaints were forwarded to service leads for investigation. It was reported that this approach meant that complaints were often resolved early at stage one and few were escalated to level two.

- The hospital complaints procedure stated that a holding letter must be sent to a patient within 48 hours of receipt of the complaint. There was then a 20-working day response time for the outcome to be shared with the complainant. All complaint responses were approved and signed off by the hospital director. The organisation had a target compliance rate for complaints closure of 75%. We were told that the hospital consistently achieved a 80-85% compliance rate and this was reported weekly at the senior management team meeting.
- Service leads completed a complaint review form which was returned to the complaints department once their investigation was complete.
- The service had received two formal complaints in the last six months and four in the last 12 months. We reviewed the complaint responses for the two received in the last six months and saw that a thorough investigation had been completed and outcomes had been shared with the complainant within the 20-day period. We were told that within the last year there had been no complaints for the service which had been escalated up to stage two of the formal process.
- Staff team meeting agendas were standardised and complaints and learning from complaints were discussed as part of the structure. We saw that learning from complaints was displayed in staff areas on the governance board.
- The service did not collect feedback from patients specifically for their experience in the imaging department. We were told tool for this was under development at the time of our inspection. Feedback was requested from patients for their experience hospital wide and we were told that feedback was shared with staff during the morning safety huddle and in monthly team meetings.
- We observed leaflets in the waiting area which contained information on how to raise a complaint. There was different information for national health service and private patients, to reflect the difference in escalation arrangements. The leaflets detailed the complaints process and who to contact. Patients we spoke with said they were happy with the care they received and had no reason to complain. They told us they were not aware of the complaint's procedure, however felt that if there was an issue they could raise it and ask for the information.
- We were given examples of complaints that had been dealt with informally and prevented escalation to a formal complaint. We requested documentation which related to an example we were given; the service was unable to provide documented evidence of this and we were told that this was because it was managed informally an incident form was not completed. This did not meet with the hospital complaints policy and was not in line with the expectation of the complaints team. There was a risk that there was no audit trail of the steps that had been taken to rectify the complaint if there was any future follow up from the complainant and the service could not accurately monitor complaints to identify themes and trends.

Are diagnostic imaging services well-led?

Good

The service had not previously been inspected, we rated Well-led as **good.**

Leadership

- Managers at all levels in the service had the right skills to run a service providing high-quality sustainable care. However, at the time of our inspection the leadership for the service was undergoing a restructure.
- The service was led by a senior radiographer with a number of years' experience in the service. There was a deputy matron post in the leadership structure which sat above the radiology department and underneath the Head of Clinical Services
- There was the Head of Clinical Services for the hospital who had oversight and overall responsibility for the diagnostic imaging department, along with the other clinical departments within the hospital. However, at the time of our inspection the deputy matron role had

been newly introduced into the structure. This was a new post that had been recruited to and the deputy matron had been with the hospital for three weeks and so was still working through their induction and not active in the leadership structure. At the time of our inspection the hospital leadership team had not defined the roles and responsibilities of the deputy matron post and were unable to articulate how the role would fit in with the leadership of the service. Following our inspection, we were told that there was a clear job description in place for the deputy matron prior to them starting in post, with the aim to strengthen the leadership team.

- At the time of our inspection the diagnostic imaging lead reported directly to the Head of Clinical Services for the hospital. They had regular one to one meetings where performance, issues and risks were discussed. We were told that the Head of Clinical Services was supportive, had an open-door policy and was responsive to concerns or issues identified.
- Within the service there was a leadership restructure planned. The service leadership would consist of a service lead and a deputy service lead. We were told that the service lead role had been appointed to. Staff were positive about the changes.
- Staff we spoke with felt supported and stated that there was good communication with the leadership team.

Vision and strategy

- The service had a vision and strategy for what it wanted to achieve. However, there were no documented workable plans to turn it into action and staff were not involved in its development.
- The vision and strategy was to "deliver imaging services which prioritise safety first and that is patient focussed and responsive. Attract high quality radiologists and radiographers and plan the development of the service."
- Staff were aware of the vision and strategy for the hospital and the department. Staff felt involved in information updates in relation to changes and the development of the strategy for the hospital. Staffs appraisal objectives were based on the vision and strategy for the hospital and the department and personal objectives were built around this. However, staff told us that they had not been involved in the development of the service planning and strategy for the department. They felt their knowledge and expertise was not used to its full potential.
- We reviewed the service strategy, we saw that is had been split into three main objectives which covered the themes of safety, staffing and development. The three objectives had actions and progress against them which had taken place to date. Examples of actions that had been completed were the introduction of national safety standards for invasive procedures used in the imaging department, the focus of safety and patient experience in team meetings and the restructure of the imaging leadership and the appointment of a new imaging manager.
- However, there were no documented future actions, timescales or ownership attached to these. This meant that the service was unable to measure and monitor progress against the objectives and it was unclear how they planned to achieve them and who was responsible for each objective.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service was a small team and the staff we spoke with had worked in the department for a number of years. We were told that the hospital was a good place to work, staff felt that they worked well together as a department and with the wider team. All staff we spoke with described a supportive and positive culture.
- Staff were proud to work for the hospital and proud of the service they provided to patients.
- The hospital organised social events throughout the year which all staff could attend, a recent example of this was a quiz night. We observed posters in staff areas advertising upcoming events. Within the service the staff enjoyed social occasions outside of work which they felt contributed to their close team working.

- We were told there had been a recent improvement in the culture within the hospital. Staff said that they felt safe to raise concerns or issues to the leadership team. Staff were aware of the freedom to speak up guardian and how to contact them.

Governance

- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The ward to board structure for the hospital was through the clinical governance and clinical audit committee. Improvement action plans were managed in these committees. Issues which were discussed at the hospital management meetings were escalated to the senior management meetings and if necessary then taken to the corporate board meetings.
- There were monthly hospital management and staff team meetings. The hospital used a corporate standard agenda for all meetings. Staff told us the minutes of the meetings were shared afterwards via email and felt that communication within the team was good. We reviewed the team meeting minutes for January to March 2019 and we saw evidence that information from hospital wide team meetings, complaints, incidents and learning was shared with staff.
- The service had a policy in place which outlined radiation protection and employers' procedures which met with the expectations of the Ionising Radiation Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations 2017. We saw that the policy was within its review date and detailed how the department would adhere to the regulations. The policy also detailed the monitoring processes which were in place so that they could demonstrate compliance with the regulations this included a quality assurance programmes, clinical audit and dose reference levels. The radiation protection/medical exposures committee for the hospital had the responsibility of monitoring the information collected and compliance in relation to the safe use of radiation and identified improvements where necessary.
- Staff felt that information was effectively fed up and down the governance structure.
- Staff felt that there had been a recent improvement in communication. Particularly from senior management down to the teams.
- The service had recently introduced a radiologist meeting for those who worked at the hospital. At the time of our inspection there had been one meeting, however staff felt this was beneficial and a positive change.

Managing risks, issues and performance

- The service had good systems to identify risks, plan to eliminate or reduce them.
- The hospital management team reviewed incidents and risk on a monthly basis at the hospital management meetings and we saw that this was a standard agenda item. In addition, there was a bi-monthly risk meeting where new risks were reviewed for approval to be added to the risk register and existing risks were reviewed.
- The service used an electronic risk register, which was department specific and was accessible to all staff via a shared drive. We observed the risk register for the service and saw that there were 11 risks. We were told that the risks had been identified through risk assessments and as a result of incidents. We saw evidence that the risks had been reviewed within the last 12 months, and actions had been put in place to reduce the level of risk identified.
- Audit and key performance indicator results were monitored through the clinical audit and effectiveness meetings. Departments who were rag rated as red were given a "safety cross" if they were not performing. Improvement plans were implemented and monitored through the meeting.
- At the time of our inspection the service did not have a defined set of key performance indicators which they were monitored against. We were told that this was something that the service aimed to introduce. However, they did record and monitor reporting times for diagnostic images and referral to imaging times. The organisation had recently updated the reporting policy which stated that images should be reported within five days.

Good

Diagnostic imaging

- Reporting times were reported through a quarterly audit of reporting times. We reviewed the quarter one reporting audit published in March 2019 and saw that the majority of image reporting was within the five-day reporting times.
- There was a governance board in staff areas on which incidents, complaints and risks were displayed for the hospital and the department.
- The hospital had identified the leadership in the radiology department as a risk. We were told that the leadership restructure should strengthen the leadership within the department.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service used an electronic picture archiving and communication system, which was the same across the organisation. There was a central information technology team who had oversight of the electronic system and responded to faults and issues reported and were available 24 hours a day 7 days a week. There was no dedicated team for this on the hospital site. The service logged faults with the team via an information technology help desk. We were told that there was sometimes a delay in accessing the help desk.
- The service was able to use the information collected about patients to monitor performance standards such as image reporting, referral to imaging times and monitoring of consent and World Health Organisation checklist compliance.
- The service practiced in accordance with General Data Protection Regulations and patient confidentiality and staff received training on this annually.

Engagement

- The service did not always engage with patients, staff, the public and local organisations to plan and manage appropriate services.
- Some staff we spoke with felt that the service could improve engagement. Staff did not always feel that their expertise or opinions were consulted on in the development of the strategy and planning of the service.
- The service collected feedback from patients and their relatives through the inpatient satisfaction survey which captured their experience of the pathway of care, following discharge from the hospital. However, this did not provide specific information in relation to the diagnostic imaging service and did not capture the feedback from patients who had not been admitted to the ward. At the time of our inspection we were told that there was a service specific patient survey in development.
- Patients feedback was captured for inpatients hospital wide and was discussed in all meetings. The hospital had a 'you said we did initiative in place'. We saw posters displayed in the diagnostic imaging waiting room which said that the department had introduced air conditioning into the ultrasound room as a result of feedback from patients, which stated that the room was too hot. However, at the time of our inspection this was not in place due to infection prevention and control issues and was due to be installed in the coming weeks.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong, promoting training and research.
- The service contributed to a number of clinical trials. The research projects were managed centrally by a team for the organisation, however the department kept logs and documentation relating to research studies.
- Radiographers were working on a project to improve care for transgender patients. At the time of our inspection they were in the development stages of the project to identify ways that they could provide a more gender natural environment. Whilst ensuring that the needs of all patients were met.
- The radiographers and radiologist staff members were working together on a chest quality audit. The aim was to develop a standardised high-quality approach

to undertaking chest x-rays which provided the best image with the lowest radiation rate for the patient. The audit was in the data collection stage at the time of our inspection. Staff told us radiographers and radiologists were keen to work together to improve patient care.

- Staff described an environment where they could initiate audits and get involved in projects to improve clinical practice. Staff were enabled and encouraged to attended training courses, conferences and were funded to obtain additional qualifications.

Outstanding practice and areas for improvement

Outstanding practice

We found areas of outstanding practice in outpatients:

- In the physiotherapy department the technical instructor was working with self-funding patients who were coming into the hospital for joint replacements as they were unable to access NHS occupational therapy services post operatively. They were working with patients when they attended the pre-assessment clinic for their surgery to help people to access any necessary equipment eg chair raises, raised toilet seats, shoe horns etc. For patients who accessed this face to face services there was a slight reduction in length of stay.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

We found areas of practice that require improvement in surgery:

- The provider should consider providing refresher training to staff around emergency resuscitation equipment so that they are able to carry out checks on equipment effectively.
- The provider should regularly check expiry dates on consumables stored as part of emergency resuscitation equipment.
- The provider should consider how to better evidence that staff employed as surgical first assistants have the appropriate qualifications and professional requirements in place.
- The provider should keep online and paper records relating to staff competencies and policies up to date if paper records are to be used.

We found areas of practice that require improvement in outpatients:

- The service should ensure that all records are legible.

We found areas of practice that required improvement in diagnostic imaging:

- The service should ensure that there is a documented audit trail for safeguarding concerns that have been raised with the safeguarding lead and acted upon internally.
- The service should make sure that there is documented evidence of all actions staff have taken to safeguard patients or investigate complaints and incidents. So that there is a clear audit trail.
- The service should ensure that staff are aware of their roles and responsibilities under the duty of candour.
- The service should ensure that there is documented evidence of all complaints received in line with the hospital's policy.
- The service should ensure that the new leadership structure provides defined roles and lines of responsibility.
- The service should consider the involvement of staff and other stakeholders in the development of the vision and strategy.
- The service should consider a review of the strategy to provide a documented plan of workable actions, to make sure that they achieve what they have set out to do.
- The service should consider a review of its engagement with staff, patients and service users to capture their views to improve the quality of services provided.