Spire Manchester Hospital

Quality Report

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

Ratings

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

Overall summary

Spire Manchester Hospital is operated by Spire Healthcare Limited. It is a new purpose built private hospital, registered by the CQC on 22 January 2017. The hospital has 37 inpatient rooms, a dedicated six bedded paediatric suite, 27-day case rooms and five critical care beds.

The hospital provides surgery, medical care, critical care, services for children and young people, outpatients and diagnostic imaging. Patients are admitted electively, there are no emergency admissions received at the hospital.

The last inspection of this provider was carried out in September 2016 where it was rated as requires improvement. Since that inspection all services have

Summary of findings

been relocated to a new hospital site in 2017, as a new registration, therefore we have not compared the previous ratings from 2016. We inspected all core services during this inspection.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced visit to the hospital on 5 February 2019.

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

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

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

Services we rate

We rated the hospital as **Outstanding** overall.

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. The hospital always looked after its equipment and premises. The hospital controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The hospital planned and provided services in a way that met the needs of local people. It put peoples' needs central to the delivery of tailored services.
- Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes.
- The hospital 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.
- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who used services. For example, patients having complex spinal surgery would have a dry run to help the theatre team ensure they could properly position them to reduce the risk of surgery. It helped operating department practitioners prepare the medical trays and understand the equipment the surgeons required and to plan for any unforeseen emergencies.
- People could access the service and appointments in a way and at a time that suited them.
- All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns. There were high levels of satisfaction across all staff groups.
- Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent, high-quality sustainable care. The hospital was led by managers who had the right skills and abilities and were compassionate, inclusive and effective.
- Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed.

Summary of findings

- Services demonstrated commitment to best practice performance and risk management systems and processes. There were effective systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. Staff at all levels had the skills and knowledge to use the systems and processes effectively.
- There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.
- There were consistently high levels of constructive engagement with staff and people who used services, including various equality groups. Services were developed with the full participation of those who used them. For example, the hospital worked with the Stroke Association, Deaf Sign Academy, Islamic and Jewish groups and patients and their families who had experience of illness such as dementia and sepsis.

However,

- Staff did not always adhere to the documentation requirements of the surgical safety checklist, although compliance was improving. We also observed two time-out procedures that were not as comprehensive as they should have been. The hospital responded quickly to address this issue during the inspection.
- Not all records of patient consultations in outpatients were detailed, clear and up to date.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good 	• Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. • The service provided elective endoscopy and interventional cardiology procedures, and these were developing activities in the hospital. • We rated these services as good overall because they were safe, effective, caring, responsive and well-led. Both departments were clean, and medicines and equipment stored appropriately.
Surgery	Outstanding 	• 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 these services good overall because they were safe, effective, caring, responsive and well-led • The service controlled infection risk well and had low surgical site infection rates. • The service always looked after its equipment and premises. Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. • The service had enough staff to ensure a safe service. They were well trained and had regular appraisals. • The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. • Staff gave patients enough food and drink to meet their needs and improve their health. Staff assessed and monitored patients regularly to see if they were in pain. • Staff were competent in their roles and were regularly assessed. They also worked well together to benefit patients and provide efficient care. • Feedback from patients confirmed that staff treated them well and with kindness.

Summary of findings

- The hospital ensured that its premises and staff met the needs of local people and people with individual needs. Patients could access the service at a time to suit them. Operations were rarely cancelled and those that had been were re-scheduled quickly.
- The hospital had clear guidelines for dealing with complaints from NHS and private patients. Complaints were taken seriously, investigated quickly and learning shared.
- The hospital had an excellent leadership team that communicated well with staff and patients. The hospital had a clear vision and strategy and gave staff the opportunity to develop their parts of the service in-line with this.
- There was a positive culture in the hospital, with staff able to contribute ideas to improve services, or challenge poor behaviour if required.
- The hospital had very clear governance arrangements and used these to ensure that the service was safe and could be improved where necessary.
- The hospital managed risk well. There were several clinical groups assessing risk and monitoring staff performance.
- The hospital engaged with staff and patients well and used feedback to develop its service**.**
- The hospital had clear processes that allowed it to quickly identify issues or share best practice. It used innovation to improve patient experience.
- However, staff did not always adhere to the documentation requirements of the surgical safety checklist, although compliance was improving. We observed two time-out procedures that were not as comprehensive as they should have been. The hospital responded quickly to address this issue during the inspection.

Critical care

Outstanding ☆

- The critical care service supports the hospital's elective surgical and medical services, accepting both planned and unplanned admissions. The critical care unit has five beds, one of which is in an isolation room. These include three high-dependency and two intensive care beds, with sufficient flexibility to meet the acuity needs of any patient admitted to the unit.

Summary of findings

- We rated the critical care service as outstanding overall. This was because the service's staff were highly motivated and had truly embedded the safety of patients as a primary focus in their day to day roles.
- Patients were protected by a strong comprehensive safety system in the unit which focused on openness, transparency and learning when things go wrong.
- All staff in the unit from housekeeping staff through to the unit's and hospital's leaders truly respected and valued their patients as individuals. Patients were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive team of people.
- This safe and caring culture was delivered in an effective and responsive way by a committed team of nursing and medical staff under the direction of an extremely strong, inclusive and innovative leadership team who were dedicated to the improvement, growth and sustainability of the service and in the delivery of high-quality person-centred care.

Services for children & young people

Outstanding ☆

- Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
- We rated this service as outstanding because it was safe, effective, caring, responsive and well led.
- Staff had received up-to-date training in all safety systems, processes and practices. There were comprehensive systems to keep children and young people safe, which took account of current best practice.
- A proactive approach to anticipating and managing risks to patients who used the service was embedded and was recognised as the responsibility of all staff.
- The service had systems to monitor patient outcomes including various hospital-wide initiatives, and local ward based actions.
- Consideration of children's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs.

Summary of findings

- There was a proactive approach to understanding the needs and preferences of different groups of children, young people and their families and to delivering care in a way that met these needs, which was accessible and promoted equality.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired leadership culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.

Outpatients

Outstanding 

- The outpatient department had 24 consulting rooms all with their own dedicated separate examination rooms. The department had four treatment rooms one with its own recovery area and a dedicated ear, nose and throat treatment room. The unit provides care for adults and children from birth.
- All staff were fully committed to maintaining high standards of infection control.
- Outpatient staff met the hospital target for compliance with mandatory training. Staff provided care and treatment in line with best practice and treatment was evidence-based.
- Staff felt they were encouraged by the organisation to give patient's a service which was focussed on compassionate care coupled with excellent treatment. Patients received timely appointments.
- Clinical governance committee meetings took place quarterly to discuss risks, incidents and key issues and quality and performance were monitored.

Diagnostic imaging

Good 

- The service provided magnetic resonance imaging scanning, computerised tomography, plain X ray, fluoroscopy, mammography and ultrasound for adults and a small number of children.
- We rated the service as good as there were systems and processes in place to keep people safe and to reduce the risk of radiation.
- The department was clean, and medicines were stored appropriately. There was evidence of multi-disciplinary team working and staff were deemed competent to deliver services.

Summary of findings

- The department used a range of national and local guidance.
- Staff were caring, and patients were treated with privacy and dignity.
- Patients who required additional support were provided with that support, complaints were few and were dealt with appropriately. There was a good open culture and the service was developing leaders for the future. Risk was well managed and there were appropriate governance structures in place.

Summary of findings

Contents

Outstanding ☆

Spire Manchester

Summary of this inspection

Background to Spire Manchester Hospital

Spire Manchester Hospital is operated by Spire Healthcare Limited. It is a new purpose built private hospital, registered by the CQC on 22 January 2017. It is a private hospital in Manchester. The hospital primarily serves the communities of the Manchester area. It also accepts patient referrals from outside this area.

The hospital provides the following regulated activities: surgical procedures, treatment of disease, disorder and injury, diagnostic and screening, management of supply of blood and blood derived products and family planning.

The hospital has had a registered manager in post since 13 March 2018.

There were no special reviews of investigations of the hospital ongoing by the CQC at any time during the 12 months before the inspection. This was the hospital's first inspection since its registration in 2017 with the CQC.

Surgeons and anaesthetists worked at the hospital under practising privileges. The regular resident medical officer was always present at the hospital. The accountable officer for controlled drugs was the registered manager.

Activity (1 December 2017 – 1 November 2018)

One incident of hospital-acquired infection – E Coli

One Never Event 6 October 2018.

Services accredited by a national body:

SGS Accreditation - Sterile Services

UKAS Medical Laboratory Accreditation - Pathology Services

BUPA Recognition - Breast, MRI

You're Welcome Quality Accreditation - for Children and Young People Services.

Services provided at the hospital under service level agreement:

Clinical and or non-clinical waste removal

Interpreting services

Medical devices

Laundry

Resident Medical Officer provision

Our inspection team

The team that inspected the service comprised of CQC inspectors, specialist pharmacist and specialist advisors with expertise in surgery, critical care, children and young people, outpatients and diagnostic imaging. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

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

We rated it as **Good** because:

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- 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 service followed best practice when prescribing, giving, recording and storing medicines.
- The service used safety thermometer results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

However,

- Staff did not always adhere to the documentation requirements of the surgical safety checklist, although compliance was improving. We observed two time-out procedures that were not as comprehensive as they should have been. The hospital responded quickly to address this issue during the inspection.
- Not all records of patient consultations in outpatients were detailed, clear and up to date.

Are services effective?

Good

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.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain.

Summary of this inspection

- 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.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Are services caring?

Outstanding 

We rated it as **Outstanding** because:

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from hospital.
- Staff cared for patients with compassion. Feedback from patients consistently confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff always took people's personal, cultural, social and religious needs into account.
- People's emotional and social needs were as important as their physical needs.

Are services responsive?

Outstanding 

We rated it as **Outstanding** because:

- The service took account of patients' individual needs.
- Facilities and premises were innovative and met the needs of a range of people who used the service.
- People could access services and appointments in a way and at a time that suited them. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were consistently 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.

Are services well-led?

Outstanding 

We rated it as **Outstanding** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Summary of this inspection

- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff groups.
- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures supported this.
- The hospital had good systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected. Governance arrangements were proactively reviewed and reflected best practice.
- Problems were identified and addressed quickly and openly.
- There were consistently high levels of constructive engagement with staff and people who used the services, including all equality groups.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Medical care (including older people's care)

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

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

Good

We have not previously rated this service. We rated it as good.

Mandatory Training

See information under this sub-heading in the surgery section

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Mandatory training for endoscopy and interventional cardiology staff was 100%. There were 10 modules which included information governance, fire safety, compassion in practice and equality and diversity.
- Staff had personal dashboards to monitor their training. In addition to this staff received email reminders when modules were about to expire, and managers monitored compliance.
- We spoke to staff regarding time given to complete training and were informed that they were all given protected time on their rotas to undertake e-learning and face to face learning.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff we spoke to were aware of their roles and responsibilities in safeguarding and knew how to raise concerns appropriately.Staff also told us that they would access the support of the safeguarding lead in the hospital if required.
- All staff in the endoscopy and interventional cardiology department were up to date with their safeguarding vulnerable adults' level 2 training.In addition to this the endoscopy department was currently training all staff to safeguarding vulnerable children level 3.This training had commenced in January 2019 and the deadline for completion was March 2019.This met with intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Healthcare Staff (January 2019).At the time of inspection staff within the endoscopy department were 92% compliant and we were told by management that endoscopy procedures for children were always carried out in the theatre environment and not in the endoscopy suite.
- The service ensured that new employees underwent safety checks.These were undertaken by the human resources department who checked criteria outlined by the Disclosure and Barring Service before staff commenced working at the hospital.
- There were operational polices in place which included safeguarding vulnerable adults (clinical policy number 10), safeguarding the care of children and young people (clinical policy number 63) and a chaperone policy (clinical policy number 42).All were in date.The policies referred to relevant statutory and professional guidance and highlighted the organisations responsibilities and referral process.

- A freedom to speak up guardian had recently been employed within the hospital and staff we spoke to were aware of how to access this support if required.

Cleanliness, infection control and hygiene

- The service controlled infection risk well, all areas we inspected were visibly clean and tidy. Infection control was included in mandatory training for all staff and the departments were 100% compliant.
- The service carried out bi-annually hand hygiene audits. An infection prevention and control lead nurse had recently been employed and was undertaking spot audit checks.Results collated showed that parts of the palms of the hands and thumbs were being missed when undertaking hand washing and this indicated a poor hand hygiene technique.Training on the World Health Organisations guidelines on hand hygiene in healthcare was currently being implemented to address this matter.
- There were hand sanitiser gel dispensers on entry to the cardiology department and endoscopy suite with dispensers located within each room of both departments. We observed staff using the gel upon entry to the endoscopy department and we observed staff washing their hands prior to and following patient contact.
- Staff were bare below the elbow and uniforms were visibly clean and tidy. Bare below the elbow posters were visible within the endoscopy suite.
- There were no methicillin-sensitive staphylococcus aureus (MRSA), Clostridium difficile (C-diff) or Escherichia coli reported by the service between October 2017 and September 2018.
- Staff had defined roles and responsibilities for patient areas of the patient pathway and for decontamination. For example, staff were allocated to roles such as endoscopy care, recovery post-procedure and equipment decontamination.
- Personal protective equipment was available, and we saw that it was used pre- post and during procedures.
- Bedside cleaning took place immediately after the endoscopic procedure. All staff in the team were involved in cleaning the procedure room and an internal cleaner carried out cleaning of the walls and floors. We saw cleaning schedules signed and dated by the internal cleaners.
- Endoscopes were cleaned immediately after use in line with hospital policies; decontamination of medical devices (Clinical Policy number 26) and the endoscopy policy (Clinical Policy number 27). Cleaning was in line with guidance on the management and decontamination of flexible endoscopes, Health Technical Memorandum (HTM 01-06).All were in date.
- Following a manual bedside clean of the endoscopes they were passed from the procedure room in a covered tray to the decontamination room through a hatch for initial cleaning, testing and decontamination. There was no standard operating procedure in place for the manual cleaning of the endoscopes, but staff had a visible poster with the steps to cleaning on the wall of the decontamination room. We were told that managers were in the process of developing a standard operating procedure for the decontamination process.
- Filtered air was used as part of the drying process for each endoscope and drying cabinets were utilised to store cleaned endoscopes. These cabinets are designed to deliver highly efficient particulate filtered air (HEPA) to the internal channels at the appropriate temperature and flow rate.Equipment was dated so that staff knew when equipment needed to be reprocessed if they were in the cabinet for long periods of time.
- Equipment was tested daily to ensure that endoscopes were cleaned thoroughly. Test reports were printed off and filed securely and these were validated by an independent authorised engineer in decontamination.
- We observed reports verifying that the air in the clean room was filtered every 3 months.This exceeded the recommendations given by the 'Institute of Occupational Medicine'. In addition to this, air changes in the endoscopy suite were verified annually. This is not a legal requirement but demonstrated good practice within the hospital.
- Every quarter sterile services carried out bioburden testing to ensure that pre-sterilisation quality control

was adequate. This was also carried out by an external company so that no bias was implicated. Bioburden testing is the terminology to describe the inherent population of microorganisms present in a product.

- The service had and was still experiencing issues with water quality and the existence of bacteria in the water supply during our inspection. This had been ongoing since the development of the site.The issue had been placed on the hospital risk register and controls and actions had been put in place to try and remedy the problem. Ongoing corporate review meetings were held.
- Staff ensured that clean and contaminated equipment was kept separately. The design of the decontamination premises prevented contaminated equipment encountering clean equipment.This was in line with the Department of Health and Social Care Health Building Note (HBN 01-06).
- We observed a clear one-way flow of endoscopes between dirty returns to clean dispatch areas which prevented cross contamination. The wash room had a negative pressure in comparison to the clean side and we saw evidence that this was checked daily.
- Guidelines from the British Society for Echocardiography on transoesophageal echocardiography probe cleaning and disinfection, and the decontamination process outlined in the hospitals decontamination of medical devices policy (Clinical Policy number 26) were followed by the cardiology team for cleaning equipment.
- Clinical waste was handled, stored and removed in a safe way. Staff used colour coded bags to segregate waste and ensured it was safely disposed of. This was in line with the control of substances hazardous to health (COSHH) regulations 2002.
- There were good waste and sharps management in place.We observed sharps bins correctly labelled and assembled with the temporary closure in place which were fully compliant with the Department of Health and Social Care Health Technical Memorandum (HTM 07-01).
- The endoscopy suite and the cardiology treatment rooms were visibly clean, tidy and free from any clutter. 'I am clean' stickers were utilised to show what equipment had been cleaned.
- Clinical areas had flooring which was washable and compliant with the Department of Health and Social Care Health Building Note (HBN 00-10).
- All chairs within the endoscopy suite waiting area were found to be wipeable, clean and fully compliant with the Department of Health and Social Care Health Building Note (HBN 00-09).
- We observed an endoscopy care pathway which entailed a risk assessment for Creutzfeldt-Jakob disease (CJD) and variant Creutzfeldt-Jakob disease (vCJD). CJD is a rare and fatal degenerative brain disorder that can be spread from an infected person via brain or spinal tissue. There was a policy on the management of CJD incorporating patients with or at risk of CJD and theatre equipment management (Clinical policy number 34).

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The endoscopy suite was built to meet the required environmental standard and staff looked after it well. Toilets were available in the waiting areas for patient/visitor use which included disability facilities. We observed that signage was dementia friendly.
- The service provided accommodation for day care endoscopy in line with the Department of Health and Social Care Health Building Note (HBN 10-02).
- Male and female toilets were available in the changing facilities within the endoscopy suite area.
- The environment was appropriate, and patient centred. There was a one-way flow through the endoscopy suite that commenced from reception to the waiting area, changing rooms, procedure room, recovery area and back to day case clinic or inpatient ward areas.
- There were three individual recovery room areas. All were spacious and visibly clean.However, one of the rooms was being used currently as a store room. We were told that this was being addressed. Each room had a sliding door for access into and out of the room. There was a privacy screen that could be opened to maintain the patient's privacy and dignity when required for any hygiene needs or investigations.
- Daily checks were made on the hatch door to the dirty returns area in the endoscopy suite.These were carried

out to ensure that the door opened and closed so that staff did not have to enter the area to return dirty equipment. The intercom was checked in both rooms so that staff could speak to the sterile services staff and not access the area. This not only ensured good practice, but it was in line with the Department of Health and Social Care Health Building Note (HBN 01-06).

- Cleaning solutions subject to Control of Substances Hazardous to Health Regulations (COSHH 2002) were stored in a locked room.
- Equipment underwent regular servicing and safety testing. We observed certificates that showed equipment had been serviced within the last year. In addition to this we were told that for cardiac cryoablation procedures an external company would attend the hospital to service the equipment if it had not been used for a while. Cryoablation is a process that uses extreme cold to destroy tissue.
- We observed the annual theatre verification summary which demonstrated that air pressures and sound levels within the hybrid theatre had passed the testing. A hybrid theatre is equipped with medical imaging devices such as computed tomography (CT) scanners or magnetic resonance imaging (MRI) scanners. The addition of these devices in the hybrid theatre allow it to function as either a conventional operating theatre or as a radiology facility.
- Accessory items marked as single use were used in accordance with the Medicines and Healthcare Products Regulatory Agency (MHRA 2013). We randomly looked at five single use items, all were in date and stored in chronological order.
- All cupboards within the endoscopic procedures room were labelled.Stock levels were checked either in the evening following clinic lists or first thing in the morning.
- Equipment used for emergency resuscitation was available in the recovery area and was easily accessible to staff in the procedure room. We observed daily signed records by staff who had checked the equipment.
- Emergency call buttons were visible within the procedure and recovery room areas.
- Oxygen cylinders in the procedure room and the resuscitation trolleys were in date and full.We observed the porters daily check audit which included medical gas cylinder checking and these were all signed and dated.
- Fire exits were clearly signposted.Fire break glass points were observed at each exit that complied with BS EN 54-11 and a review showed that all fire extinguishers within the endoscopy suite and cardiology department were in date with their annual service.
- Environmental checks were carried out daily within the endoscopy suite. We saw evidence of these checks for the month of January 2019 and were told that an external company was now monitoring this from February 2019.Reports would be sent to managers daily and alerts raised if temperatures were out of range.
- We were told that cardiology only had one balloon pump at the hospital. If this piece of equipment was to break down or become faulty, patient lists would have to be cancelled.This was not on the hospital risk register but was included on the departments risk register and actions were in place if this was to happen**.**

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. There were systems and processes in place to reduce the risks to staff, patients and their families. The services kept clear records and asked for support when necessary.
- Risk assessments were carried out on bariatric patients and all were deemed as high risk.Due to the high risk it was hospital policy to carry out endoscopic procedures on bariatric patients within the theatre environment and not the endoscopy suite.
- All staff were trained in immediate life support.In addition, staff within the interventional cardiology department were trained in advanced life support.
- Comprehensive risk assessments were carried out for people using the endoscopy service.The service ensured that patients were suitable to be cared for and treated in the day case environment. There were procedures in place to identify and manage patients with Transmissible Spongiform Encephalopathy such as

Creutzfeldt-Jakob Disease (CJD) and variant Creutzfeldt-Jakob Disease (vCJD). Patients were screened for their admission; this was to prevent any risk of cross infection from equipment.

- Staff checked the pregnancy status of patients. We observed a patient declining a pregnancy test prior to undergoing an endoscopic procedure.This was clearly documented in the patient's medical records and on the patient's risk assessment.
- We observed staff carrying out a Spire safe surgical checklist which was based on the World Health Organisation (WHO) surgical safety checklist (2009). This entailed completing a pre-op checklist with the patient, team brief, a sign in in the procedure room, a time out before the procedure commenced, a sign out before the patient left the procedure room and a team debrief. One staff member read from the checklist and all staff were involved in the process to ensure that no step was missed.
- We observed the endoscopy team leader checking the equipment before the patient arrived and liaising with the central sterile services department. We were told by the team leader that they would discuss the need of turning around the equipment if they had a busy procedure list and prior planning of the lists would be completed the day before to ensure that they ran smoothly.
- Staff used the numerical early warning score (NEWS 2) for patient observations. This involved measuring a patient's vital signs such as temperature, blood pressure, heart rate, respiration rate and oxygen saturation.Patients were monitored throughout the procedures and regularly monitored in recovery and the ward area until they were well enough to be discharged home.
- We reviewed a safe sedation during procedure policy (Clinical Policy Number 37) which was in line with national standards and benchmarked against the Royal College of Anaesthetists. Patients received information prior to their procedure regarding conscious sedation and were given informed choices as to whether they wanted it or not.Information was also given to patients on not to drive a motor vehicle and to remain with another adult for 24 hours following the procedure.
- Clinical staff had daily huddles each morning to assess risks for the clinic and to discuss patients for that day. These daily huddles included sharing information about health risks of patients attending for the procedures and any planned activities for that day.
- Triage in cardiology was carried out by a cardiac specialist nurse. Patients were brought into clinic for formal investigations. Pre-assessments were carried out on all patients undergoing cardiology intervention procedures. No patient would go to theatre for a procedure without an electrocardiogram (ECG) being performed pre-admission and this was reviewed by the senior cardiology specialist nurse. This ensured patient safety and prevented operating theatre cancellations on the day. If an issue was identified on the ECG, the consultant cardiologist would be contacted immediately, and the patients GP would be notified of their findings.
- We did not see any cardiology interventions during our inspection but were told by the cardiology specialist nurses that a team brief including everyone's roles and responsibilities would be carried out prior to the procedure. A consultant cardiologist, two registered nurses, a physiologist in cardiology, an operating department practitioner and a radiographer would be present to ensure patient safety was always maintained. A transfer out flowchart was discussed in the team brief so that each person would know where to go and who to call if the patient needed to be transferred to a local NHS trust.
- A major haemorrhage scenario was undertaken by the cardiology team before the first ablation procedure was carried out. This involved the consultant haematologist. Findings from this scenario highlighted the need for a designated person to collect blood required from the theatre fridge and a copy of a flowchart to highlight the procedure in anticipation of these events. We were told that the team planned to carry out these scenarios on a quarterly basis to ensure competence was maintained.
- Venous thromboembolism (VTE) assessments were carried out by the cardiac specialist nurses during their pre-assessment process as well as other assessments, such as slips, trips and falls and wound care.

- Resuscitation scenarios were carried out within the departments regularly to keep competencies up-to-date.
- Patients who were at risk of deteriorating, or any concerns that the cardiology nurses had, would contact the intensivists based in the hospital critical care unit or the consultants at the local NHS trust for advice.
- We were told by the cardiology nurse specialists that before carrying out a percutaneous coronary intervention (PCI) patients were always risk assessed. The service had a risk assessment for PCI and a service level agreement (SLA) for patients that may need to be transferred to the regional specialist unit if the hospital critical care unit was not appropriate.
- We were told by the cardiology specialist nurses that the local ambulance service had been invaluable in the implementation and plan of transferring patients to the local NHS hospital.This was to ensure that vital cardiac equipment would fit in the ambulances.
- A cardiac arrest bleep went off daily at 9am and designated staff would attend.A roll call would be carried out which was led by the resuscitation lead.In addition to this the cardiac arrest team would be aware of patients in the hospital and would know what procedures and interventions were being carried out daily.This roll call ensured all the team would be aware of the risks for that day.
- Patients were given discharge information with contact details on if they had any concerns when they got home.In addition to this, patients were telephoned at home by the patient services team the following day to see how they were following their procedure.

Nurse staffing

- The service had enough medical and nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff were being rotated to endoscopy from the theatre's rota. This would continue until the endoscopy unit was utilised fully and had its own dedicated fulfilment of staff. Theatre teams worked within the 'Association for Perioperative Practice' (AfPP) guidance regarding minimum staffing requirements.Endoscopy was on the organisations action plan for development this year.At the time of inspection interviews were taking place for a permanent team leader of the endoscopy suite. Staff were to be allocated to endoscopy permanently and six staff members had raised their interest in this prior to recruitment being advertised.
- We observed good numbers and a good skill mix during an endoscopic procedure. There was a registered anaesthetic nurse, a healthcare assistant, an operating department practitioner, a registered nurse team leader and a consultant.All knew their roles and responsibilities for the day.
- We were told by managers that a practice based educator was to be developed or recruited in theatres. This had not yet commenced at the time of inspection.
- One-to-one nursing care was always carried out within the recovery area.
- On review of the nursing rota there had been no shifts that had gone below agreed staffing numbers.
- The service reported a low level of sickness and low turnover rate of staff.Most staff had been with the service since it had moved to its new premises in 2017.
- Bank and agency staff were used if required. However, no staff member could work within the endoscopy department without completion of the competency requirements. Bank staff used in the cardiology department were qualified cardiac care nurses that worked in tertiary centres within catheter labs.

Medical staffing

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

- There were nine consultant endoscopists currently worked under practising privileges within the service.
- The consultant cardiologists who had practising privileges were supported by heart physiologists employed by the organisation.
- No locum or agency medical staff were used in the endoscopy or cardiology service.

Records

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

- Patient records within the endoscopy department were electronic.However, the patient consent form, NEWS 2 chart, prescription chart, care plans and risk assessments were all paper based.The endoscopy nurse and the endoscopy consultant would document the procedure and their findings on the electronic system and this would be printed off and stored in the patient's paper record.
- We observed that the electronic record consisted of various fields that had to be completed by staff before they could move on to the next section. This ensured that all details were completed fully.We reviewed five individual patient records and found all fields completed with information given on care provided and any individual needs of the patient required during the procedure.
- Storage and transfer of images was completed through the picture archiving and communications system (PACS). There was 24 hour PACS support available if required.There was information technology (IT) support corporately if required.
- We observed a wipe board within the endoscopy procedure room that had patient, staff present and procedure details.This was updated during the procedure and was used to confirm details on the surgical checklist at the end of the procedure.
- Each piece of endoscopic equipment used had its own serial number and this was input into the electronic system. The programme recognised when scope numbers were not supposed to be used during a procedure and it would flag this up immediately. This ensured good track and traceability and protected both staff and the patient.
- The electronic system within the endoscopic procedure room was not yet programmed to print out histology forms. We observed staff hand writing these forms and these were counter signed by another member of staff to ensure that the specimens obtained were correctly labelled. There was a plan to move to electronic histology forms.
- A track and trace system was utilised at each stage of the decontamination process.Information was printed off and staff signed and dated the printout at the time of decontamination.
- Each patient was seen by the consultant endoscopist before they were discharged, and the findings of the procedure were discussed.A written report of the investigation was completed, and a copy sent to the patients GP and the patient if requested. The report included details of samples that were taken and sent off to pathology for testing.
- Interventional cardiology procedures were all coded and the prothesis (stents) used were scanned into an electronic management system to enable track and traceability.A log book was held in the hybrid theatre in which a radiographer monitored the radiation limits and the contrast used.
- All paper records were stored securely in a lockable cabinet in a locked room behind the nurse's station on the ward area.Computers were password protected.
- Records and confidential information were kept in line with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).In addition to this we observed a patient records policy (Clinical policy number 8) that was in date and for review in 2021.
- We looked at five patient records and saw that they all had the initial referral letter from their GP, consent form, prescription chart, NEWS2 chart, scan images and the report which included the consultation notes. All were legible, dated and signed.

Medicines

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

- The service followed best practice when prescribing, administering and recording medicines.
- Medicines (including controlled drugs) were kept in a locked cupboard within the procedure room. We reviewed a random sample of three controlled drugs and all were within the manufacturers expiry dates and kept in chronological order.Controlled drugs were checked on the day of a procedure and again at the end of the procedure. If no procedures were being carried out in the endoscopy suite the controlled drugs were checked every three days.
- Drugs that needed to be stored at lower temperatures were stored in a fridge within the procedure room. Fridge temperatures were checked daily. We looked at

the schedule for January 2019 and all were in range, signed and dated. However, on inspection we did not see a schedule for the period 01 February to 05 February 2019, we raised this on inspection and were told by management that an external company was now monitoring the fridge and room temperatures. The hospital received a daily report and if temperatures became out of range an alert would be sent straight away to the hospital for action by the management team. The hybrid theatre did not receive reports and therefore staff monitored these ranges themselves daily.

- Pharmacy support was always available in the hospital.
- We observed three weekly audits that had been carried out by a member of the pharmacy team on the storage and security of medicines in the endoscopy department and the hybrid theatre. Examples of the audit tool questions were 'are the controlled drug keys kept separate and held by an operating department practitioner or signed into a key cupboard when theatre not in use' or 'stock is rotated with shortest shelf life at the front'.All were 100% compliant.
- Medicines were prescribed and administered by the consultant endoscopists for pain relief and sedation. These were counter-signed by a registered nurse within the department.We observed that the medicines to be used during the procedure were labelled and kept in a tray with key sites protected. Key sites are medical devices that access sites or open wounds and if contaminated are likely to cause infection.
- Entonox was used by the new consultants which was welcomed by the staff and the leadership team as it helped to increase volume of patients and reduce recovery time. We did not see any evidence of this being audited to corroborate their findings.
- Oxygen and Entonox were prescribed on an individual basis by the consultant.
- One of the cardiology nurses was a non-medical prescriber and was hoping to expand this role within the team as the service developed. Peer support was available for this by a local NHS trust.

Incidents

- The service managed patient safety incidents well. Staff we spoke to knew how to report an incident and we were told that lessons learnt from incidents within the whole hospital were shared with all departments.We were told by staff of a never event that had occurred in the wider hospital and what lessons had been learnt from this scenario.
- Incidents were discussed in the daily morning huddles and any updates given. Staff described an open culture within the whole organisation and this was evident in conversations we had regarding the recent never event within the hospital.
- Staff had access to a monthly update of the hospital's incidents and complaints and what actions were taken and lessons learnt from these.
- There were no clinical or non-clinical incidents in the period January 2018 to December 2018 within interventional cardiology department. The endoscopy department reported four, no harm, incidents in the same period.

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

Not sufficient evidence to rate

We do not currently rate the effective domain for independent endoscopy and diagnostic services.

Evidence-based care and treatment

- **Endoscopy and interventional cardiology provided care and treatment based on national guidance and evidence of its effectiveness.**
- The services carried out audits which were benchmarked to local and corporate policy, Department of Health (DoH) guidance and the National Institute for Health and Care Excellence (NICE) guidelines. Examples of guidance followed was NICE (QS124), Quality Statement 1: Direct access to diagnostic tests and NICE (NG12) Suspected cancer: recognition and referral.
- Care pathways were available in both services for the procedures that they undertook. NICE guidance and the Royal College of Physicians (RCOP) was used to benchmark the organisations policies, protocols and standard operating procedures.
- We reviewed the hospital cardiology standards that were based on national guidance such as the British

Cardiovascular Intervention Society, British Heart Rhythm Society and the European Society of Cardiology. These were in draft form and were to be ratified post inspection at the hospital intervention working group meeting in March 2019.

- We also reviewed clear processes for booking interventional cardiology tests and policies and protocols were in place.
- The central sterile services department (CSSD) received updates from the 'Institute of Decontamination Sciences' via the team leader. These were cascaded by monthly team meetings and via emails. In addition to this, CSSD networked regularly with a partner organisation to ensure best practice was carried out.
- We observed the hospital's version of standards that must be met by a sterile services department. This was documented in the sterile services departments quality management systems manual (Clinical policy number 36).
- Health Technical Memorandum (HTM 01-06): Management and decontamination of flexible endoscopes and HTM 01-01 for the decontamination of surgical instruments were followed within the service.
- External audits were carried out in the central and sterile services department. This ensured that no bias was implicated, and that regulations and standards were adhered to. We saw evidence of an external audit that measured the air change rates, pressure differentials and microbiological sampling and all had passed the rigorous testing.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health.
- Patients were supported to be independent following their treatment by receiving information on when they could next eat and drink and in what circumstances they should seek further medical advice.

Pain relief

- Staff assessed and monitored patients regularly. Staff assessed patients pain using a numerical rating score of one to four.One being no pain and four being in severe pain and this was documented on the NEWS 2 chart. However, we observed a patient being admitted in the ward area for an endoscopic procedure and staff were only asking if the patients were 'o.k.'? If the patients said 'yes' then a score of 1 would be documented. There were no direct questions asked if the patient was in pain which did not follow the core standards for pain management in the United Kingdom. We raised this with staff at the time of inspection
- Pain control was discussed with the consultant endoscopist prior to the procedure and conscious sedation was offered.Although the patient again was not asked directly if they were in pain, the theatre staff asked the patient if they were feeling relaxed prior to commencing the procedure and asked if they were feeling 'o.k.' during the procedure.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The endoscopy department was working towards attaining 'Joint Advisory Group' (JAG) accreditation for their services. This is a national organisation that assesses details of how endoscopy services are delivered and monitored. A clinical review team member from the hospitals corporate department was due to come into the hospital in February to discuss how to achieve JAG status. We observed the hospital action plan for the department to achieve this accreditation.
- The patient electronic information management system allowed management to see what volumes of endoscopic procedures were being carried out.During the period January 2017 to February 2019 a total of 587 oesophago-gastroduodenoscopies (OGD's), 10 endoscopic retrograde cholangiopancreatographies (ERCP's), 136 Flexible sigmoidoscopies and 364 colonoscopies had been performed.
- We were told by management that consultant endoscopists were choosing to use Entonox instead of sedation during the procedures and that patients were pain free using this option. In addition to this, patients could drive home after receiving Entonox provided they had not had additional sedation during the procedure. However, there was no audit data to corroborate these outcomes at the time of inspection.

- Managers told us that insufflation (blowing into) of carbon dioxide (CO2) instead of air during colonoscopy was used as it reduced pain following the procedure. Studies have shown that the use of CO2 can reduce post-procedural pain, however CO2 sufflation might also lead to CO2 retention in the human body, however staff told us that more research was needed within this area. We were told that there were plans to audit this practice, however we did not see any evidence of data collection at the time of inspection to corroborate this.
- We observed an audit for the period January 2018 to December 2018 of patient's pre-assessment ECG's which demonstrated that on the day cancellations had gone down.
- The cardiology nurses were currently carrying out an ECG audit. Data was not available at the time of inspection.
- The cardiology service was benchmarked against other Spire hospitals and the NHS. Data was submitted through the National Institute for Cardiovascular Outcomes Research (NICOR) to audit quality improvement. Data was not available at the time of inspection to look at the audit results since procedures began in March 2018.
- We were told by the cardiology specialist nurses that there were no key performance indicators (KPI) in place for the catheter lab at the present time but there were plans for this in the future as the service grew.

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.
- Staff had the right skills and knowledge to assess patient needs and provide care for patients undergoing endoscopy or interventional cardiology procedures.
- Staff received annual appraisals and regular one-to-ones with their manager. Clinical supervision was provided by the service as well as regular reflection and discussion.
- All staff had competency files. We reviewed five files, and all had action plans and review dates signed by both themselves and their manager. Although staff were deemed competent, ongoing training and development was essential for their roles.
- The service had an induction programme for any new starters. We spoke with two staff members who said that the induction programme had been invaluable to their learning. In addition to this, all staff were given a supernumerary period; this period was not a set timeframe but tailored to the individual's needs.
- The workforce skill mix was reviewed the day before a procedure by the team leader and staff were only rostered who had completed their competencies in endoscopy procedures.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Study days were available for staff in endoscopy to keep updated, both internally and externally. We were told that staff were booked onto an external study day the week following our inspection.
- Practising privileges were monitored and reviewed bi-annually for both consultant endoscopists and cardiologists. We were told by the cardiac specialist nurses that a consultant had recently had his practicing privileges removed following an investigation into their practice. To maintain practising privileges, consultants must provide evidence for example, an annual whole practice appraisal, indemnity cover and up to date disclosure and barring service certificate. We were told post inspection that the hospital had been invited to attend a neighbouring trusts Medical Oversight Group which was established by the responsible officers of the local NHS trust who employ doctors with practising privileges. This supported a joined up approach to working between the two hospitals.
- The two cardiac specialist nurses were both advanced life support (ALS) trainers and one held a clinical examinations module at Masters level. We were told by management that the organisation was now a

resuscitation council approved course centre; this allowed the advanced life support trainers to organise courses for internal and external parties to attend their premises for training.

- Training was also provided to ward staff by the cardiology specialist nursing team in taking and reporting on electrocardiograms (ECGs), NEWS2 and anaphylaxis. The cardiology team were in the process of implementing a competency document in cardiovascular care for ward staff.
- We were told by the cardiology specialist nurses that they provided teaching sessions eight or nine times a year delivering basic life support, paediatric basic life support and treatment of anaphylaxis to GP surgeries. Training was provided free of charge and a certificate of attendance from the hospital was given following attendance.
- ECG training was given to new nurses on induction. Extra sessions for staff were available if needed.

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.
- Service staff worked together to provide effective care and support for patients. There were agreed care pathways for example, patients who had a diagnosis of cancer or patients who had cardiac problems. Specialist nurses would network with external agencies to ensure good care was provided based on national guidance and best practice.
- Staff were members of peer groups and internal/ external networks where professional support and advice could be sought.
- The departments had good relationships with staff in the wider hospital, specifically in theatres and radiology.
- The cardiology team had recently attended a cardiology forum in London and used this day to network with other internal and external parties to benchmark practice.
- The cardiology team worked with an external company for all interventional procedures in relation to heart physiology. Staff told us that this was invaluable for not only patient safety but for staff and human factors.

Seven-day services

- The endoscopy suite was not open every day due to the service not being fully developed in terms of patient flow. At the time of our inspection the suite was open Monday, Wednesday, Thursday and Friday from 9am to 5pm.The service also provided evening sessions from 5pm to 9pm if required. At weekends NHS waiting lists for contracts for endoscopic procedures were carried out in main theatres. The hospital did not carry out any emergency endoscopy procedures.
- There was an on-call service at the weekends and patients who were discharged on a Friday were advised of action to take if there were any concerns. In the first instance this would be to call the ward.
- Cardiology interventions were carried out Monday to Friday from 9am to 5pm. If a cardiology patient required transfer to the local NHS hospital between the hours of 9am to 5pm they would be transferred to the designated NHS trust but if out of hours the patients would be transferred to the local NHS trust that was on call for that day.

Health promotion

- Consultant endoscopists and nursing staff provided information to patients on life-style choices which could help to relieve their symptoms. We observed a consultant endoscopist giving advice to a patient on their diet following an endoscopy procedure.
- BUPA wellness was available and used by the cardiology department. This was a dedicated separate department which was franchised by BUPA UK.
- Patient health events were carried out on Saturday mornings. These were carried out by cardiology, gastroenterology, orthopaedics and ear, nose and throat teams. These events were advertised on the hospital website, social media and by word of mouth from patients and staff. The next event would be held on February 27th, 2019 and this would be a cardiology event encompassing topics such as breathlessness, palpitations, angina or chest pain.

Good

Medical care (including older people's care)

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff followed hospital policy (Clinical policy number 78: Consent to investigation or treatment) and were clear on their responsibilities when gaining consent from patients before their procedure.
- Information was provided for patients to read and sign at home before attending for their appointment. The information was discussed again on admission and consent was checked by both the admitting nurse and the consultant before the procedure began. This ensured that consent was given, and it gave the patient the option to withdraw consent before the procedure commenced.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. We were told by staff that they would speak to the safeguarding lead at the hospital for advice and support in this area. There was a poster demonstrating a mental capacity act clinical brief dated February 2016 displayed on the cardiology office wall to help staff to determine how mental capacity was determined. This briefing was submitted by the corporate central team for staff awareness and would be renewed when a change in the subject had occurred.
- We were told by the cardiology nurse specialists that if they thought a patient lacked capacity, a mini mental health assessment would be completed. A separate consent form for patients who lacked capacity was available in the organisation.
- For patients who lacked capacity and were to undergo endoscopic or cardiac procedures a best interests meeting would be held. Advanced planning and adjustments would be made if required.

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

Good

We have not previously rated this service. 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 saw staff caring for patients with compassion. We observed staff introducing themselves to patients and their families and we observed staff asking the patients how they would want to be addressed. This was then documented in the patients notes for all colleagues to be aware.
- Reception staff at the main entrance to the hospital greeted patients as they entered. We asked a patient on their experience of this and were told that although the staff were extremely polite and caring they could hear other patient's diagnosis and reasons for admission as well as the financial cost of their treatments whilst sitting in the waiting area.
- At the time of inspection, patients were admitted to the inpatient ward area for endoscopy procedures as the day case unit was closed. Patients had their own rooms which ensured privacy and dignity was maintained during the admission procedure.
- Dignity shorts were provided to patients undergoing lower gastro-intestinal procedures which ensured that privacy and dignity was maintained.
- When patients were receiving lower gastro-intestinal procedures a screen was also put around the patient to ensure their privacy and dignity was always maintained. We were told that during the procedure staff were limited into entering and exiting the procedure room.
- During the procedure we observed that care was provided sensitively and compassionately. Staff monitored the patient and ensured that they understood any explanations that were given during the procedure.
- Patients could be accompanied by a family member or friend if they wished during their consultations or procedures. We observed staff specifically asking patient's if they wanted a chaperone during their procedure. We also observed a chaperone policy (Clinical Policy number 42) that was for review in July 2019.

- Music was available within the procedure room and each patient was offered the choice of having it on or not. There were various options of music genre to each patient.
- Privacy and dignity were continued in the recovery area and through to the discharge process in the ward environment.
- We observed thank you cards from patients in the cardiology team office. In addition to this, verbal comments had been documented in a file within the office, but this had not been shared with the wider team.

Emotional support

- Staff provided emotional support to patients to minimise their distress. Staff in the service understood the impact the procedures and potential diagnosis could have on patients.
- During the inspection we saw that staff ensured patients were comfortable throughout the procedure. In addition, regular reassurance and support was provided throughout the patient care pathway.
- Follow-up telephone calls were carried out the next day following the procedure. This entailed establishing if the patient had any concerns and obtaining feedback on their patient journey.

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 staff describing endoscopic and cardiac procedures in plain language so that patients could understand what the treatment entailed.
- We observed staff speaking sensitively with patients over the telephone regarding the cost of the interventional cardiology treatments. Staff also told us that when patients came into hospital for their consultation, costs were again discussed so that the patient was aware of the financial element of the treatment.
- Patients in the endoscopy suite were given the choice to view their procedure on a screen. We observed that there was no pressure on the patient to agree to this option and that patient choice was respected.
- The consultant endoscopists ensured patients were able to understand the outcomes of their procedure and provided feedback about their findings. This feedback was briefly given in the procedure room but for those patients who had received sedation it was also given again when back in the ward environment.
- We saw that patients were given the opportunity to ask questions if there was anything they did not understand.
- We observed a conversation with a patient over the telephone about fees and the nurse broached the topic with compassion and sensitivity.

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

Good

We have not previously rated this service. We rated it as good.

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people.
- There were two reception staff manning the main entrance reception to the hospital to ensure that patients were dealt with in a timely manner.
- A television was situated in the main reception area as well as the provision of magazines.
- We observed leaflets on health awareness, for example understanding stress, understanding blood pressure, taking control of alcohol and understanding cholesterol.
- There was a canteen based on the ground floor open to staff, patients and relatives. Staff were extremely friendly and the area was visibly clean and tidy.
- Patients relatives were offered the opportunity to either stay in the individual patient rooms on the ward area or in the patient lounge. There was a waiting room area based outside the endoscopy suite with enough seats for family members.

- The endoscopy suite was brand new and purpose built to ensure services were delivered appropriately. The discharge lounge was a bright room with a wall of windows. Height adjustable chairs were available in the waiting room area.
- There were clear pathways for both endoscopy and interventional cardiology.
- Telephone appointments were carried out with the cardiac specialist nurses where appropriate. The calls were carried out in the nurses offices which ensured that confidentiality was maintained at all times. We observed the nurses carrying out telephone appointments in a sensitive and calming manner.
- There was free car parking at the hospital for patients, relatives and all members of staff.

Meeting people's individual needs

- The service took account of patient's individual needs. Peoples individual needs and preferences were central to the planning and delivery of the services offered.
- Patients were telephoned the day before the procedure to check information and give instructions on fasting and omission of certain medications.
- Interpreter services could be provided for patients with communication needs, for example interpreter services and those with dementia or learning difficulties. We were told by staff that they would know in advance of a patient who had communication needs and plans would be put into place before their arrival to the hospital. In addition to this, leaflets could be obtained in other languages from external providers, for example a cardiology leaflet could be obtained in braille for those with eyesight problems.
- A room in the outpatient department called the 'Tulip' room had recently opened to give patients living with dementia a calm and quiet place to wait. This room could also be used to break bad news.
- Time was given to patients before and after the procedure, so they were not rushed through any part of the process. Staff provided support and discussed what patients needed to do when they left the hospital. Written leaflets were also given to the patients on discharge.
- The cardiology nurses were training patients to take their own pulse rates as this measurement could highlight a regular or irregular heart rhythm. If a patient had any concerns they could contact the nursing team or their GP for advice. Feedback from patients was very positive. Although feedback was given verbally, the nurses had documented this and filed the comments in their office. However, this had not been shared with the wider hospital.
- We were told by staff that there were sessions booked in March 2019 with the Deaf Sign Academy which would help to improve the services ability to communicate with patients and their families who had hearing loss. We received confirmation of these training sessions post inspection. In addition to this we were informed post inspection that the Imam from the local NHS Trust had agreed to run two cultural awareness sessions about the Islamic faith in March 2019.

Access and flow

- People could access the service when they needed to. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Patients were either NHS, self-funded or through insurance.
- Histology specimens taken during endoscopic procedures could take up to five to seven days for the results to come back.
- Referrals for cardiology interventions were received from consultant cardiologists, respiratory specialists and diabetic specialists.
- At the time of inspection there were 10 clinical sessions per week in the interventional cardiology department. We were told by management that due to the demand of these services the team needed to expand.
- Patients were followed up after seven to 10 days in outpatient clinics following an endoscopic procedure.
- Patients undergoing cardiology intervention procedures were followed up by telephone by a cardiac care specialist nurse the following day.

Good

Medical care (including older people's care)

- Cardiology intervention results were given on the same day following the procedure. Scans were sent encrypted to the consultant and patients GP on the day of the procedure.
- Cardiology specialist nurses worked very closely with the consultant cardiologists so that patients received their tests/investigations in time for their appointments. At the time of inspection patients were seen within days of referral. There were no waiting times at the time of inspection.
- The hospital had recently signed a contract with the NHS for hips and knees. The pre-assessment was carried out by the cardiology specialist nurses and any issues identified the patient would be referred to their GP. We were told that the clinical commissioning group would not cover any further investigations and that costs would have to be explained to the patients if they requested to have them undertaken at Spire Manchester, or could choose to continue treatment within the NHS.
- Pre-admission telephone calls were carried out by the patient services team. We spoke to staff from this team who told us they were very proud of this service as it had reduced the do not attend rates and cancellations of procedures. In addition to this any patient details that required altering or re-labelling could be completed so that there was no delay in obtaining records on the day of treatment. However, we spoke to one patient admitted for an endoscopic procedure who told us that they had missed their pre-admission phone call and was told that they would be called back. This telephone call did not occur, and the patient then worried for the rest of the day that their procedure would be cancelled.

Learning from complaints and concerns

- The service had received no written formal complaints for the period January 2018 to December 2018. It had a clear policy and process in place and patient information was available to patients and their families on how to make a complaint if they wished to do so.
- We observed information on how to make a complaint in the main reception area. We also observed that the external website had a page for feedback and complaints and this was easy to navigate to.
- The service had a patient experience manager who notified the hospital director and matron of all complaints as soon as they were received in the hospital. Compliance with complaints was monitored through a clinical scorecard and at a corporate and national level.

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

Outstanding ☆

We have not previously rated this service. We rated it as outstanding

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

Leadership

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Service leads had the skills, knowledge, experience and integrity they needed to lead a service. This was in line with guidance from the British Society of Gastroenterology (2007).
- The service had clear job descriptions for the members of the team, and the responsibilities of both the core and the wider team in the running and development of the endoscopy and cardiology service.
- The interventional cardiology team was run by highly experienced cardiac care nurses who both had clear understanding of where the service was going. Support was given from the heart physiologists, consultant cardiologists and intensivists based in the hospital and the local NHS hospital.
- Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. All managers prioritised safe, high quality, compassionate care and respected and valued the opinion and contribution of staff, patients and service users. They all also inspired and motivated staff to succeed and for the hospital to deliver exceptional patient care.

Good

Medical care (including older people's care)

- Staff told us that the new management structure was exceptional, and that senior management were outstanding and always visible. There was an open-door policy to all managers and we observed that senior management not only drove continuous improvement and celebrated safe innovation, the hospital director knew all the staff within the hospital on first name terms. Staff told us that this helped them feel part of the structure and not just as employees in a hospital business.
- Staff told us that if they worked late then they always received a verbal thank you from middle and senior management.
- Staff were delighted to tell us that senior management served them their Christmas dinners and they all had the utmost respect of the Hospital Director who had helped to clear snow outside the hospital working with the portering staff.

Vision and strategy

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.
- The service had plans to grow activity through the under-utilised endoscopy and hybrid theatre for interventional cardiology.
- At the time of inspection, endoscopy meetings were jointly held with monthly meetings in theatres. Management told us that when the endoscopy suite was fully utilised the vision was for dedicated bi-weekly endoscopy meetings.
- We were told by the cardiology specialist nurses that they wanted to improve on the services that they offered, for example they wanted to set up a heart failure service to improve the overall health of atrial-fibrillation (AF) patients. They had a consultant involved that was helping with their plans but due to capacity of staffing it could not be developed at the present time. Atrial Fibrillation (AF or A-fib) is an abnormal heart rhythm characterised by rapid and irregular beating of the atria.
- Projects for further cardiology interventions were at the forefront of the cardiology teams planning. For example, Cardiopulmonary Exercise Testing (CPET) and Cardiac Stress MRI were projects the department was planning to do in the future.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff we spoke to were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.
- There was strong collaboration, team working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.
- Staff told us that middle and senior management were very visible and accessible if needed. There was an open-door policy with all management and staff spoke very highly of the senior team.
- We spoke to staff and they were aware of the organisations freedom to speak up guardian and how to contact them. However, all the staff we spoke to told us that their peers, middle management and senior management were very approachable and supportive and therefore had no need for the guardian at the present time.
- We observed posters displaying a whistleblowing helpline number and safeguarding flowcharts for any concerns.

Governance

- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to benchmark and improve care outcomes. A multidisciplinary daily huddle was carried out whereby each manager from every department confirmed staffing, safeguarding

concerns, incidents and complaints and any issues with patient safety. Following this huddle, a morning huddle was carried out with the individual teams in endoscopy and cardiology.

- Regular staff forums and newsletters were available for staff to keep updated within their own department and the wider hospital.
- There was evidence of oversight of staff training, competences and maintenance of professional registration as well as systems in place for shared learning.
- The hospital produced a governance and quality report quarterly with targets to be achieved for compliance. We saw evidence of these reports which included hand hygiene, mandatory training, staffing and complaints.
- The hospital was in the process of developing a new policy for interventional cardiology that would include angioplasty, electrophysiology and devices with detailed sections on bookings and admissions, preoperative, anaesthetic, intra-procedure and emergency contingency guidelines. This policy was work-in-progress by the cardiac forum.

Managing risks, issues and performance

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service recognised risk in various ways, such as through environmental risk assessments, clinical risk assessments, staff discussions and external sources such as health and safety requirements.
- The endoscopy and the cardiology department demonstrated commitment to best practice performance and risk management systems and processes. Staff at all levels had the skills and knowledge to use the systems and processes effectively.
- Managers proactively managed risk and had contingency plans in place to react and manage unexpected events. For example, agreements were in place with external companies for equipment breakdown. Records showed that some equipment had needed maintenance, and this was actioned. This assured us that processes were in place when unexpected events occurred and that these processes were effective.
- We observed that water infection was on the departmental risk register. This had been an ongoing risk since the build of the hospital and it was regularly discussed. There were actions being taken to resolve this issue.
- The hospital produced a document for staff identifying the top five risks and an appropriate risk rating. This document was mirrored with the risks in the department which all had red, amber and green (RAG) rating scores.
- Staff attended national forums on a quarterly basis. This enabled the services to share and obtain information relating to endoscopy and cardiology risks and performance. Similarly, the cardiology specialist nurses attended the Spire quarterly critical care nursing network meeting. In addition to these meetings, both endoscopy and cardiology attended working groups based within Spire.
- The cardiology service had developed a clear audit plan for 2019, which included WHO checklist audits, cardiovascular outcomes and nursing notes against the patient care pathway and nursing risk assessments. Data was not yet collated for this period but results for the six months prior to the inspection were demonstrating that objectives were being met.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. We saw evidence of this through governance and quality board meeting minutes.

Managing information

- The service collected, analysed, managed and used information well to support all its activities. There were systems and processes in place to maintain security of information including patient records. Paper records were stored securely in a locked room and information technology systems, email correspondence and electronic records were encrypted.
- Images could be transferred securely to other NHS trusts and GP surgeries.

- Information governance was part of staff mandatory training and this included General Data Protection Regulation (GDPR) training. Figures demonstrated that both departments training in this subject were 100% compliant to the organisation target of 95%.
- The hospital external website was easy to navigate and easy to place an enquiry. Information provided on the website included endoscopic procedures, interventional cardiology procedures, consultant information and costs of treatments.

Engagement

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Inspiring people awards were regularly given out. Staff could nominate individuals and vouchers would be awarded. Staff told us that this encouraged them to put people forward for awards.
- Objectives were graded one to four through the appraisal process and staff told us the higher the level achieved, the greater the salary increase. Staff told us that this was an incentive for them to ensure that they kept up-to-date with their development.
- We were told by senior management that they had good links with the local commissioners which was helping to raise the profile of the hospital. For example, Manchester's locality plan, 'Our Healthier Manchester' had strategic aims to improve the health and wellbeing of the people of Manchester and Spire were working with the local commissioners by proactively supporting people's health and holding free events within the hospital, such as hip and knee pain advice, free heart health events, free cosmetic surgery events and injury prevention for runners. These events engaged both patients, their families and staff.
- Senior management used multiple methods of communication as they recognised that e-mail communication was not always effective as some staff did not always look at their emails daily. We observed video blogs that had been produced to help get key messages to staff. For example, duty of candour, risk management and changes to the daily crash call test. These blogs were welcomed by the endoscopy staff as they did not access their computers daily.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning when things went well or wrong, promoting training, research and innovation.
- We observed a new procedure following a new implementation plan which had just been authorised to be carried out within the hospital. It had been examined and had gone through various levels of approval, such as the medical advisory committee to ensure that it was evidence based and safe for patients. The procedure was a minimally invasive endoscopic procedure for the treatment of gastroesophageal reflux disease, which delivers radiofrequency energy in the form of electromagnetic waves through electrodes at the end of a catheter to lower oesophageal sphincter (LES) and gastric cardia (the region of the stomach just below the LES. This procedure was classed as non-surgical and patients would not require an inpatient stay. The hospital was waiting for the radio-frequency kit to be delivered and then patient lists could be booked and carried out.
- The cardiology team were planning to do national events in addition to the local events that they currently carried out. For example, staff wanted to attend events countrywide to show patients how to take their own blood pressure and pulse rates. In addition to this, staff told us that they would like to attend more critical care events as both specialist nurses were advanced life support trainers and trained to teach the module. These plans would be commenced when more staff were recruited into the service.

Outstanding ☆

Surgery

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

Are surgery services safe?

Good ●

We rated it as **good.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- More than 96% of theatre and ward staff had undertaken most mandatory training modules against a target of 95%.91% of staff had completed the information governance module.
- Managers could easily see which members of staff on their team had completed training.
- Not all frontline staff had protected time to complete mandatory training.However, the staff we spoke with told us that they could usually find time within their schedule to complete training.Staff that completed online training at home and could claim back time for this.Some staff had "productive" days where they could review updates to policies and guidance.
- We reviewed four staff files and saw staff were up to date with mandatory training.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The staff we spoke with could give examples of when they had raised safeguarding concerns in the past.
- More than 96% of theatre and ward staff had undertaken adult safeguarding training and more than 93% children safeguarding training (the target was 95%). There were also safeguarding leads within the service that staff could refer to for advice. There was a poster clearly showing who the safeguarding lead for the service was.
- There was a paediatric safeguarding lead who staff could refer to should they have any concerns about children using or visiting the service.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. They used control measures to prevent the spread of infection.
- The hospital had a link nurse for infection prevention and control who staff could refer to for any queries. The link nurse undertook quarterly hand hygiene audits with the ward areas achieving 100% compliance in the most recent observational audit.
- Hand gel dispensers were on the entrance and exit of each ward and in theatres. Each patient bedroom had hand gel dispensers and a sink. There were numerous posters throughout the hospital reminding staff, patients and visitors to wash their hands. We observed staff regularly using hand gel on the entrance and exit of wards and theatre areas.
- The hospital operated a bare below the elbow policy.
- Patients that met certain criteria were screened for Meticillin-resistant Staphylococcus aureus during pre-assessment.
- Equipment within the wards had green "I am clean" stickers on them with the date they had been cleaned.

- Decontamination of surgical equipment was the responsibility of the sterile services department. They were present at every morning theatre briefing to provide updates on the autoclaves and washers.We saw theatre equipment being cleaned post-operatively and a record being made in the theatre logs.
- The service had low rates of surgical site infections. Of the 5,300 surgical procedures carried out between October 2017 and September 2018, there were 11 reported surgical site infections (a rate of 0.2%). In December 2018, Public Health England published details of surgical site infection rates.It stated that between April 2013 and March 2018, reporting hospitals showed infection rates for hip and knee replacement surgery as between 0% and 2.9%, and 0% and 2.8%, respectively.In comparison, of the 153 hip replacement operations conducted at the hospital in the 12 months to September 2018, there were zero surgical site infections. There were three surgical site infections (1.9%) for knee replacement procedures.
- However, we observed a member of staff put a dressing on a patient's arm without using gloves during one surgical procedure.

Environment and equipment

- The service had suitable premises and equipment and looked after them well. The areas we visited were visibly clean and tidy.
- The two ward areas were clearly signposted. The entrances to the wards required secure access with entry controlled by the respective reception desks.
- We saw that the equipment used in wards and theatres, including anaesthetic equipment, had been safety checked and were serviced regularly, including annual reviews of critical theatre ventilation systems.
- The hospital had a forward planned preventative maintenance programme for theatre and this was monitored using an electronic database.
- The hospital had enough surgical equipment, and this was available and fit for purpose.This included equipment for bariatric surgery.
- Inpatients had private bedrooms with their own en-suite facilities. There was free Wi-Fi and a TV in each room. The rooms had a large shower area with hand rails which provided sufficient space for patients with mobility issues.
- We spoke with five patients who complimented the standard of the inpatient rooms. The heating and ventilation controls in one bedroom did not work properly, but staff addressed this quickly by placing a fan in the room.
- We checked several fire extinguishers and saw they had been serviced appropriately.
- Doors within the hospital had a sticker indicating their specific fire rating. This allowed staff to easily recognise how long each door could withstand a fire.
- Each ward contained a dirty and clean utility room. The clean utility room, which contained medicines, was locked and required a security pass to enter. Within the room the individual cupboards containing medicines all required keypad security access. The dirty utility room contained details about the different coloured clinical waste bags and what should be placed in each.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- Staff completed a risk assessment form for each patient. This simple checklist helped staff establish whether there was a clinical risk to a patient having surgery. Those patients identified as having an anaesthetic risk attended an anaesthetic clinic to establish suitability for surgery.
- The hospital had developed an enhanced clinical risk assessment (this was a draft document at the time of the inspection) that assessed patients against a list of 16 comorbidities. The results would determine whether a patient was safe to be admitted to a general ward; needed an anaesthetic review; needed admission to the critical care unit; or required a multidisciplinary review (including pharmacy and cardiology).

- The services planned operations 10 days in advance.Staff discussed the procedures and any risks that needed to be considered including patient allergies, anaesthetic risk, the availability of equipment, and patients with individual needs.
- Patient lists were rarely changed. However, if there was a requirement, the paperwork used for the theatre list changed colour to make it clear to all staff members. If the list had to change again, an incident would be raised and investigated.
- The theatre team met daily at 7.45am to discuss that day's theatre list.We observed one briefing.Staff discussed specific patients and whether there were any anaesthetic or allergy risks, the equipment available, and staffing requirements.
- Staff completed a "stop medication form" for patients prior to surgery.Patients were also given clear information about what to do with their medication in the event of the surgery being delayed or cancelled.
- Each bedroom had a call bell, emergency buzzer and a cardiac buzzer.We observed staff responding to the cardiac buzzer drill appropriately.
- The five patients we spoke with told us that staff responded quickly to the call bell.
- Staff in the inpatient wards operated intentional rounding whereby
- The 12-bedded recovery area was situated close to the critical care unit with direct access should patients deteriorate rapidly after surgery.
- The hospital had a Major Haemorrhage Policy that set out the steps staff should take (including out of hours) if a patient experienced major blood loss.Staff could quickly access blood stocks which were located close to the theatres.
- Certain staff within the recovery and theatres had been trained in emergency paediatric life support and were on duty when required.
- Anaesthetists only sedated the next paediatric patient once the previous patient was stable in recovery. This allowed them to better respond to emergencies.
- If necessary, patients having complex spinal surgery would attend a dry run to help the theatre team ensure that they could properly position them to reduce the risk of surgery.It also helped operating department practitioners prepare the medical trays and understand the equipment the surgeons required.
- The hospital had introduced an initiative called 'Stop Before You Block', a campaign aimed at reducing the incidence of inadvertent wrong sided nerve blocks.
- The resident medical officer conducted daily ward rounds to review patients and their medication requirements. They could be called earlier should patient needs dictate.
- The hospital used the latest version of the National Early Warning Score which was updated in December 2017. The system helped staff identify deteriorating patients (and those with sepsis) quickly and had been endorsed by .The same system was used to ensure that only medically fit patients were discharged.
- The ward manager (responsible for both wards one and two) held a daily staff briefing each morning updating staff on any incidents, changes to patients' conditions, and any new patients due to be admitted that day.
- The hospital operated a surgical safety checklist. We observed six checklists being completed over a two-day period. Most of these checklists were completed thoroughly, and there was strong communication between the theatre team with all members participating.However, on two occasions, we found that the time-out stage of the checklist was not as comprehensive as it should have been.The teams did not introduce themselves by name and by role. One of the surgical teams also did not discuss any anticipated critical events that might occur during the procedure.
- We told the provider about this during the inspection and within 24 hours a team from the head office had conducted an audit (an observation of three-time out procedures).The audit found that most staff were engaged with the process.It highlighted one procedure where a member of staff had to intervene to ensure another fully engaged. However, this demonstrated that staff felt empowered to challenge others.
- The hospital audited compliance with the surgical safety checklist. In March, May and July 2018 observational audits showed that staff followed the checklist every time. However, there was a decline from 91% to 84% in

the document audit (the target was 95%). We spoke to the hospital about this at the time of the inspection.They told us that the results had prompted them to speak to some consultants to remind them of their responsibilities relating to documentation. Results from November 2018 showed that compliance with documentation had increased to 92%.

Nursing and support 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 level of care and treatment.
- The was a relatively low rate of bank and agency staff in the inpatient wards, averaging at approximately 10% of the 12 months to November 2018. This was higher at the start of the reporting period but had steadily declined.
- There were low levels of sickness rates in nursing staff in the wards and theatres; an average of 2.2% and 4.1% respectively for the 12 months to November 2018.The Spire target nationally was 3%.
- Theatre boards included details of the patients listed for that day, the theatre team, and confirmation that staff had the appropriate skills. This included staff with advanced and basic life support training, and blood transfusion competencies. The service ensured there were always two operating department practitioners on call with the required competencies to provide cover when necessary.
- There were appropriate staffing levels on the wards: 1:5 (morning), 1:6 (afternoon), 1:7 (overnight).There were appropriate staffing levels in the day case unit (1:7). Three healthcare support workers had also recently been recruited to the day case unit to provide additional support.
- There were two members of staff per paediatric patient in the recovery area; one to ensure all paperwork was complete, and another to monitor the airway.An anaesthetist could be easily called if required.
- Two additional pre-assessment clinic staff had been recruited which meant there were now three staff assessing a patient's suitability for surgery.
- There was a corporate induction for all new staff joining the hospital which included the values, promises, history and strategy of the organisation. Staff were expected to complete training in several core competencies.
- However, some staff voiced concerns about the ability of the existing staffing levels to cope with increasing demands on the service. Whilst staff felt the hospital still provided safe patient care, they told us that any shortages were covered by goodwill.
- There were high turnover levels of inpatient nursing staff in the last 12 months (27%).However, the hospital had recognised this was a concern. New staff were being recruited in most departments, the ward manager had begun a preceptorship programme to attract, recruit and retain student nurses. A theatre manager had recently been recruited.

Medical staffing

- The hospital had a service level agreement with an agency to supply two resident medical officers who worked rotating periods to cover the service 24 hours per day, seven days per week. The agency provided appropriate training for the resident medical officers, including adult and children safeguarding, mental capacity, advanced life support, immediate and advanced paediatric life support.They also received a hospital induction.
- There was always a resident medical officer on the premises who carried out routine work during daytime hours and who was on call out of hours. There was a separate resident medical officer who covered critical care. Shift patterns ensured resident medical officers had sufficient break periods. After each shift there was an effective verbal and written patient handover.
- If a resident medical officer became sick, there was an agreement with the agency to provide another within four hours.
- On call medical staff had committed to being able to attend hospital within 25 minutes if required.

Records

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

- Most records within the surgical service were paper-based. The paperwork for admitted patients were stored in a locked room behind the nursing station in each ward.Older records were kept within the medical records department which required secure access.
- We reviewed 16 medical records and drugs charts.All contained appropriate assessments for venous thromboembolism, allergies, nutritional requirements and risk of falls.
- A 'patient alert' sticker was placed on the front of any patient files to clearly highlight to staff if there was important information they needed to be aware of. In addition, a red sheet was placed at the front of the file providing further detail of the alert, including sensory impairment, dementia or physical disabilities. The alert had a 'date active' and a 'date inactive' date.
- Records included information about allergies, anaesthetic difficulties, safeguarding issues, do not attempt cardiopulmonary resuscitation orders, refusal of blood products, or infections.
- Discharge documentation could be shared electronically with patients' GPs if the GP practice had signed up to use the same information sharing system. Otherwise patients were given copies of their discharge summaries to give to their GP
- The hospital conducted a quarterly medical records audit.
- Where necessary, individual patient records where kept in a wall mounted folder within private rooms. They could not be seen by passing members of the public.

Medicines

- The service followed best practice when prescribing, administering and recording medicines.
- We reviewed 12 drug charts. All charts contained venous-thromboembolism assessments, and details of any patient allergies.
- We saw that controlled drugs were stored securely.
- The control drug registers were up to date, and there was a clear procedure for destroying controlled drugs.Controlled drug registers checks were carried out weekly to ensure they were completed fully by consultants. Staff were empowered to challenge and report those consultants that did not complete the registers when they should.
- Patients own medicines were stored in bedside lockers that had secure keypad access.Staff would assess a patient's ability to self-administer and would support them to do so if appropriate.
- Staff had access to the latest version of the British National Formulary (a reference book that contained information and advice about prescribing specific medicines).
- Medicines were prescribed appropriately, and patients given advice about taking them after they had been discharged
- Staff received training in medicines management, including giving controlled drugs.
- Pharmacy staff carried out twice daily ward rounds with the resident medical officer and nurses.
- Pharmacy staff carried out regular audits, especially of controlled drugs.A new drug chart was introduced which had helped to reduce duplication and made it clearer for consultants and the resident medical officers to use.
- Fridge temperatures were monitored electronically with an alert being raised should the temperature fall outside pre-set parameters.
- There were several resuscitation trolleys and anaphylaxis kits, including one in each ward and within the theatre environment. These were appropriately stocked and showed the expiry date of the drugs contained within.
- There was a sepsis trolley on ward two. This was appropriately stocked with medicines in date. There were clear guidelines on the trolley about how and when to use the medicines, including antibiotics.
- We saw evidence the medicine stocks were checked regularly by the pharmacy team. Any stock that was approaching its expiry date had a different coloured label.
- All prescribing was paper-based.

- The pharmacy was open Monday to Saturday, and there were on-call arrangements for out of hours requests.
- Between September and December 2018 there were seven medication incidents in the theatres and wards. The main issue related to administration errors. There was a clear pathway to report and investigate incidents, and to share learning.
- There was no antibiotic stewardship policy in place at the time of the inspection.However, the pharmacy manager and the infection control lead had drafted a policy, and this had been ratified shortly after our inspection.

Incidents

- The hospital 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.
- Incidents were reported using an electronic system which automatically alerted the manager responsible for the investigation.
- The hospital had reported one never event in the 12 months prior to the inspection.We saw evidence that the event had been investigated.Whilst the final investigation report was awaiting sign off, we saw evidence that immediate learning (via 48-hour flash reports) had been shared throughout the hospital. We also saw an initial action plan that had been developed to help prevent recurrence.
- Staff we spoke with within the wards, theatres and pre-assessment departments were all aware of the never event and when it had occurred. Staff were also reminded, in the daily safety huddles, the number of days that had passed since the last never event. The never event was discussed within the quarterly surgical safety committee. We were assured that the hospital had taken the incident seriously and ensured that it had learned from it.
- Staff we spoke with could clearly articulate what Duty of Candour meant. We saw examples of incidents where the service had followed the Duty of Candour guidelines.
- The service produced 48-hour flash reports. These were used to highlight either complaints or incidents that had led to a change of practice. The 48-hour flash reports were shared throughout every hospital within the group and each hospital had to acknowledge that they had been read and distributed throughout the local service. The flash reports were discussed at three consecutive daily huddles to ensure that all staff had been provided within the relevant information.
- All clinical incidents were reviewed by the medical advisory committee.
- All NHS patient safety alerts were discussed in the surgical safety committee and actions sent to relevant staff to ensure the alerts were acted upon. This included an NHS alert into the risk of harm from inappropriate placement of pulse oximeter probes. We also observed staff discussing this alert in a theatre briefing.

Safety Thermometer (or equivalent)

- We saw evidence of safety thermometer results being displayed outside of wards.This showed that there had been no catheter associated infections, no pressure ulcers, three falls and 95% compliance with venous thromboembolism assessments.
- The hospital updated a scorecard each quarter that showed the outcomes for various clinical measures. It highlighted there were low incidences of venous thromboembolism, falls or pressure ulcers.

Are surgery services effective?

Good

We rated it as **good.**

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The hospital had a comprehensive system in place for managing medical devices and ensuring that these were up to date. Items identified as being out of date were placed in a quarantine area.

Surgery

- We observed staff in theatres and wards adhering to National Institute for Health and Care Excellence guidance on infection control and preventing surgical site infections.
- The 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.
- The hospital took account of the Association for Peri-operative Practice guidelines on accountable items and ensured theatre equipment such as swabs were counted before and after surgery to check that no items had been retained.
- The hospital carried out checks that venous thromboembolism assessments had been conducted on each patient. Between November 2017 and December 2018, there was a 95% compliance rate with these assessments.
- There were several staff huddles to discuss staff activity and specific patients. There was a head of department huddle, led by the hospital director, at 9.15am each morning. Any significant events that had taken part over the intervening 24 hours were discussed. Each department, including theatres, catering, wards, and housekeeping were involved. We observed one handover and witnessed discussions about specific patients, complaints and incidents, and the sharing of best practice. These huddles had been introduced by the most recent leadership team.
- The hospital acted in accordance with the Association of Anaesthetists of Great Britain & Ireland guidelines on Immediate post-anaesthesia recovery (2013) and had at least one member of staff trained in European paediatric advanced life support (the majority of the 15 anaesthetic and recovery staff were trained to this level).
- The same guidelines required services to ensure a dedicated recovery bay for children, which the hospital did.
- The hospital worked to the Association for Peri-Operative Practice guidelines for scrub team staffing levels and management, including two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner, and one recovery practitioner.
- Theatre staff used a team brief board in theatres that displayed the patients being operated on and the order of the list. The board displayed the relevant patient detail in accordance with the National Safety Standards for Invasive Procedures (2015) for team briefs. We witnessed several theatre team briefs, most of which were excellent; staff were focused and participated well.
- The hospital conducted several internal audits. For example, it carried out a review of whether staff had correctly recorded the use of implants, sampling ten patients. Staff complied with the requirements 89% of the time.
- The hospital had introduced a system to track prostheses it used in surgery. Prostheses were scanned in and out of stores which allowed greater stock management control and efficiency.
- We saw evidence that patients had a full assessment of their needs, including social needs – those patients that had carers, or required input from the local authority were identified during initial consultations and pre-assessment.
- Patients were given information at the pre-assessment stage about infection control, pain management, compression stockings and Meticillin-resistant Staphylococcus aureus. They were also given a green bag to bring their own medication to ensure that the hospital knew what they were taking and whether this would affect surgery or any other prescribed medication.

- There was a bariatric nurse to support those patients having bariatric surgery. Following discharge, patients would be given a follow up appointment with the bariatric nurse and a consultant. The hospital could also access dieticians via an agency.
- Of the 210 breast implant procedures performed between October 2016 and June 2018, the hospital had obtained consent from all patients to submit data to the Breast and Cosmetic Implant Registry.
- The hospital completed falls risk assessment audits. his showed that whilst nurses complied with the assessment's requirements most of the time, in one area – "If 'high risk' score has been calculated has a variance tracker been completed with intended actions?" – nurses only completed this section on 33% of occasions. The audit also contained an action plan to address this issue which included additional training for staff.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health. The service used a malnutrition screening tool to assess patients' nutritional requirements.
- Surgical inpatients could choose their meals from a daily menu. Catering staff took dietary requirements into account. There were red alerts on menus for patients with an allergy. Separate kitchen utensils were used for patients requiring gluten free, halal or kosher foods.
- Most of the patients we spoke with told us that the food was good.
- Any patients requiring support to eat were identified during morning handover.
- Of the five inpatients we spoke with, all were provided with water that they could easily reach.
- All five patients told us that staff had asked them about whether they were suffering from nausea after surgery.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief when required. The hospital had an up to date pain management policy
- The hospital used a pain score system (zero to four; four being the worse pain imaginable), and its policy set out guidance on the type of pain relief that would most likely be effective, and guidance on uncontrolled or significant pain.
- 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.
- We spoke with five inpatients. Three of the patients we spoke with told us that staff had asked about their pain score following surgery. Two patients told us that staff only asked if they had pain, not what level it was.
- The hospital had access to several consultants that specialised in chronic pain management. We spoke with one patient who praised the work of this team in helping them manage their pain.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The hospital had produced several pathways for staff to follow including sepsis and recovery.
- The hospital was named as a "Quality Data Provider" by the National Joint Registry. The certificate highlighted the hospital's "commitment to patient safety".
- The National Joint Registry monitored the performance outcome of joint replacement operations. The data showed that between 2003 and 2018, the hospital was performing in line with the national average for patient outcomes for hip and knee replacement surgery.
- The hospital began using the robotic arm for joint replacement surgery in October 2018, so there was insufficient patient outcome data. 51 patients had undergone surgery using this method since the service began.
- The hospital's quality report showed that in 2017, the hospital had submitted data in 29% of cases. This has increased to 70% in 2018.

- As part of the Private Health Information Network (an independent, government-mandated source of information about private healthcare) of 1,131 patients surveyed July 2017 to June 2018, 98% of patients were likely to recommend the hospital to others.
- 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. The hospital sent us its 2019 action plan to help improve health inequalities.
- There were over 6,600 patient visits to the operating theatre between October 2017 and September 2018.There were only 12 unplanned returns to theatre during this time. There was only one unplanned transfer of care to another healthcare organisation.
- The hospital's quality report contained details on the number of perioperative deaths. By quarter three of 2018/19, there had been no perioperative deaths. There were also no patient deaths within 31 days of surgery.

Competent staff

- The service made sure that staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support.
- We spoke with nurses and theatre staff and saw evidence that competency files were kept up to date. For example, most of the recovery department staff were up to date for immediate and advanced life support, and European paediatric advanced life support. Two members of staff had still to complete their advanced life support training but there was a plan in place to ensure they received this.
- New staff underwent a formal induction programme including corporate induction, and training on core competencies. Some staff, including new starters in the day case unit, were initially supernumerary and would shadow a mentor. Other staff, such as operating department practitioners, were not supernumerary but risk assessments were carried out to confirm what type of work they could do.
- We reviewed four staff files and saw they had completed numerous staff competencies including infection prevention and control, consent and the mental capacity act.
- Surgical first assistants were assigned a consultant as a mentor. They also had a log book detailing the work they had undertaken which would be signed off by their mentor.
- Staff had the opportunity to develop and progression plans were discussed in their appraisals. We saw evidence that several staff had taken the opportunity to develop as surgical first assistants. Other staff had also progressed within the organisation to managerial level.
- Appraisals were held yearly but the hospital was aiming to introduce these quarterly.
- Student nurses starting within the organisation were allocated a mentor. They were also given a student nurse pack containing the information they needed to help do their jobs. This included the differing shift patterns in the inpatient wards and the day case area. It included a comprehensive induction checklist of training that nurses had to ensure they completed.
- Several health care assistants were accessing the Acute Illness Management course. The hospital had recruited nursing associates and there were several apprenticeship programmes.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. We saw evidence of consistent multidisciplinary working in the hospital.
- 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.
- Planning for spinal surgery was comprehensive and included detailed multidisciplinary team working. We saw an example of where vascular and spinal surgeons, anaesthetists, operating department practitioners and the pathology team met to discuss a particularly complex patient. There were discussions about major blood loss and plans to mitigate this risk. The team held "dry runs" to ensure that all staff knew their roles in case of an emergency.
- The daily safety huddle and theatre briefings were attended by staff from different departments, including radiology (to ensure x-ray services were available). Staff discussed, amongst other things, patients listed for that

day, any that had complex requirements and what additional measures or staffing might need to be put in place, and on-call arrangements. This helped services to run efficiently.

- Consultants, physiotherapists, nurses and theatre staff could be involved in pre-operative assessments to help the admission and discharge of complex patients.
- Physiotherapists were involved in the discharge of all orthopaedic patients.
- Physiotherapists were based on the day case unit. They could liaise with the ward manager about patient lists and provide advice to staff and patients about surgery including anterior cruciate ligament procedures and joint surgery
- The hospital could access occupational therapists (via an agency) and social services should their circumstances require it.
- Patient discharges were planned from their first consultation with a surgeon. Expected discharge dates and recovery plans were discussed and agreed. All five patients we spoke with were aware, in advance of their admission of their likely discharge date. One patient told us how their recovery plan included use of the physiotherapy services at the hospital.

Seven-day services

- The hospital provided some seven-day services.
- Most operations were conducted between 7.30am and 9pm when the final patient should be in recovery. However, some consultants provided surgery (primarily spinal) for patients during the weekend. Staffing for weekend surgery was provided on a voluntary basis, but the service was considering moving to a six-day working week.
- Emergency surgery could also be conducted out of hours if necessary.
- 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 24 hours a day, seven days a week service. This included orthopaedic/musculoskeletal physiotherapists who could help discharge patients outside of normal working hours.

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 day room on ward two 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 understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff had training on consent, the mental capacity act and deprivation of liberty safeguards as part of their core competency training.
- Staff we spoke with could explain the process of assessing a patient's capacity. This included requesting a review by the resident medical officer to conduct a mini-mental state assessment. Staff could provide examples of where a patients' surgery has been delayed due to concerns about a patient's capacity to consent. Staff also gave examples of where multidisciplinary teams had to make best interest decisions.
- Staff in the pre-assessment clinic checked that patients understood the procedure they were due to have. They told us that they would speak to the consultant should they have concerns about a patient's ability to understand and consent for surgery.
- Of the four records we reviewed during our inspection relating to cosmetic surgery patients, all had received the required 14 day cooling off period as recommended in the Royal College of Surgeons publication 'Professional Standards for Cosmetic Practice'.
- The provider had produced a clinical briefing document to provide an overview for staff about the Mental Capacity Act (2005)

Outstanding ☆

Surgery

Are surgery services caring?

Outstanding ☆

We rated it as **outstanding.**

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- One patient described the ward staff as "excellent, efficient and super friendly".
- We observed theatre staff talking to patients in a friendly yet professional manner during surgical procedures. They clearly explained what would happen during the operations.
- Five ward staff, including the ward manager, had undergone additional training run by the National Dignity Council and had been awarded certification as Dignity Champions.
- Staff within the ward could easily maintain patients' privacy and dignity as every patient had private rooms. We observed staff asking patients whether they preferred their doors open or closed.
- One patient told us how their dignity was maintained by staff including when changing their wound dressings.
- All five patients we spoke with explained how staff responded quickly when they were in pain, and that staff responded quickly to call buzzers. They told us how staff at all levels took time to interact with them. Patients did not consider nurses or medical staff to be rushed.
- We observed staff in the reception area of the pre-assessment clinic offering to go through the patient's details in a quiet part of the waiting area.
- The recovery area contained 12 bays which could be individually curtained off. It was also easy to segregate the bay used for children.
- Staff responded compassionately to patients that were in pain. All patients told us that their pain had been well managed.
- The hospitals friends and family test scores were consistently high, averaging 97% of patients recommending the service between June and November 2018. The average response rate was 32%.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- We spoke with a patient who described how staff kept them and their family involved with their care. This included an example of staff telephoning a patient's partner when the patient was confused (due to pain medication) to update them on their clinical progress.
- We observed two members of staff helping and encouraging a patient to walk following orthopaedic surgery. Staff did not rush the patient and ensured they were given enough time to practice.
- The hospital's 'Tulip Room' was available to staff, patients and relatives for use in holding sensitive and distressing discussions, and for breaking bad news. This area also provided patients living with dementia a calm place to wait or breastfeeding mothers a place to breastfeed.
- Staff could describe making adjustments to help reduce anxiety in a patient with learning disabilities. This included allowing their companion to be with them at every stage of the clinical process.

Understanding and involvement of patients and those close to them

- We saw evidence of different support groups that staff could refer patients to
- Confidential discussions could be easily had in the private patient rooms.
- The hospital provided examples of how it involved patients and those close to them. For example, a patient requiring major spinal surgery, and their family, were involved in a number of multidisciplinary team meetings to understand their care requirements. A further patient with complex medical and psychological needs also had several multidisciplinary team meetings at their bedside. They were supported through a planned discharge and treatment plan, to community based care.

- The hospital carried out" dry runs" for those patients having complex spinal surgery. This provided those patients the opportunity to understand what will happen to them on the day of surgery, ask questions, and gain reassurance.
- Staff carried out pre-admission telephone calls to patients to confirm the logistics of the admission, and also to give patients the opportunity to further discuss any concerns or questions they might have about their procedure.
- The hospital told us that patients could be admitted the night before surgery for non-clinical reasons, including where patients were anxious or had large distances to travel.
- The hospital provided chaperones to patients if they required it. There were signs in patients' bedrooms and we saw further information in the pre-assessment room.

Are surgery services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- The hospital planned and provided services in a way that met the needs of local people. It put peoples' needs central to the delivery of tailored services.
- The hospital's facilities and premises were innovative and met the needs of a range of people who used the service.
- 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 main reception area provided details to patients and visitors about the different ways and formats information could be provided. This included leaflets in large text format and braille, and hearing loops set up at various parts of the hospital. The hospital could provide interpreters including sign language and a foreign language translation service .
- The day room in ward two contained contacts for local support groups including the Manchester City Council Dementia Support Team.
- The hospital's pre-assessment team identified those patients that required interpreter services and would pre-book support for appointments.
- The hospital had a dementia lead who could support staff that had questions about caring for patients living with dementia. The dementia lead would ensure that staff undertook dementia competencies.
- The hospital had several "dementia friends" (who were volunteers) who could provide advice to staff and family members about patients living with dementia. These staff were clearly identified within the ward's areas. Staff had training in dementia included in their core competency assessments.
- There were large information boards within each ward area containing photographs of the staff on ward and their roles. The board explained what the different uniform colours meant.
- The boards contained individual promises to patients about how each member of staff pledged to care for them. For example, one member of staff promised to "deliver a high standard of care to all my patients by making sure all their needs are well looked after".
- The hospital allowed breast feeding throughout its premises.
- We saw an example of where the hospital had given a patient a later appointment for their pre-assessment visit to help them avoid rush hour traffic.
- The hospital provided a quiet area where staff, patients and visitors could pray.
- We heard examples of where hospital staff had liaised with social services and occupational therapy services to ensure that patients had the right facilities in place following discharge.
- The hospitals vision statement included playing "an active role in the Greater Manchester health economy". We saw evidence of the hospital having meetings with local NHS trusts to discuss patient care.

Meeting people's individual needs

- The service took account of patients' individual needs and proactively sought to understand these.
- The area of recovery designated for children was fully screened from the other bays (used for adults). There were further side cushions for the trolley to further screen the view.
- Staff provided examples of where patients, requiring complex surgery, had been brought to theatre in advance of the procedure to view the facilities, and, importantly, to ensure that they could be positioned correctly for the surgery and to reduce the risk of pressure sores. There was evidence of a holistic approach to meet the individual needs of this patient.
- Staff could describe examples of where patients with learning disabilities, or that were anxious, had visited the hospital prior to surgery to help overcome their anxiety.
- Patients living with dementia were identified during pre-assessment and supported through their care. Staff described a patient that had previously been treated as a day case, but due to ongoing deterioration with their health, and in conjunction with their family, they were treated as an inpatient. The hospital provided additional staff to provide one to one care for the patient.
- The hospital used a "This is me" form for patients living with dementia. This was a simple form that provided details about the person including their cultural and family background, events, people and place important in their lives, and their routine and personality. The form provided information to enable hospital staff to know more about the patient.
- Patients living with dementia were provided with a blue pillow. Along with an alert in their records, the pillow provided an easy way for all staff to readily identify patients living with dementia.
- Patients living with dementia were given a "dementia box" on admission. These contained activities for patients such as colouring books. There were also distraction aids that helped staff distract patients during observations.
- There was a multi-faith prayer room. The hospital worked with different religious faiths to raise cultural awareness. The hospital provided single sex Pilates classes to meet the needs of people from different faiths.
- There were single occupancy changing rooms/toilets for transgender patients.
- Whilst there was no mental health liaison support on site the hospital had access to agency staff who could provide this support where necessary, for example, if a patient experienced post-operative delirium.

Access and flow

- People could access the service and appointments in a way and at a time that suited them.
- Hospital appointments were primarily sent by letter to patients. The pre-assessment clinic staff told us that text reminders were sent to patients in advance of their appointment. Patients would also be telephoned if they did not attend to ascertain the reason and to see if any adjustments could be made to help them attend.
- The hospital had its own pathology services on site which reduced the time taken to obtain test results.
- All five patients we spoke with told us that they were seen in a time scale that suited them.
- Pharmacy staff conducted daily ward rounds and prioritised the review of urgent take home medication to allow patients to be discharged quickly.
- The hospital had a process for emergency out of hours return to theatre. This included on call staff having a commitment to being able to return to hospital within 25 minutes. Anaesthetists would only leave the site once the patient was stable and staff were satisfied the patient was safe.
- The hospital had identified a previous issue with only 35% of patients having a face to face pre-assessment prior to surgery. The remainder were assessed by telephone. This led to some patients being deemed unsuitable for surgery on the day and the procedure being cancelled. In response, the hospital had increased the number of staff within the department (from one to three) and allocated a designated area for the assessments to take place.

- At the time of the inspection 75% of patients received a face to face pre-assessment that helped identify any risk or concerns that would prevent surgery. This pre-assessment helped to reduce the number of cancellations, readmissions and transfers out. The hospital's quarterly quality report showed that for the first three quarters of 2018/19, the hospital was meeting its target for avoiding cancellations on the day of surgery, something it had not done since 2015. There had also only been one unplanned transfer of care in the 12 months to November 2018.
- We saw an example of where pre-assessment checks had identified a complex patient that required additional support from anaesthetists and their GP prior to surgery being booked. There was another example of where pre-assessment checks led a patient having surgery to correct a previously undiagnosed condition.
- Spinal patients and those having joint surgery were also pre-assessed by the physiotherapy team. This helped identify any issues that might affect surgery, but also identified any social factors, including changes to a patient's home, that could be made to ensure they could be discharged quickly.
- Urgent patients could be identified at several stages including their first consultation, pre-assessment clinic, or through multidisciplinary reviews. Complex patients were discussed at theatre briefings and morning huddles.
- Eighteen operations were cancelled in the 12 months to November 2018 for non-clinical reasons. All patients were offered another appointment within 28 days and none of these had their procedures unexpectedly cancelled for a second time.
- The hospital had relatively low theatre utilisation rates of 50%.It had a trajectory plan to increase this to 70% in 2019.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff.
- The hospital had two complaints processes; one for privately funded patients and one for NHS funded patients.
- 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.
- For the year ending December 2017, over 77% of complaints were resolved within 20 working days (against an organisation target of 75%).

Are surgery services well-led?

Outstanding ☆

We rated it as **outstanding.**

Leadership

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. There was compassionate, inclusive and effective leadership at all levels.
- We spoke with several staff about leadership within the hospital. We found that most staff considered the leadership team to be excellent. One member of staff described the hospital director as a "breath of fresh air". Another member of staff described the hospital director and the matron as "inspirational", and a third said the management team made them feel valued.
- The hospital conducted a consultant survey in 2018 which included a comments section. There were several extremely positive comments about the relatively new leadership team including the "excellent changes" and "positive impact" that had been made by them. There were some comments made about the availability of surgical equipment, but these had been recognised by the medical advisory committee and the medical devices committee, both of which had begun work to look at improvements in this area.
- Staff described the leadership team as visible and approachable.
- Part of the hospital's "Fix Build Grow" strategy for 2019 focused on management development and succession planning. The plan aimed to develop a programme to ensure the hospital could identify and produce high quality leaders from within the organisation.

- There were regular staff huddles and briefings in both wards and theatres to ensure that frontline staff received all relevant information.
- 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

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.
- The hospital had a vision to be the "first choice for private healthcare for patients, consultants and GPs in Greater Manchester". It also had a vision to "work in partnership with our local NHS organisations" and "play an active role in the Greater Manchester health economy".
- The hospital's vision included ensuring patients were treated with dignity and kindness, and with respect for diversity in the community. It also aimed to be a "good employer" and work in partnership with local NHS organisations.
- The theatre department had developed a "Fix Build Grow" strategy for 2019.This included increasing theatre efficiency to 70% by the end of the financial year, building stronger relationships with other hospital departments, and growing staff numbers and skill mix.
- The hospital had a clear strategy for 2019 that used the same "Fix Build Grow" framework. This included fixing the staff turnover rates, building on the NHS work it did by developing relationships with local trusts, and growing the patient satisfaction levels to ensure it ranked as a top ten spire hospital.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against strategy and plans. The quarterly quality report provided detailed updates on the hospital progress towards its strategy targets and what actions were needed to ensure continued progress.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns.
- Staff told us that the new senior leadership team, including the hospital director and the matron, had helped produce an open culture within the organisation, especially within the last 12 months.
- The hospital group had implemented the Workforce Race Equality Standard, a requirement for all independent healthcare providers from 2017.The hospital sent us its 2017 submission which showed that, at that time, its systems did not allow it to provide complete data against all nine indicators. As a result, the hospital group had put together an action plan to address this issue. This included, amongst other things, forming an Equality and Diversity Committee, introducing a central tracking system to help better monitor data, and improvements to human resources processes.
- Staff felt empowered to challenge poor behaviour in the organisation. We saw examples of where staff had challenged consultants, and where practising privileges had been suspended to address poor performance.
- The hospital had a Freedom to Speak up Guardian. We saw posters in staff rooms and in wards explaining who the guardian was, their role and how to contact them.
- The hospital had conducted a consultant survey in 2018 asking numerous questions about the quality of service provision, equipment availability and working relationship (amongst others).This showed that 64% of consultants rated the service as "excellent" or "very good".29% rated the service as "quite good" (response rate of 177 consultants).

Governance

- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to develop. Governance arrangements were proactively reviewed and reflected best practice.

- The hospital had a comprehensive system in place to monitor practising privileges. A team reviewed the database daily to ensure that consultant information was up to date. This included General Medical Council registration, appraisals, indemnity insurance, and disclosure and barring service checks. The hospital had recently introduced an automated reminder system that emailed consultants in advance of the expiry of certain information.
- The hospital had a medical advisory committee which met quarterly. The committee was set up to review clinical services and procedures and ensure they were provided by competent surgeons. The committee also reviewed serious complaints and clinical incidents.
- The medical advisory committee reviewed each consultant that held practising privileges every year to ensure that their private work conducted at the hospital has been discussed with their NHS responsible officer. The hospital director also had links to the responsible officers of the consultants holding practising privileges.
- The senior management team and medical advisory committee conducted a biennial review of consultants' scope of practice to ensure that they only carried out procedures they were trained in. Theatre staff were empowered to challenge those consultants who listed patients for procedures they did not specialise in.
- The clinical leadership group met monthly. The group discussed clinical incidents, accidents and near-misses. It also discussed medicines management, patient safety issues and reviewed new policies and procedures. Any action arising from the meeting were placed and tracked on an action log. The log contained details of the agenda item, action required and action owner, and target date for completion. The log also contained details of the progress to date.
- The hospital had a robust system for reviewing potential new surgical procedures. Consultants wanting to introduce a new procedure had to follow a strict pathway. They had to set out the risks and benefits to patients of the procedure, as well as the costs. There was involvement from the sterile services department and the stores department. The report had to detail any research about the effectiveness and benefits of the procedure and set out how the procedure could be audited. The final sign off come from the matron, hospital director, and a representative from the medical advisory committee.
- The acute services manager met with the team leaders on a weekly basis to discuss complaints and incidents, 48-hour flash reports, finance, new procedures and any safeguarding issues.
- Team meetings all used similar agendas to ensure consistency in what and how information was shared. We spoke with a housekeeper who confirmed that they had had monthly meetings to discuss any issues and regularly spoke with the ward clerk to understand what patients were being admitted and what areas would need to be cleaned.
- The hospital had a medical devices management committee that met monthly to discuss issues relating to equipment. We saw minutes for two meetings. Of the 27-people invited to attend the meetings in January and February 2019, about 50% attended.Eight people had not attended either of the meetings in 2019.Actions from the meetings were recorded, with an action and owner, and whether it had been completed. But, there was no deadline dates for the actions.

Managing risks, issues and performance

- The service had good systems to identify risks and plans to eliminate or reduce them. There was a demonstrated commitment to performance and risk management systems and processes. Problems were identified and addressed quickly and openly.
- The service used a daily cardiac arrest drill to provide assurance that every cardiac arrest bleep holder knew what was expected of them in case of an emergency. We observed the response to one drill. Each bleep holder, apart from one, met at a predefined location quickly. The exception was a member of staff that had only been within the service for 24 hours. Whilst they had been told of their responsibilities, this was stressed again, and a short-term mitigation plan was put in place to ensure that they responded appropriately during the next drill.

- The hospital had local safety standards for invasive procedures in place, including the five steps to safer surgery. The safety team brief board was clearly visible and was effective and clearly used to improve and maintain patient safety.
- The hospital had developed a surgical safety guardian role with the aim of improving clinical practice in relation to surgical safety, challenging poor behaviour, delivering training sessions on surgical safety, and co-ordinating human factors training. It was also their responsibility to review team briefs and debriefs to establish any issue or trends and conduct surgical safety audits.
- The surgical safety committee met quarterly, and its purpose was to ensure that the hospital worked in accordance with the groups Surgical Safety Standards in the Perioperative Environment policy. The terms of reference for the committee set out the membership, the number of people present for the meeting to take place (including those members with mandatory attendance). The output from the meeting was reported to the clinical governance committee. There were clear strategic goals, including ensuring compliance with national and legislative requirements, and ensuring the service was patient-centred.
- 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. An overview was presented to each staff at the end of the year as part of a national audit week. Individual hospital areas were highlighted, including general findings and learning that had taken place.
- The hospital had a register in place setting out specific risks to the business and how to control these. There was a total of 16 risks and each had a description, key control and details of how the hospital could be assured the risk had been minimised. We saw specific actions in place, and that each risk had been reviewed and updated.

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.
- In 2018, the National Joint Registry praised the hospital for the timeliness of its data submissions. The hospital was performing “better than expected” when compared to the national average.
- The hospital submitted data to the Private Health Information Network. The network reported that between July 2017 and June 2018, the hospital had “good participation” when reporting data. This meant that the hospital was “regularly submitting complete health outcomes information for the majority of eligible procedures”.

Engagement

- The service consistently engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. It developed its services with participation of staff and patients and there was a demonstrated commitment to acting on feedback.
- Staff could contribute to the design of services. For example, heads of departments were expected to develop their own “Fix, Build, Grow” strategy.
- We saw evidence that senior managers listened to staff feedback. For example, the hospital had recruited a theatre manager to help distribute workload better amongst theatre staff.
- The hospital group operated an Inspiring People award scheme. We saw evidence of staff being presented with a certificate during our inspection.
- The hospital had a three-year patient engagement strategy (2018 to 2020) which was in line with the wider plan to become the “go-to private hospital in Manchester, famous for clinical quality and customer care”. The strategy focused on patient satisfaction levels and aimed to “inform” patients, “listen and learn”, and “act and evaluate” on the information they received.

- The hospital's 2019 strategy included a focus on developing relationships with local NHS hospital trusts.
- The hospital provided details of several support groups for patients and families, including information about early onset dementia. It also had chaplaincy services.
- The hospital operated a "You Said We Did" engagement initiative with patients, seeking their views on how to improve the service. This included introducing changes to the menu offered to patients.
- In April 2018, the hospital held several free health information sessions for patients to listen to, and ask questions about, various health conditions including causes and treatment options for hip pain, robotic surgery for knee pain, the management of back and neck pain.
- The hospital held a staff awareness workshop led by a representative from the Stroke Association who shared personal experiences of accessing healthcare using a wheelchair. The representative was asked to carry out an environmental audit and tweeted about the positive feedback and engagement from staff who attended.
- The hospital secured the service of the Deaf Sign Academy to run sessions for staff on British Sign Language to improve the team's ability to communicate with patients, families, visitors and colleagues with hearing loss.
- The Imam from Manchester Royal Infirmary had agreed to run two cultural awareness sessions for the Islamic religion in March 2019.
- All patients were sent an online survey to complete after discharge.

Learning, continuous improvement and innovation

- The hospital was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.
- The service had a theatres managers group for all hospitals within the North-West region. The group met quarterly to conduct peer reviews and audits. The links with the other sites within the region helped provide staff cover if necessary.
- 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.
- Staff had some autonomy to help design and improve services. For example, the system used to scan prostheses was designed, developed and introduced by staff within the medical devices department. A member of staff told us that they were proud to have been given this responsibility and they were now actively looking at other ways to further improve stock control.
- The medical advisory committee identified that different orthopaedic surgeons liked to work with different surgical kits. This added to the complexity and efficiency of kit preparation by operating department staff. The committee was undertaking work to try and increase the use of a standardised equipment.
- The hospital had access to a robotic arm system to assist during joint replacement surgery. The robotic arm helped reduce the risk of removing tissue from outside of pre-defined areas within the joint and to avoid the removal of healthy tissue. The technology could help reduce post-operative pain and reduce recovery time. The hospital's website referenced studies to support these claims.

Outstanding ☆

Critical care

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

Are critical care services safe?

Outstanding ☆

We have not previously rated this service. We rated it as **outstanding.**

Mandatory training

- The service provided mandatory training in key skills to all staff and managers proactively made sure everyone completed it. Staff in the service had achieved high annual training compliance rates in just over a month from the start of the compliance year.
- The Spire Manchester Hospital mandatory training calendar ran between January and December annually. Core mandatory training included, although was not limited to, modules on safeguarding vulnerable adults and safeguarding vulnerable children; consent; communication; documentation and record keeping; incident reporting; the care of patients with dementia; and, patient centred dignity in care. The mandatory training modules were supported by a range of core critical care competencies.
- The corporate target for completion of mandatory training each year was 95%, with the figures 'reset' at the beginning of each year. For 2018, the critical care service reported 100% compliance with mandatory training.
- At the time of the inspection in February 2019, 82% of all mandatory training for 2019 had been completed for the critical care service.Six staff out of a total of 19 permanent and bank staff members had fully completed their mandatory training at the time of the inspection, with the deadline for remaining staff being the end of the calendar year. The critical care manager expected outstanding training to be completed in due course when relevant staff returned from absence, during the next bank shift, or when training courses had been pre-scheduled.

Safeguarding

- The service had comprehensive systems to keep people safe, which took account of current best practice. Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The whole team was engaged in reviewing and improving safety and safeguarding systems.
- All staff in the critical care service were up-to-date with their safeguarding vulnerable adults' level two training and safeguarding vulnerable children level three training. This was in line with guidance provided in the Intercollegiate Document: Safeguarding children and young people: roles and competencies for health care staff 2014. It exceeded the hospital's training target of 95%.
- Training included the awareness, recognition and reporting of suspected female genital mutilation and child sexual exploitation.
- When appropriate, older paediatric patents (16 and 17 years old) were risk assessed for suitability of transfer to the adult wards rather than to the children's ward after their critical care admission. Younger paediatric patients were reviewed and supported in the unit by the hospital's paediatric nurse.

- Staff were aware of, and could describe, the types of safeguarding incidents that should be reported. Staff were aware of how they could access further help and advice.
- Any known safeguarding concerns were shared with relevant departments and staff following the patient's pre-admission assessment consultation.
- The hospital's matron and child safeguarding lead were trained to level four and could provide advice and assistance to staff in the service as required.
- A 'missing child' protocol and flowchart was prominently displayed in the unit.

Cleanliness, infection control and hygiene

- The critical care service controlled infection risk well. Staff proactively kept the equipment and the premises clean to a high standard. They used control measures to prevent the spread of infection.
- We observed all treatment areas and rooms in the unit, including the clean utility, sluice utility, patient shower-rooms, kitchen, storage room and staff room. All areas were visibly and spotlessly clean, tidy and uncluttered.
- Housekeeping staff cleaned the environmental areas while nursing staff cleaned beds and equipment. We reviewed the cleaning rota, which was fully completed for all days the unit was open. Laminated cards were used to identify when bed bays had been completely cleaned and were ready for admission of the next patient.
- Disposable curtains were used around each bed bay to maintain privacy. These were all visibly clean and the last date of change had been clearly recorded.
- There were enough antibacterial hand-gel dispensers throughout the unit, and within each bed bay. Hand wash basins were located within each bed bay.
- We observed staff complying with the 'arms bare below the elbow' protocol, washing their hands between patients and using personal protective equipment including gloves and aprons. This was in line with the NICE QS61 statement three: "People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care".
- Green 'I am clean' stickers were used throughout the unit to identify equipment that had been cleaned and was ready for use. Staff also used laminated signs in each bed area to confirm that the whole area had been cleaned and was ready for use for the next patient.
- Staff appropriately followed and recorded tap flushing processes, including in the patient shower-rooms and kitchen areas. At the time of the inspection two, back-to-back washbasins had been taken out of use as water tests had identified the presence of a bacterial load in one of the basins. There were enough washbasins throughout the rest of the unit to maintain effective hand hygiene standards. Flushing, treatment and testing of the basins over a period of six weeks was ongoing at the time of the inspection; however, the hospital later provided evidence that treatment had been successful. Water quality was monitored through the hospital's quarterly water safety group.
- Infection control was given a high priority in the service. Patients were screened for any potential infections at the pre-admission assessment stage. In line with the hospital's policy, patients who had positive results were treated, and rescreened, prior to admission to hospital. As a result, there had been no cases of hospital acquired methicillin resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus, and Clostridium difficile (C. difficile) on the unit in the previous year. One case of Escherichia coli (E. coli) was identified; however, this was not acquired in the critical care service.
- The isolation room was used for patients with active infections and had a separate negative pressure ventilation system to reduce the risk of any infections spreading.
- The service had a link nurse for infection prevention and control, who delivered regular training and updates to staff.

Environment and equipment

- The service had suitable premises and equipment and looked after them well. Staff were trained on the use and management of equipment within the unit.
- The unit was purpose built and located on the first floor of a modern building, co-located with the theatres and recovery area.

- Entrance doors to the area, and subsequently to the unit, were protected with a security system operated from the nurses' station. This ensured that patients' safety was maintained.
- The unit provided five beds. Four of the beds were in individual bays and the remaining bed was in an isolation room accessed through a gowning lobby. When available, the isolation room was also used for paediatric patients to maintain their privacy, dignity and safety. An observation window enabled staff to view the room without having to enter it.
- Each bed area included sufficient space for staff to provide safe care and to use equipment safely. Electrical equipment in each treatment area was powered by uninterruptable power supplies from two ceiling mounted pendant arms, each with an independent power supply. This meant that equipment could still be safely used if power to one pendant failed. A business continuity policy was in place to ensure staff could continue to appropriately care for critically ill patients during an emergency.
- All the bays, and the isolation room, were compliant with the Department of Health published Health Building Note 04-02 (HBN 04-02) for critical care units. This guidance determines the equipment that needs to be located in a critical care unit and the minimum amount of space required per bed to safely locate and utilise that equipment.
- The hospital held a central equipment asset maintenance and replacement log, which included equipment for the unit. We did not review the log during the inspection; however, we found no issues of concern in our review of a random sample of portable electrical equipment throughout the unit and in its store room. All equipment we reviewed had been tested and displayed the planned date for the next test. Equipment that was faulty was segregated within the store room and was appropriately labelled as not for use.
- Staff core competencies included training and appropriate use of equipment used within the service. This programme commenced at staff induction and continued throughout the year with four formal training sessions per year supported by equipment manufacturers. Equipment competencies were reviewed as part of staff annual appraisals. We saw evidence of this in our review of four staff files.
- Waste was collected in foot operated bins through the unit. Clinical waste was appropriately segregated, bagged and stored awaiting disposal.
- We reviewed a random selection of equipment and consumable stock held within the clean utility store. A stock rotation system was in place with items stored to encourage the use of oldest stock first. Staff had a developed a simple, but highly effective, colour coded chart to quickly and easily identify the earliest expected manufacturers' recommended expiry date of equipment held.
- Staff recorded any consumable equipment that was due to expire within the communication handover folder. A process was in place with the theatre recovery areas to swap such items so that the equipment was used before it expired; this helped to reduce wastage.

Assessing and responding to patient risk

- Staff took a proactive approach to anticipating and managing risks to people who used the critical care service. Patients transitioned seamlessly from surgery, through the critical care service, and subsequently to the wards because there was advanced planning and information sharing between teams. This was embedded and was recognised as the responsibility of all staff. Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- As the majority of admissions to the unit were planned as part of elective surgery, assessment of each patient's risks, likely dependency, and acuity needs commenced at the pre-admission assessment stage. Staff worked with the admitting consultant, and pre-admission assessment nursing team, to understand individual patient needs. This ensured smooth patient transition into the unit from the theatre recovery area and subsequently out of the unit to the ward.
- To ensure the best possible patient outcomes were achieved, staff in the critical care service worked closely

with other departments in the hospital, including the pre-operation assessment team, the surgical team, the medical team and cardiac team to plan individual patients' care.

- The service ensured appropriately skilled staff were available to support each patient. For example, each shift had at least one staff member with immediate life support or advanced life support training. Similarly, the service ensured that at least one paediatric immediate life support trained staff member was on each shift when a paediatric patient was being cared for.
- All staff on the unit (five permanent nursing staff and 14 bank nursing staff) had undertaken basic life support training. Eleven staff, including all the permanent staff, had been trained in immediate life support and all five-permanent staff had been trained in advanced life support.
- The unit held one resuscitation trolley, which was stored close to the entrance of the unit where it was easily accessible if needed. The trolley was secured with security tags; which meant that staff were assured it had been checked and held appropriate supplies of equipment. We checked a range of equipment and consumables held in the trolley, which were within their manufacturer's recommended expiry dates. We reviewed the trolley check log, which was fully completed daily.
- The service had a service level agreement in place with a local NHS children's hospital for the transfer of deteriorating paediatric patients if this was required. A flowchart was held as a quick reference guide for the steps to be taken in the transfer.
- The service held a copy of its transfer policy along with relevant transfer flowcharts and checklists alongside a prepared transfer trolley, transfer grab-bag, medicines, and portable ventilation equipment.
- Although the unit had not needed to transfer any patients out in the previous year, a process was in place to obtain consultant cover on the unit to enable the resident medical officer and nurse to accompany the patient during transfer. Further, a formal transfer summary using the Safer Care SBAR (situation, background, assessment, recommendation) protocol enabled clear communication and information handover between critical care and ward staff.
- We reviewed five sets of patient records. All five records included risk assessment for the development of venous thromboembolism (blood clot), the development of pressure ulcers, and the risk of falls. We saw evidence that patients were reassessed as their conditions changed, and that blood clot prophylaxis medicines were prescribed and administered appropriately.
- Patients' physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation were continually monitored and recorded to determine if escalation of care was needed. This enabled staff to calculate and, where necessary, escalate the patient's care accordingly, using the National Early Warning Score system.
- The age-specific Paediatric Early Warning Score system was used to monitor paediatric patients and escalate their care accordingly.
- All beds on the unit were connected by telemetry to the nurses' station, which meant that vital signs could be monitored remotely. This was particularly important for one bed that, although used for less complex patients, was not directly viewable from the nurses' station.
- We saw evidence that nursing staff escalated care to the unit's medical staff appropriately and that prompt multidisciplinary team assessment of patients was carried out if a patient showed signs of deteriorating or of developing sepsis.
- Staff had received training in the recognition and identification of sepsis. This included the use of the Sepsis Six bundle, which consists of three diagnostic and three therapeutic steps all to be delivered within one hour of the initial diagnosis of sepsis. Staff had a clear understanding of sepsis and to monitor the signs for it and could access the hospitals sepsis guidelines. Algorithm flowcharts for identification and management of sepsis were displayed around the unit.
- Adult and paediatric resource folders were held at the nurses' station; this enabled quick access to relevant policies and flowcharts in emergency situations including the sepsis screening and access tool, the sepsis six pathway, and the neutropenic sepsis protocol.
- Each patient was reviewed twice daily by a consultant in line with the Faculty of Intensive Care Medicine's Core

Standards for Intensive Care Units 2013. Although there was no microbiology input to the ward round, staff had telephone access to an on-call microbiologist for advice if required. Patients were reviewed twice daily by the critical care pharmacist, who provided advice on medicines and undertook medicine reconciliation for each patient.

- Patients were assessed for risks of developing pressure ulcers. Pressure relieving mattresses were available on the unit, and within the hospital, for any patient identified as being at risk. Staff could contact a tissue viability nurse for specialist advice, if required.
- Although the service did not have a separate outreach team, staff on the unit supported patients in their transfer to the ward. They also supported requests from the ward to assess patients as and when required.
- Safety huddles were held at the start of each shift. A handover document ensured that key information about each patient was discussed during these meetings. Staff were informed of any key messages received from the daily hospital safety briefing, and information from relevant incidents or alerts was also shared.

Nurse and allied health professional staffing

- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- At the time of the inspection, the flexible but varying planned admission demand on the unit meant that the service was staffed by five permanent staff members supported by 14 of the hospital's own critical care trained bank nurses. The service did not need to routinely use agency staff; in the previous two years only one shift had been covered by an agency nurse.
- At least one staff member was scheduled on the rota every day. Additional staff requirements were calculated in line with the expected planned admissions.
- Staff duty rotas, which we reviewed during the inspection, were agreed in advance to ensure enough staff were available for the planned admissions. The service used a safer staffing tool to calculate patient dependency and recommended staffing levels. This meant the service met the core standard recommendation to provide one-to-one care for level three patients and one-to-two care for level two patients.
- Paediatric staffing level requirements were calculated daily and were in line with Royal College of Nursing staffing guidance.
- The ward manager was retained on-call for any unplanned admissions when the unit was closed. Permanent staff also supported the theatre recovery area, and wards, during periods when the unit was closed.
- The critical care service had a dedicated specialist critical care physiotherapist. This meant the service ensured assessment and provision of physiotherapy input for at least 45 minutes per session daily in line with the Core Standards for Intensive Care Units 2013.
- Physiotherapy rehabilitation needs, and expectations were discussed with patients at pre-admission assessment stage. Additional physiotherapy, following discharge, could be provided at the hospital or through referral to community physiotherapy teams. The service had links with a private occupational therapy service to which patients could be referred if required.

Medical staffing

- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service was clinically led by a consultant intensivist.
- The service had 14 consultants. Consultant cover was scheduled for 24 hours a day, seven days a week, with a consultant on call for unplanned admissions on days when the unit was not planned to be open. This meant, at full, capacity there was one consultant for five patients. This maintained, and exceeded, the consultant to patient ratio recommendations of the Core Standards for Intensive Care Units 2013 of one consultant for every eight to fifteen patients.

- All consultants lived within an appropriate area to meet the core standards of attending within 30 minutes. There was sufficient consultant cover to ensure each patient received a twice-daily consultant review again in line with the core standards.
- Consultant cross-cover was in place to ensure continuity of consultant availability during periods of absence.
- Twenty-four critical care RMO medical staff, under contract to the hospital by a third-party provider, supported the service. A critical care resident medical officer (RMO) was scheduled for each shift the unit was open. RMO medical staff were expected to hold a grade of ST4 (specialist trainee in their fourth year of training) or above. At least one RMO was qualified to consultant level.
- We reviewed the medical rota which confirmed there were sufficient medical staff scheduled for the demands of the service.
- Resident facilities, located near to the unit, were available for RMO use.
- A process was in place to monitor the number of hours worked by medical staff on the unit. This ensured medical staff were not 'overstretching' themselves or breaching the European Working Time Directive. Leaders told us they were confident that nursing staff would raise concerns if they felt an individual medic was at risk.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The critical care service, in line with the rest of the hospital, predominantly used paper records with blood test results reported electronically. Pathology tests and results were reported on through the hospital's 24-hour pathology service.
- We reviewed five sets of patient records. All records were of a high standard and included clear, structured care pathways for all types of surgical admissions to the unit.
- We saw evidence of clearly detailed summaries of events requiring admission to the unit, multidisciplinary input into plans for care; risk assessments; monitoring of observations; nutrition and fluid balances; consent for treatment; and discussions with patients were clearly documented. Care was appropriately escalated in the one case where this was identified as being required. This meant staff had access to all the information needed to deliver effective, integrated and co-ordinated care, treatment and support to patients admitted to the unit.
- A range of audits relating to the quality of records were carried out as part of the service's annual audit calendar. Compliance with standards required in the nursing documentation of the care pathway, and with the standard required for patient risk assessments was 98% for both measures in January 2019. Audit of the notes of consultant and doctor review indicated 91% compliance; this related solely to the accurate timing of notes made in the records. All the audits included appropriate action plans that clearly set out the audit objectives, the action required to meet the objectives, an owner for each action and target completion date.

Medicines

- The critical care service had systems in place for the safe storage, administration, prescribing and disposal of medicines. Compliance with medicines policy and procedure was routinely monitored, and the pharmacist provided input into the investigation of any medicines management incidents on the unit.
- The critical care service operated in line with the Core Standards for Intensive Care Units 2013 recommendation for a dedicated critical care pharmacist for every critical care unit. Absence cover for the critical care pharmacist was provided by the hospital's main pharmacy team. However, the pharmacist told us they planned their leave or absences for periods when the unit was closed or was expecting limited numbers of planned admissions.
- The pharmacist received the planned patient admission list at the start of each month. This enabled the pharmacist to start planning care in advance and enabled closer working with the consultants and resident medical officers. The pharmacist proactively reviewed new patients. Patients already on the unit were reviewed twice a day.

Critical care

- With the assistance of our medicine's inspector, we reviewed five sets of medicine prescription and administration charts. All the records indicated that medicines reconciliation had been carried out within 24 hours of admission, and any changes were recorded.
- All medicines prescriptions were legible, signed, dated and documented any patient allergies to medicine. Venous thromboembolism (blood clot) prophylaxis and antibiotic medicines had been prescribed and administered appropriately in line with relevant guidelines for all patients who required them. We saw evidence that antibiotic usage was subsequently reviewed. Any omission of medicines was recorded along with the reasons for this.
- Staff on the unit managed the medicines stock with twice daily stock checks. A stock rotation process was used to ensure the oldest medicines were used first. This reduced any wastage.
- Medicines were held securely in locked cabinets within temperature controlled rooms. An inflammable cupboard was used to store any alcohol-based medicines. We checked a range of medicines and equipment held in these rooms. All were within the manufacturers' recommended expiry dates.
- Temperature sensitive medicines were stored appropriately within locked fridges. A random selection of medicines in the fridges were within the manufacturers' expiry dates.
- Staff manually recorded the maximum, minimum and actual temperature ranges within the ambient temperature of the rooms and in the fridge. A process was in place to seek advice from the pharmacy if the recommended temperatures ranges had been exceeded. Staff told us that such advice could include shortening the 'shelf-life' of the affected medicines, or disposal of the medicine.
- We reviewed the temperature logs which had been fully completed. An automatic central temperature monitoring system, used in the hospital, was not yet fully operational within the critical care unit. However, staff told us plans were in process to purchase additional sensors which would enable the unit to be appropriately connected to the system.
- Controlled medicines were stored in locked cabinets. We reviewed a range of controlled medicines held and all were within the manufacturers' recommended expiry dates.
- We reviewed the controlled medicines order book and stock log books, which were in a 'theatre style register' that enabled staff to document wastage. A review of the entries showed these medicines had been appropriately signed for by two staff members, and stock levels were accurately recorded. There was evidence within the logs of quarterly pharmacy review.
- Patients' own controlled medicines were kept separately within the controlled drugs cabinet and were recorded using a separate register. We reviewed the register which had been appropriately completed.
- An emergency intubation drugs grab-box was stored on the unit. The box was usually filled by the pharmacy. During the inspection it was noted that the box had not been restocked after use on the previous weekend. We raised this with the critical care manager who took immediate action to address the issue.
- Anaphylaxis kits were available on the unit and held with the transfer trolley. These were sealed units; all seals were intact and within the recommended expiry dates.
- Staff used denaturing kits in the disposal of unused controlled medicines, which was managed through the hospital pharmacy.

Incidents

- The service managed patient safety incidents well. There was a genuinely open culture in which all safety concerns raised by staff and people who use service were highly valued as being integral to learning and improvement.
- Staff recognised incidents, including near misses, and reported them appropriately on the hospital's online incident system. Incidents were automatically referred to the ward manager to review and to decide what level of investigation was required. All unplanned admissions to the unit were recorded as an incident so that learning from these could be shared.

- When things went wrong, the unit's leaders thoroughly investigated, appropriately included staff in evidence gathering, and analysed the available information to identify lessons from each incident.
- Staff apologised and gave patients honest information and suitable support during and following incidents. Staff had received training in, and were able to describe their responsibilities under, the duty of candour.
- Staff confirmed they received feedback from incidents and learning from them was shared in the daily safety huddles and staff meetings. Learning from incidents external to the unit were also identified and shared with staff. This included feedback from relevant incidents that occurred in other parts of the hospital through the daily hospital safety briefing, or within the provider's hospital network through a 48-hour flash briefing. Incidents were discussed in the unit's governance meetings.
- Between January 2018 and December 2018, a total of 18 incidents were recorded by staff on the unit. Eleven of these were assessed as causing no harm to the patient, while the remaining were classed as causing low/ minimal harm. There were no incidents that resulted in moderate, severe harm or death. We reviewed the incident reports, which indicated appropriate investigation of the incident, actions taken, grading and identification of lessons learned.
- There were no serious incidents reported in the critical care service between January 2018 and December 2018 under the Serious Incident Framework 2015 that met the reporting criteria set by NHS England.
- A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There were no never events reported in the critical care service between January 2018 and December 2018. However, staff had an awareness and understanding of the one never event that had occurred in the hospital since it opened. This demonstrated that learning was appropriately shared with all teams.
- We reviewed the investigation of one medicine management incident in the critical care unit. This related to an apparent 7.5 ml discrepancy in a liquid controlled medicine. The incident had been reviewed appropriately, with advice taken from the pharmacy team. No patient harm was identified. Although the discrepancy was within the manufacturer's tolerance levels for bottle volume of liquid medicines, staff identified that it was likely to be related to wastage due to residue on the single-use bungs used when drawing up the medicine into syringes, particularly where various sizes of syringes were required. Staff had taken quick action to source new bungs that could accommodate different sized syringes to prevent a similar incident from occurring in the future.

Safety Thermometer

- The service used safety monitoring results well. There was ongoing, consistent progress towards safety goals reflected in a zero-harm culture. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. The Spire Manchester hospital submitted data to the safety thermometer programme at hospital-wide level.
- Although we did not request individual performance results for the department, the hospital's performance against the harm free care targets were displayed on the unit. This demonstrated that harm free care was embedded within the hospital and, within the unit it showed 100% compliance. Between 1 January 2018 and 31 January 2019, the hospital reported no incidences of grade two to four pressure ulcers, no falls, no incidences of venous thromboembolism (blood clot), and no catheter related urinary tract infections.

Are critical care services effective?

Good

We have not previously rated this service. We rated it as **good.**

Critical care

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.
- Staff in the critical care service used a wide range of evidence-based corporate and local policies, protocols and patient pathways based on national guidelines, such as the Intensive Care Society, National Institute for Health and Care Excellence, as well as guidance published by the relevant professional medical bodies such as the Royal Colleges and British Medical Association.
- The service's strategy included the aim to become fully compliant with the Intensive Care Society's standards by 2020.
- We reviewed several policies during the inspection. The documents were based on up-to-date evidence and best practice and referenced guidance from the National Institute of Health and Care Excellence, professional bodies, and the Faculty of Intensive Care Medicine's Core Standards for Intensive Care Units 2013.
- The hospital's resuscitation policy linked directly to the Resuscitation Councils flowcharts, and basic life support teaching guidance. The hospital's procedure for the care of children and young people in Spire, referenced the intercollegiate safeguarding guidance and guidance from the Royal College of Anaesthetists, the Royal College of Paediatrics, and the Association of Medical Royal Colleges.
- The hospital's policy for the administration of oxygen linked to guidance from the British Thoracic Society. The policy for the management of Creutzfeldt-Jakob disease and variant Creutzfeldt-Jakob disease referenced guidance from the Health Protection Agency and the National Institute of Health and Care Excellence guidelines.
- The critical care service was part of the Greater Manchester Critical Care and Major Trauma Network. The network provides a whole system approach to the delivery of safe and effective services across the Greater Manchester region. Although the service had not been peer reviewed by the network, it participated in, and submitted data and information to, the network's risk over network (RiCON) project.
- The RiCON project aims to improve patient safety within the regional critical care network by allowing different units to share problems and best practice to improve the quality of care offered to all critical care patients in the network.
- Staff carried out assessment of delirium (acute confusion) in patients at risk of delirium using the 'Confusion Assessment Method for intensive care' (CAM-ICU) guidelines. This was supported using a confusion assessment flowchart which was clearly displayed on the unit.
- Mortality and morbidity reviews which enabled the identification of any areas of improvement or learning for the service, were a standing item in the critical care quarterly working group meetings.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other preferences.
- The hospital had developed links with a local Kosher delicatessen to enable the provision of Kosher meals to patients within the hospital.
- One patient we spoke with described the food as 'really good'. The patient noted that the catering staff would aim to meet patients' preferences by making 'something to suit' if the patient wanted food that was not listed on the menu.
- Although the critical care unit did not have a dedicated dietician, dietetic review and support was available to all patients that required it. Similarly, speech and language therapy support were available if required. A dedicated bariatric specialist nurse supported bariatric patients throughout the hospital.

- The critical care manager confirmed that, although rare, the unit could support patients requiring total parenteral nutrition or nasogastric feeding. This would be prescribed by the consultant on advice from a dietician. All patients were monitored for malnutrition.
- Our record review indicated that the patients we reviewed did not require specialist dietetic input or assessment; however, all five records showed that nursing staff had appropriately and accurately recorded patients' fluid and nutritional balances.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- There were processes in place to assess patient's pain. Individual care plans included pain assessments for all patients, which included observing the signs and symptoms of pain.
- A pictorial pain score tool was used for self-assessment of levels of pain experienced by children. Age-appropriate pathways were in place which provided appropriate guidelines to staff on the provision of medicines and pain relief.
- Pain relief was routinely prescribed as part of individual patient management, and additional pain relief was available at patient request.

Patient outcomes

- Monitoring of the effectiveness of patient care and treatment by the critical care service was in its infancy and still embedding.
- Between September and December 2018, the critical care unit provided planned care for 67 patients, while a further 18 patients were unplanned admissions. Of these patients, three were cared for at level 1, 31 were cared for at level 1b, 50 were cared for at level 2, and one was cared for a level 3.
- Level 1 patients are acutely ill and requiring intervention or those who are unstable with a greater potential to deteriorate. Level 1b patients are in a stable condition but are dependent on nursing care to meet most or all the activities of daily living. Level 2 (also known as high-dependency) patients may be managed within clearly identified, designated beds, resources with the required expertise and staffing level or may require transfer to a dedicated level two facility / unit. Level 3 (also known as intensive care) patients need advanced respiratory support and / or therapeutic support of multiple organs.
- Service leaders told us that, although there were other critical care units within the provider's network of hospitals, benchmarking patient outcomes against these was difficult. This was because few of the critical care units in the provider's network offered directly comparable levels of service. However, the leaders had defined a range of performance metrics and data, that were to be monitored from September 2018 onwards.
- The service monitored the number and types of central, arterial and venous lines inserted during patients' admission to the unit. Of the 85 patients cared for between September and December, 54 patients had venous lines inserted; 30 had arterial and venous lines inserted; and, one patient had central, arterial and venous lines inserted. None of the patients developed infections at the line site.
- Of the same cohort of patients, 27 had urinary catheters inserted during their admission to the unit but none of these developed a catheter related urinary tract infection.
- The corporate provider was not subscribed to the Intensive Care National Audit and Research Centre (ICNARC), which meant that benchmarking the hospital's critical care service against other similar services was not possible. However, the hospital completed local benchmarking by collecting outcome data where measures were comparable
- The service's leaders worked closely with the Greater Manchester Critical Care and Major Trauma Network and submitted data to the RiCON project. This enabled the service to understand the role it played in critical care services in the region, and to share learning and improvements between regional critical care providers.

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.

Critical care

- All five permanent nursing staff and nine of the 14 bank staff had completed a post-registration award in critical care nursing. This equates to a completion rate of 74%, which exceeds the 50% recommendation in the Core Standards for Intensive Care Units 2013.
- New nursing staff to the service underwent a three-day supernumerary unit induction, guided by a set programme checklist. Assessment of clinical and essential equipment competencies were undertaken during this period. This included working two shifts shadowed by an experienced member of staff.
- At the time of the inspection, the hospital had recently introduced an updated set of core competencies which staff on the critical care unit were in the process of completing. We reviewed four staff files, two for permanent staff and two for bank staff. All the files we reviewed evidenced full compliance with and sign-off of the previous core competencies, while completion of the new core competencies was ongoing.
- All bank staff were required to complete the same core competencies as permanent staff. Agency staff were required to undertake and be signed-off on a service specific induction before commencing their first shift on the unit. This included completion of a competency checklist and review of relevant policies.
- Medical staff received a unit induction to familiarise themselves with the critical care unit, policies, procedures and work instructions. This was supported by a handbook given to all staff.
- We reviewed the RMO induction files for 23 of the 24 RMO medical staff working in the unit. All bar four files demonstrated full induction sign-off; the remainder had partially completed sign-off. We discussed this with the critical care manager who confirmed the staff involved had been unable to complete during their first attendance and had not worked on the unit since. The manager assured us that these would be completed by the individuals on their next allocated shift.
- The service supported the use of resident medical officer core skills passports, which provided evidence of core competency skills. These were transferrable throughout organisations within the regional rotation network.
- The critical care service had a service level agreement with a local NHS trust to support five-day placements for staff in the NHS critical care unit providing care for level three patients. This enabled staff to maintain their skills in providing complex care to these patients.
- All permanent nursing staff in the unit had received an appraisal in 2018 through the hospital's 'Enabling Excellence' programme. These reviewed staff competencies and discussed areas of development. Although there was no formal policy for appraisal of bank staff, the critical care manager assured us that she regularly met with bank staff to discuss performance and development.
- Consultant's appraisals were carried out by their substantive NHS employers. However, a process was in place for sharing the appraisal documentation with the service's leaders.
- Team development was supported by staff development days throughout the year and included training scenarios on various subjects including the escalation of deteriorating patient and equipment training. The service was due to participate in a sepsis awareness day later in February 2019.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, pharmacy staff and allied health professional staff supported each other to provide good care.
- All nurses attended safety handover huddle at the start of each shift. Information about each patient, their needs, and any notable events in their care during the previous shift were discussed. The huddle also shared information about safety alerts, incidents, or learning, and key messages from the hospital's daily briefing.
- Consultant ward rounds were undertaken at least twice a day. However, due to the nature of service, it was not always possible to co-ordinate a full range of multidisciplinary representation at each ward round. This meant there was a risk that communication between multidisciplinary team members could be disjointed. However, there was a strong emphasis within the service on achieving effective communication within patient records and ensuring staff could be contacted by telephone for additional clarifications or advice.

- The service had set up an encrypted communications group application for the consultant and nursing staff groups; this enabled staff to share relevant information quickly and securely. This supported the manual communications diary which was held in the RMO office.
- Medicines, including antibiotics, prescription and usage was monitored in a twice daily ward-round by the pharmacist. Although there were no specific microbial ward rounds, timely telephone advice could be obtained from a microbiologist if required.
- There was no dedicated dietetic or speech and language therapy support for the unit; however, staff had contact details to be able to request patient review by a dietician or therapist if required. Staff told us their requests were responded to in appropriate timescales.
- Nursing and medical staff on the unit supported requests from ward to review patients if there were any concerns of the patient deteriorating. Similarly nursing staff supported the transfer of patients from the unit back to the ward.

Seven-day services

- Most of admissions to the unit were planned admissions following surgery. This meant that, currently, the critical care unit was not consistently open seven-days a week.
- However, the critical care service maintained on-call consultant and critical care service manager cover seven days a week for unplanned admissions. This meant the service could respond as required on days when no planned admissions were expected. The service recognised a need for a second on-call nurse; however, as this was dependent on a need to consistently increase activity levels in the unit, it was recorded as a risk on the service's risk register.
- The critical care service was supported by 24-hour radiology and pathology services.
- Resident facilities were located near to the unit which meant there was RMO cover available throughout the day, and on-call at night and weekends when the unit was open. Patients were reviewed twice daily in consultant led ward rounds.
- Staffing rotas showed that nurse staffing levels and consultant cover were enough to meet the Core Standards for Intensive Care Units 2013 during all periods the unit was open.
- Dedicated critical care pharmacy support was provided twice daily by the critical care pharmacist. Out of hours and at weekends the unit was supported by the hospital's main pharmacy team.

Health promotion

- There were limited opportunities for staff to undertake health promotion, due to the nature of the care provided by the unit. However, the service supported staff to promote healthy lifestyles including smoking cessation at relevant opportunities and staff could signpost patients to alcohol liaison services if needed.
- The service supported the hospital's health awareness day.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. All staff had completed mandatory training relating to the two Acts.
- Staff understood their duties to ensure patients had capacity to consent; this included recognition that consent was decision specific. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- Staff were aware of the Fraser Guidelines and Gillick Competencies. Gillick competence is the principle used to judge capacity in children to consent to medical treatment without the need for parental permission.
- Consent was obtained for care and treatment appropriately from patients who were conscious and had capacity to give it. The process ensured the patient could give their decision-specific informed consent.
- Where patients had fluctuating capacity, the resident medical officer undertook and recorded mental capacity

assessments. When the patient was unconscious or did not have the capacity to give consent staff made decisions about care and treatment in the best interests of the patient.

- Staff were aware of the potential impact of delirium on patient's capacity to consent. Staff assessed this using the confusion assessment method for intensive care units (CAM-ICU). Flowchart guidance was clearly displayed in the unit for this.
- Our records review indicated that all five patients had been appropriately assessed for capacity to consent to care and treatment.
- Staff we spoke with had a good understanding and were aware of their duties under the deprivation of liberty safeguards. Although it was rare for the critical care unit to care for a patient who would require a deprivation of liberty authorisation, staff were aware of how to locate the relevant forms and the process to request the authorisation from the local authority.

Are critical care services caring?

Outstanding ☆

We have not previously rated this service. We rated it as **outstanding.**

Compassionate care

- Staff cared for patients with compassion and kindness. All staff including doctors, nurses, allied health professionals, and housekeeping staff promoted a caring, compassionate and supportive environment. People were respected and valued as individuals and were empowered as partners in their care, practically and emotionally.
- There was a strong, patient-centred culture in the unit from all levels of staff. Staff were highly motivated and inspired to offer care for patients with kindness, compassion, and respect through supportive relationships with patients and their families. This was encouraged by the service's leaders, and staff mandatory training included a module on Compassion in Practice.
- One patient we spoke with told us that 'staff were always by the [their] bedside', which made the patient 'feel safe'. We observed good caring and compassionate interactions with the patient by nursing and housekeeping staff.
- Another patient described staff as 'attentive' and 'customer focused' and that the relaxed atmosphere 'gives calmness to patients here'.
- Feedback from people who used the service, and those who were close to them was positive about the way staff treat people. This was in line the National Institute of Health and Care Excellence's Patient experience in adult NHS services quality standard QS15 statement one. A range of thankyou cards were displayed in the unit from patients and relatives who were appreciative of the care and service they were given.

Emotional support

- Staff saw patients emotional and social needs as being as important as their physical needs Staff provided emotional support to patients to minimise their distress. People's privacy and dignity was embedded in everything that staff did.
- Patients were always treated with dignity by all staff involved in their care, treatment and support. Consideration of their privacy and dignity was consistently embedded, and this was encouraged by the unit's leaders. We observed staff providing reassurance and comfort to patients and their relatives. Staff demonstrated a clear understanding of the emotional and social impact that a patient's care, treatment or condition had on their wellbeing and on those close to them.
- Staff in the service told us of examples where they had met an individual's emotional needs. A staff member stayed overnight, past the end of their shift, with a patient who had significant anxiety.
- Patients felt really cared for and that they mattered. A patient on the unit at the time of the inspection told us that, due to a previous bad experience, they had some significant reservations about being transferred out of the unit to the ward. We later spoke with the patient on

the ward, where they told us the assurances provided by critical care staff and the actions taken by the critical care staff member during the transfer had addressed their reservations and anxiety.

- Another patient told us they had been assigned a nurse, who followed the patient's journey from pre-admission through to surgery and into critical care. This nurse stayed with the patient past the end of their shift, which the patient described as maintaining 'good continuity'. The same patient noted that staff had offered the use of the isolation shower-room to maintain the patient's dignity at a time when staff were caring for a mixed group of patients.
- The critical care service could refer patients to a psychologist for support if required.
- The service had access to the hospital's end of life team leader to support patients, families and staff if required.
- Although it was extremely rare for patients to die in the hospital, the service had contacts with a local undertaker service. This enabled staff to work closely with families and the undertakers to avoid, where appropriate, the need to temporarily transfer deceased patients to the mortuary at a local NHS hospital.
- The hospital had developed links with local Jewish and Muslim community groups and plans were in place for further developing staff faith awareness workshops days in 2019.
- The hospital had a multi-faith prayer room which was located close to the critical care unit. The prayer room was open 24 hours a day and available for use of patients, carers and staff. Staff could request the attendance of multi-faith chaplains as required by patients.
- A relative's room, which was appropriately furnished and decorated, was located just outside the unit's main doors. This provided families with a private, quiet area to sit and for supportive private conversations to be held.
- The hospital's 'Tulip Room' was available to staff, patients and relatives for use in holding sensitive and distressing discussions, and for breaking bad news.

Understanding and involvement of patients and those close to them

- Relationships between patients who used the service, those close to them, and staff were strong, caring, respectful and supportive. Staff involved patients and those close to them in decisions about their care and treatment.
- Patient communication needs were recorded during the pre-admission assessment process and were understood by staff providing care. This was in line with the National Institute of Health and Care Excellence's Patient experience in adult NHS services quality standard QS15, statements two, four and five.
- The unit was supportive of patients that wanted to come back to visit to understand their care. One patient attended the unit during our inspection to thank staff for their support.
- One patient told us they had been made fully aware of the plans, post-surgery, to stay in the critical care unit for two to three days. The patient's family could visit at any time and that staff had provided 'good support for the family [who were] able to talk to staff'.
- Another patient told us that their planned stay in the unit had been extended by an extra night due to unexpected complications. The patient said they were kept aware of the changes in the plan, that staff 'remained calm, and had offered to phone the patient's family to provide updates on the patient's condition.
- One thank-you card displayed in the unit stated, "I can't praise the staff in critical care enough. They were a calming influence with my family on visits, which helped me not to worry. They were caring, polite and respectful, and easy to talk to. They were good listeners and always asked if I was happy with what they were doing."
- An entry in the hospital's feedback survey from a patient's relative commented on a consultant's input to the patients care. It said, "He is very experienced and caring. He comes every morning and evening to review my mum, and he calls me on the phone to update me."
- Children were given the unit's direct contact number if they had any concerns, including concerns about the surgery, plans for their stay on the unit, or general concerns.
- Staff provided an example where the critical care manager had worked closely with a young paediatric patient whose initial surgery had been postponed due

to the patient's anxiety. The manager ensured she was present when the patient returned to the hospital for the rescheduled surgery. This meant the patient remained calm and continued with the surgery.

- The unit supported open visiting for relatives and carers of patients. Staff welcomed and supported relatives to stay with their loved ones on the unit for as long as they wanted. Staff encouraged relatives and carers to be involved in the care of the patient.

Are critical care services responsive?

Good

We have not previously rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

- The critical care service had developed approaches to providing care to patients that involved their patients as partners in their care which ensured continuity of care.
- The service planned and provided their services in a way that were tailored to and met the individual needs and preferences of local people. This enabled the service to offer care and support to critically ill level three patients and meant that transfer of such patients to other local NHS organisations was unlikely. All level three and unplanned admissions were reported as incidents and reviewed by the leadership team to determine if there was any learning or improvements that could be identified from these admissions.
- The hospital website included information for patients and visitors about the unit. This included a detailed set of frequently asked questions developed by the consultant intensivist. These explained the differences in the three levels of care offered on the unit; a description of a typical day on the unit; an explanation of how long patients spend on the unit; the most common procedures likely to require critical care support; and, the benefits of having a critical care unit on site.
- The unit had a point of care blood gas analysis machine. This enabled staff to quickly obtain relevant results to assist in planning patients' care. Similarly, a portable X-ray machine was stored on the unit, which enabled quick response to X-ray requests from the hospital's radiology team.
- The critical care staff provided an outreach assessment service into the wider hospital. This enabled critical care nursing and the resident medical officer to aid and provide advice to ward staff for patients that were at risk of deteriorating.
- Critical care staff were actively involved in the transfer of patients being stepped down from the unit to the ward areas; this included reviewing the patient within 24 hours on the ward and until staff were assured no further critical care input was required.
- The critical care service supported the hospital's contract with regional NHS trusts in providing care for patients admitted for bariatric surgery and for spinal surgery. Similarly, the service had good links with a local NHS hospital's outreach service to enable the support of patients with extra-corporeal membrane oxygenation (EMCO). ECMO is used when a patient has a serious condition which prevents the lungs or heart from working normally.
- Service leaders were in the process of working with consultant colleagues throughout the hospital to encourage them to bring more complex types of surgery, such as cardiac surgery, to the hospital due to the additional support that the critical care service could provide.
- Although the hospital did not have an organ donation team, staff in the critical care service had links for advice with a specialist nurse in organ donation who had previously worked in the unit.
- There were no specific overnight accommodation facilities for relatives in the hospital; however, overnight stays could be accommodated for relatives in the respective patients' rooms on the general ward.

Meeting people's individual needs

- The critical care service took a proactive approach to understanding the needs and preferences of different groups of people, including those with protected characteristics or complex needs, and delivered care in a way that met those needs.

Critical care

- Most of admissions to the critical care unit were pre-planned to support patient recovery after elective surgery. This enabled the critical care manager and consultant intensivist to plan nursing and medical staffing levels accordingly to meet the needs and the acuity of the patients. This included ensuring the unit was supported by paediatric trained staff as and when required, including close working with the hospital's child safeguarding lead. Admissions were planned so that paediatric patients were care for in the unit's isolation room.
- Additional needs for individual patients were identified either through their referral or during the pre-admission assessment process. An alert sheet was completed prior to admission detailing if the patient had any physical, sensory or mental impairments, allergies, or communication needs. The alert sheet was filed at the front of the patient records, and an alert sticker placed on the cover to remind staff to check the alert sheet.
- Children and other vulnerable adults, such as those living with dementia or with learning disabilities, were invited to visit the unit as part of the comprehensive pre-admission assessment process. This enabled the patients to familiarise themselves with the surroundings and the staff prior to undergoing their surgery.
- All permanent staff in the unit had undertaken dementia awareness training and were Dementia Friends. Clocks within each of the patient bays and isolation room were dementia friendly and displayed sun and moon symbols and the date. A dementia resource box was held in the general ward and could be accessed by staff on the critical care unit if required. Dementia Friends leaflets were available within the relatives' room.
- Blue pillow slips were used to easily and discretely identify patients that may require additional support such as living with dementia or learning disabilities. Hospital passports were supported for any patient that required them; these enabled staff, families and carers to record the patient's communication and spiritual needs, their preferences, likes and dislikes, and any reasonable adjustments needed.
- Bariatric equipment, chairs and beds were available on the unit, and bariatric beds were available within the hospital as required. Maximum weight warnings were clearly displayed on equipment within the unit, and reference sheets were easily accessible for staff to check if they had any concerns.
- Lifts were located close to the unit which meant it was accessible to people living with mobility difficulties.
- The service had a wide-range of patient information leaflets, including a child-friendly leaflet explaining the service. Staff could access and print copies of the standard leaflets in a wide-range of other languages for patients whose first language was not English. Telephone and face-to-face translation services were available to staff; this included access to British Sign Language interpreters.
- Televisions had not been included in the design and build of the unit. However, a portable television and DVD player, including a range of DVDs were available if required. Staff told us they had worked with the hospital's IT department to enable streaming of the football World Cup to a patient's tablet computer.

Access and flow

- People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.
- Most admissions to the unit were planned admissions following planned surgery. This meant that bed occupancy was usually planned. However, there was sufficient capacity within the unit and flexibility in nursing and medical staffing arrangements to manage any unexpected and unplanned admissions.
- Between September and December 2018, the critical care unit provided planned care for 67 patients and had 18 unplanned admissions, one of which was for a level three patient. The unit's flexibility meant that this patient did not need to be transferred out to an NHS critical care service.
- Between January 2018 and December 2018 there were no surgical cancellations because of a lack of bed availability on the critical care unit.
- Our records review showed that all five patients, in the records we looked at, were reviewed by a consultant in line with the Core Standards for Intensive Care Units 2013. The standards require review of a patient to be

undertaken by a consultant within 12 hours of admission to the unit. Four of the five patients were reviewed by a consultant on admission, and the remaining patient was reviewed by a consultant within five and a half hours after admission to the unit.

- The critical care service did not currently monitor the time between the decision that a patient could be discharged and when the patient was discharged to the ward. This meant the service was currently unable to assess performance against the core standard recommendation of transfer within four hours of the decision.
- The service monitored patients' length of stay on the unit. The average length of stay on the unit was 1 night for each level 1 and level 1b patient; 1.3 nights for level 2 patients; and, three nights for the level 3 patient.
- Between January 2018 and December 2018, there were no discharges from the critical unit to the ward out of hours (between 10pm and 7am).
- We found no evidence to indicate that any breaches of the single-sex accommodation guidelines had occurred.

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.
- The service received no formal complaints from patients or carers between January 2018 and December 2018. However, wider learning from complaints in the hospital or other Spire locations was shared with staff in governance meetings, staff meetings and safety huddles as appropriate.
- Complaints leaflets were available within the department and the relatives' waiting room. The leaflets provided clear details about how to complain, the stages of a complaint, and how to request independent review of complaints through the relevant NHS and independent healthcare complaints handling organisations.
- Staff in the unit were aware of the complaint's procedure but, where possible, proactively addressed concerns with patients and their carers at their point of care. This reduced the likelihood of concerns escalating to formal complaints.
- A large range of thank you cards and compliment cards from previous patients were displayed in the unit. These reflected similar positive sentiments to those expressed by the patients we spoke with during the inspection.

Are critical care services well-led?

Outstanding ☆

We have not previously rated this service. We rated it as **outstanding.**

Leadership

- Leaders at all levels in the service demonstrated the high levels of experience, capacity and capability needed to deliver excellent, high-quality, person-centred and sustainable care. The service was led by managers who had the right skills and abilities and were compassionate, inclusive and effective.
- The critical care unit delivered its services within the hospital's acute services division led by the acute services manager, who was part of the hospital's senior management team. There was a strong managerial structure in place through the matron to the hospital director.
- The unit was clinically led by a consultant intensivist supported by the critical care manager. two permanent registered nurse critical care sisters, with at least one sister per shift. All staff members we spoke with could describe the managerial and escalation structures within the unit.
- The unit's leaders clearly understood, and could describe, the issues, challenges and priorities to delivering a critical care service within an independent hospital setting. These challenges focused on encouraging increased levels of activity within the unit, including providing support for more level three patients.
- The leaders had a strategy to achieve this through promoting the benefits and safety of the critical care service in supporting more complex types of surgery to consultant surgeons in the hospital and the wider region. The leaders had clear plans for how they envisaged to grow the service, including through support of cardiac surgery in the hospital.

- Without exception the medical, nursing and support staff we talked with on the critical care unit spoke extremely positively about the unit's leaders, and of the hospital's senior management team. Staff described their leaders as being exceptionally visible, supportive, open and approachable.

Vision and strategy

- The critical care service's vision, strategy and supporting plans were stretching, challenging and innovative, while remaining achievable. They were fully aligned with plans in the wider health economy, including the Greater Manchester Critical Care and Major Trauma Network. The service's senior leaders demonstrated a commitment to system-wide collaboration and leadership.
- The hospital's vision was 'to be the first choice for private healthcare for patients, consultants and GPs in Greater Manchester'. This vision was reflected in the hospital's values and promises, which focused equally on safety, dignity, kindness, and respect of diversity of patients, customers and staff while working in partnership with local GPs, NHS organisations and the Greater Manchester health economy.
- The critical care service's vision and strategy for 2018 to 2020 was a developing framework which supported the hospital's strategy and core values. The framework had defined aims to achieve full compliance with the Core Service Standards for Intensive Care Units by 2020 through a fully functioning seven-day service offering evidence-based care and treatment for all the hospital's patients requiring level two or level three care. It was clear that the framework had been defined to meet the needs of the hospital as well as the wider health economy with strong links between the service and the Greater Manchester Critical Care and Major Trauma Network.
- Actions required to achieve the aims were defined as were the known risks and challenges. These included, although were not limited to, engaging with consultant partners in the hospital and region to understand their needs and equipment requirements to accommodate more complex patients and surgery types; further recruitment and training of permanent nursing staff as activity levels in the unit increase; and the recruitment of a dedicated practice-based educator.
- Senior and service leaders recognised that increasing activity levels was key to sustainability of the service, to mitigating the service's risks and to increasing funding to achieve the unit's aims of providing a seven-day service.
- Staff we spoke with at all levels could describe the strategy for the unit and understood their roles in achieving it. This included permanent and temporary nursing staff, and resident medical officers, who were clearly invested in the success of the unit.

Culture

- Managers across the service were inspirational in promoting a positive culture that supported and valued staff and created a sense of common purpose based on shared values that motivated staff to deliver and succeed. There was strong collaboration, team-working and support across all functions within the service and a common focus on improving the quality and sustainability of care and people's experiences.
- We spoke with medical, nursing, pharmacy and housekeeping staff during the inspection. Without exception, staff we spoke with were proud of the critical care service and the hospital as a place to work. Staff felt this was a culture promoted throughout the hospital by the hospital director and senior management team.
- It was clear from our observations and discussions with managers and staff that the culture of the unit was focused on the needs of the patients. Staff at all levels were empowered to raise concerns with their line or senior managers and to request a temporary stop to procedures without any fear of repercussions if they had any safety concerns. The hospital had a Freedom to Speak Up Guardian and staff knew how to contact the guardian if needed.
- There was a palpable ethos of strong collaboration, team-working, quality and support within the unit. More than one staff member described the service and their colleagues as a 'family' and mention was made of the support provided by the critical care manager.
- Following a recent, unexpected death on the unit a range of support measures were put in place for staff, including debriefing sessions with the consultant. The

consultant subsequently praised staff in feedback, noting: "The team performed superbly…and I would like to pass on my thanks to all. I am reassured that we did everything we could for this patient."

- The results of the ward nursing, including critical care, staff survey, carried out in January 2019, were provided to us after the inspection. The results showed high levels of positive or neutral results (95%) of staff who believed that the organisation treats all people as equals regardless of individual differences, backgrounds, characteristics, seniority and preferences.
- We saw evidence of the service complying with the regulatory duty of candour in line with the joint Nursing and Midwifery Council and General Medical Council guidance, Openness and honesty when things go wrong: the professional duty of candour. This confers on the organisation a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Service leaders and nursing staff, we asked understood the regulatory duty and could describe the triggers for the duty.
- Staff could use the on-site gym.

Governance

- The service systematically improved service quality and safeguarded high standards of care by proactively creating an environment for excellent clinical care to flourish. Governance arrangements were proactively reviewed and reflected best practice for critical care services. A systematic approach was taken to working with other organisations in the Greater Manchester Critical Care and Major Trauma Network to improve safety and care outcomes.
- Governance within the critical care service was led by the consultant intensivist, who also chaired the hospital governance committee and was a member of the hospital's medical advisory committee. Staff at all levels were clear about their roles and accountability for governance matters and fed into a range of hospital governance boards.
- Governance leadership oversight of the critical care services was provided through the quarterly resuscitation and critical care working group meeting. We reviewed three sets of minutes from this meeting. The meeting had oversight of performance through the service dashboard, staff training, medicines management, risks, complaints, incidents and lessons learned. It also fed directly into the hospital's quarterly medical advisory committee.
- Effective action plans for improvement were in place and progress against these was reviewed at each working group meeting. The meeting also included mortality and morbidity case review for any relevant cases throughout the hospital that may have an impact on the critical care service. We saw evidence that learning from these, from the hospital daily safety briefing and alerts from Medicines and Healthcare Products Regulatory Agency (MHRA) central alerting system, were shared with staff in the unit safety huddles, staff meetings, and by email newsletters. Processes were in place to ensure that bank staff received any relevant procedural changes and learning.
- Staff from the critical care service attended, and provided input, into a range of other governance committees. These included the medicine and pain management committee; the blood transfusion committee; the point of care testing committee; the medical devices management committee; and the paediatric steering group. Unit staff meetings were held every six weeks.
- Service level agreements were in place and effectively managed with a local NHS trust to maintain staff exposure to, and competency in providing, level three care.

Managing risks, issues and performance

- The critical care service demonstrated commitment to best practice performance and risk management systems and processes. It had effective systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. Staff at all levels had the skills and knowledge to use the systems and processes effectively.
- The critical care leaders could describe the main risks to their service. These were reflected on the service's risk register which fed into the hospital's risk register. We

reviewed the risk register during our inspection, which included five risks for the unit. The risk register clearly set out a description of each risk, the key controls and assurances already in place, gaps in the controls and actions required to mitigate the gaps. Four of the five risks had been rated as low.

- Sustainability of the service was the key risk, rated as high, that was recognised at all levels; levels of activity in the unit were prime drivers for this and for staffing of the unit. The service leaders also recognised there was a risk (deemed to be low risk) relating to the hospital's ability to respond to unexpectedly deteriorating patients when the critical care unit was not scheduled to be open.
- It was recognised that providing a consistent service across seven days a week was a driving factor in the service's ability to increase the numbers of permanent staff and reduce reliance on bank staff. The leaders could describe the actions being taken to achieve this, through encouraging consultants to undertake more complex types of surgery, or surgery on patients with more complex histories.
- The critical care service had defined a range of performance measures against which it had started to collect data from September 2018. The leaders demonstrated a good understanding of the unit's (positive and strong) performance against these measures, including internal and external factors that may impact on them.
- The service had developed a clear audit plan for 2019, which included audits of unplanned transfers to the unit, temperature monitoring; consultant and doctor review of patients; critical care chart audit; nursing notes audit against the care pathways; nursing risk assessments; and, an outreach audit. We reviewed four audits that had been carried out in January. These all included appropriate action plans that clearly set out the audit objectives, the action required to meet the objectives, an owner for each action and target completion date.
- Staff attended the Greater Manchester Critical Care and Major Trauma Network and Risk over Network (RiCON) meeting each month. This enabled the service to share and obtain information relating to critical care risks and performance. Similarly, the critical care manager attended the Spire quarterly critical care nursing network meeting.

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 accurate, valid, reliable, timely and relevant.
- The service was not currently subscribed to the Intensive Care National Audit and Research Centre (ICNARC). This meant that benchmarking the service's performance against other similar units was not currently possible; however, leaders told us that this is an area that was being explored corporately by Spire.
- The service's collection of bespoke performance measures and data enabled leaders to understand areas of improvement. This demonstrated a commitment to sharing data and information proactively to drive and support decision making in the service as well as hospital-wide working and improvement.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Although patient records were predominantly paper based, the records we reviewed were of a good comprehensive standard. In conjunction with electronic reporting of test results, staff told us they had all the information needed to provide safe care and treatment.
- Standard operating policies works instructions and procedures were readily available on the hospital's intranet, and in hard copy form on the unit. We reviewed the hard-copy documents held and these were the latest versions; all had a clear review date in place. The critical care manager had put in place a robust sign-off system for permanent and bank staff to confirm they had read and familiarised themselves with relevant policies.

- Urgent updates, including patient safety and equipment alerts, were shared with staff during the handover safety huddles.

Engagement

- The critical care service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. There were consistently high levels of constructive engagement by the critical care service with staff, people who used the service and external partners, including in the development of the service.
- The service supported the hospital's commissioning for quality and innovation (CQUIN) programme, which was based on actions to improve health inequalities. The two-year programme was in its second year at the time of the inspection, and including a range of projects to understand, identify and raise awareness of inequalities and how this could be applied to a range of protected characteristics.
- Hospital discharge data for December 2018 indicated a high level of satisfaction of 95% in the hospital's friends and family test survey with 75% of respondents indicating they were extremely likely to recommend the hospital, while 92% of respondents indicated the hospital had met or exceeded their expectations.
- The service had just started collecting critical care service specific patient satisfaction data, at the time of the inspection. As such, it was expected that future patient satisfaction data would be specific to the unit itself.
- The results of the ward nursing, including critical care, staff survey carried out in January 2019 were provided to us after the inspection. The results showed high levels of positive results for staff overall engagement (96%) and satisfaction with their work (98%), their manager (98%), and the executive leadership (95%). The survey also identified that (96%) of staff responded positively to questions relating to the safety of the hospital.
- The service, and the critical care manager, supported nursing staff with revalidation with their professional body. This included meeting with staff and enabling reflective conversations to be used as evidence by staff members during their revalidation.
- The service's medical leadership proactively promoted recruitment of consultant anaesthetists and resident medical officers. The unit supported an open evening for potential new medical staff, and opportunities were provided for new medical staff to work/shadow on the unit and to determine if the role was suited to them before accepting the post.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The service had a fully embedded and systematic approach to improvement, which was seen as the way to deal with performance and for the service to learn.
- The critical care service had an embedded relationship with the Greater Manchester Critical Care and Major Trauma Network. This promoted safe working and improvements in all the network's units. The service had a service level agreement for the transfer of patients to hospitals within the network, although the unit had not needed to transfer any patients out in the last 12 months.
- The service had a service level agreement with a local NHS hospital trust for staff development. This enabled service staff to spend up to five days in an NHS critical care unit looking after patients receiving level three care.
- Mortality and morbidity reviews were embedded in the service's working group meetings, which enabled sharing of learning from relevant cases throughout the hospital.
- The service supported nursing students from a local university to experience the provision of critical care services to patients. This included tracking and caring for elective surgical patients throughout their whole admission journey.

Outstanding

Services for children & young people

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

Are services for children & young people safe?

Good

We rated it as **good.**

Mandatory training

- Staff had received up-to-date training in all safety systems, processes and practices.
- The service had systems and processes in place to ensure that staff could access mandatory training. Staff we spoke with confirmed they had enough time to complete mandatory training.
- Mandatory training was mainly e-learning, but some was face to face. The training covered 10 modules including; safeguarding children and vulnerable adults, compassion in practice, manual handling, infection prevention and control, information governance equality and diversity, anti-bribery, health and safety and fire safety.
- Mandatory training completion was monitored centrally so that any staff who had not completed their training could be flagged by the line manager for individual follow up.
- The service reported 100% of staff had completed mandatory training.

Safeguarding

- The service had an up to date corporate safeguarding children and young people policy which was available to staff on the intranet. The policy was supported by an algorithm that was displayed at the nurse's station.
- There were comprehensive systems to keep children and young people safe, which took account of current best practice. For example, the paediatric ward had a 100% safeguarding level 2 training target, this had been met between December 2017 and November 2018. We also noted at the time of inspection 51% of staff were level 3 trained.
- We reviewed the risk assessment carried out by the ward manager relating to those who were not compliant, this showed mitigations put in place to ensure the service worked in line with the intercollegiate guidelines. For example, the service ensured there was always a registered children's nurse with level 3 safeguarding training on site when children were in the hospital.
- All registered paediatric consultants working at the hospital were required to have level 3 training. Appointments were only made with consultants who had provided evidence of up to date training.
- Staff had access to a named designated professional for safeguarding, all staff we asked could name these individuals. Staff could escalate any safeguarding concerns to the ward manager and matron who were both level 4 trained.
- The whole team was engaged in reviewing and improving safety and safeguarding systems, staff gave examples of relevant referrals. All staff we spoke with had undertaken safeguarding training and were able to describe the importance about making safeguarding personal.

- We reviewed one safeguarding referral and found it was appropriately referred by the member of staff to the local authority. We also noted that documentation was robust and complete.
- Any patient considered at risk of female genital mutilation (FGM) or child sexual exploitation was referred to the safeguarding team for follow up. We heard of two examples of how staff followed the process after patients had enquired about FGM surgery.
- Staff completed a paediatric safeguarding risk assessment at the pre-operative appointment to identify any children at risk. Although there was a focus on quality and safety, data provided by the service showed poor compliance rate across 2017 – 2018 for completing the safeguarding checklist. Compliance figures ranged from 0% - 40% in 2017 and 56%- 80% in 2018. To address this, checklists were now part of the children and young person's pathway, so all patients should have a completed assessment. In seven patients notes we reviewed we saw there was a comprehensive safeguarding risk assessment form that was completed by a registered children's nurse.
- There were systems to identify if a child/young person was on a child protection plan, stickers and a different colour form called the safety alert form was placed in the care plan to alert staff.
- Spire Healthcare had an abduction policy, the service adapted the policy to ensure it was tailored to the location. The policy was supported by a missing child flow chart that illustrated the steps staff must follow in an event a child went missing.
- In December 2018, the service conducted a mock abduction scenario to ensure all staff were aware of the system in place to prevent a child being abducted. Learning taken from the scenario resulted in adapting the corporate policy so that it could be used locally.
- Staff were vigilant and would challenge visitors to the ward to safeguard children. The ward issued swipe electronic cards to parents so that they could enter and leave the ward when they wanted to. A log of these cards was kept at the nurse's station and was updated once the card had been returned. Parents told us they were confident with leaving their child with the staff on the ward, they felt it was safe and that staff were extremely attentive.
- The ward had an excellent range of information leaflets in a child format explaining about keeping safe, one board displayed 'learn pantosaurus five easy rules for staying safe'. The leaflet used the acronym "PANTS" to highlight the importance of different areas including; privates are privates, always remember your body belongs to you and no means no.

Cleanliness, infection control and hygiene

- The environment was visibly clean and tidy. There were systems and processes to control infection and promote hygiene. We saw that the infection prevention control policy was in date and available on the intranet.
- There were systems in place to prevent healthcare associated infections. The paediatric ward reported no cases of hospital acquired infections including; clostridium difficile, MRSA, and methicillin susceptible staphylococcus aureus since it had been opened
- The service promoted infection prevention control practices, for example we saw child friendly posters displayed around the ward about infection prevention and handwashing techniques. These were also located above sinks and on entry to the ward. Parents of patients we spoke with confirmed staff washed their hands before and after treating their child.
- All clinical areas had soap dispensers, hot and cold running water and paper towel dispensers. Antibacterial rub dispensers were also located at intervals on the corridors and upon entry into the ward. We observed all dispensers were clean and full of the relevant product.
- In each patient room, there were dispensers for aprons and gloves in small, medium and large sizes. This meant staff could easily access the appropriate personal protective equipment (PPE) as required. We observed staff using PPE when required, they adhered to 'bare below the elbow' guidance and washed their hands after each patient contact.
- Systems were in place to prevent the spread of communicable infections, signage was placed on the room doors to ensure staff were aware to barrier nurse. However, staff said they had never come across a patient with a communicable disease.
- Comprehensive monthly audits of infection prevention and control were completed. The audit tool was based on the World Health Organisation patient safety observational hand hygiene tool. It measured hand hygiene according to the '5 moments' approach which defines the key moments when healthcare workers

should perform hand hygiene. We found no concerns with audits and staff complying with infection control measures, compliance rates were 100% across the last six months.
- To support staff in maintaining levels of infection control, the ward benefited from dedicated housekeepers and a domestic team. Staff cleaned equipment after use and a sticker was used to indicate equipment that had been cleaned. Each area had completed cleaning schedules that showed regular cleans.
- Waste was separated and disposed of in appropriate colour coded bins.

Environment and equipment

- Access to ward areas were controlled using magnetic door locks, staff spoke with those wanting to access the ward via the intercom to verify their identity.
- The children's and young people's ward had a warm, family-friendly atmosphere despite it being a hospital ward. A chosen safari theme was used in all rooms, the colours were bright, bold and the illustrations were child focused.
- We found the ward environment was free from clutter, wheelchair accessible, and with enough equipment for staff to carry out their roles.
- The ward consisted of six rooms with en-suite and a playroom. All rooms were spacious, had call bells, contained a safe with a key pad for valuables, and a pull-out bed for parents staying overnight.
- Specialist equipment for all age ranges, including that required for resuscitation was available and fit for purpose on the ward. Each room had the correct paediatric oxygen mask and oxygen cylinder which was checked the morning before the room was being used.
- The resuscitation trolley was located on the adult ward which was adjacent to the children's ward. The trolley held children's resuscitation equipment on it. This ward could be accessed by staff via a swipe card. All equipment was checked daily by the paediatric nurse. This documentation was kept on the children's ward. At the time of inspection, we found no gaps on the daily check log.
- There was consideration of a suitable environment for children living with sensory, behavioural or mental health needs. Patients were offered a quiet room if they needed it, this was in the outpatient's area.
- The ward had a large playroom, it was clean and tidy with a variety of toys for children of different ages. We saw a range of toys including games, action figures and books for children to pick from. Children could role play using the kitchen, or the doctors set and for babies there was foam flooring for them to sit, roll or crawl on.
- At the time of inspection, the sensory light was in the play room but was out of use but when it was working, was available to all children. It had been logged for repair.
- A dedicated recovery area in theatre was separated from the adult area, we found no issues with the environment, it was colourful and appropriate for children.
- The hospital had a service level agreement with an external medical devices team, they were responsible for the maintenance of all devices and equipment, using a live database to log and monitor each item. Equipment we checked had been safety tested.
- Staff we spoke with told us patients being treated on a paediatric pathway completed an environmental risk assessment. Data received from the hospital confirmed that 100% of paediatric patients had an environmental risk assessment between January 2018 and December 2018.

Assessing and responding to patient risk

- A proactive approach to anticipating and managing risks to patients who used the service was embedded and was recognised as the responsibility of all staff.
- The hospital had an admission policy that set out safe and agreed criteria for admission of children. For example, all children who needed to be admitted for interventional radiology, day case or in-patient procedures had to be older than 12 months old or weigh more than 10kg. Staff completed a risk assessment that produced a clinical risk score that informed staff if the patient was eligible for admission.
- The service followed guidelines for the Provision of Anaesthetic Services (GPAS) 2017) which highlighted the importance of staff assessing paediatric patients prior to their surgery, caring for them during their procedure and post-operatively having up to date paediatric competencies.
- We found that pre-operative assessments were carried out by a registered nurse (child branch), who talked

through the risks associated with the surgery and the treatment plan. For older children (16-17) a risk assessment by the paediatric nurse was carried out to determine if the child could be treated on the adult pathway. If it was deemed appropriate for those older children (16-17 years old) to be assessed pre-operatively under the adult pathway a registered nurse completed the assessments.

- Children who were admitted for surgery underwent a pre-operative assessment under the children and young person's pathway, this was carried out by the registered children's nurse.
- The ward manager attended the senior management daily safety huddle to support the hospital in assessing and responding to patient risk. This took place with all heads of departments across the hospital which gave opportunity to discuss any departmental concerns that potentially affected other areas.
- In accordance with the Resuscitation Council's height and weight of each child on admission so that drug calculations were could be safely worked out. We saw that the ward had clear emergency treatment calculations or a quick reference document for calculating drugs.
- The service used a paediatric emergency care system (pecs) to assess children during an emergency. The weight of the child determined the colour group they belonged to. On admission children were given a wrist band of that colour, which alerted staff to use the prepacked bag of that colour in an emergency. The packs contained a precalculated drug chart so that staff could act quickly. Prepacked paediatric emergency care system bags went with the child to theatre.
- Staff used paediatric early warning scores (PEWS) to identify and respond appropriately to changing risks to children using the service. These assessment tools enabled staff to identify if the clinical condition of a patient was deteriorating and required early intervention and or escalation to keep the patient safe.
- Data from the hospital records audit, covering PEWS completion, temperature recording, pain scores and other areas showed lower compliance by medical staff in three areas against the hospital target of 95%. The percentage of records with PEWS completed was 89%, temperatures completed was 75% and pain scores with every observation was 92%. Results had been escalated to the clinical lead so that immediate action could be taken.
- Staff had access to the resident medical officer, who was present at the hospital 24 hours a day seven day a week.
- The service had an escalation and transfer policy for seriously unwell children. All staff we spoke with were familiar with the arrangements needed for transferring a child who required urgent critical care to the neighbouring NHS trust.
- A side room on the critical care unit was designated for children and young people undergoing scoliosis surgery. All children were cared for by a registered children's nurse who was trained in paediatric life support and specialised in critical care. The nurse was supported by an adult nurse with paediatric competencies.
- We reviewed records to ensure staff completed the World Health Organisation (WHO) surgical safety checklist including markings of the surgical site. All records were completed appropriately.
- There was a dedicated recovery area for children that had child appropriate equipment including resuscitation equipment. The service ensured there were two registered nurses in recovery per child. All nurses were trained in paediatric immediate life support and had paediatric competencies.
- There were arrangements in place to provide parents and carers with support, once they left the hospital. Parents or carers were given the ward number to call if they had concerns when they went home, and staff also explained the emergency out of hours arrangement.
- The service followed NICE guidelines for sepsis recognition, diagnosis and early management. The sepsis pathway was in date and available to all staff. A sepsis trolley was located on the ward, it contained the appropriate equipment for the management of sepsis.
- The service had not suspected or treated any children for sepsis and therefore we were unable to confirm if staff delivered treatment within the recommended sepsis pathway timelines.

Nurse staffing

- Children and young people's services had systems and processes in place to provide the required nurse staffing levels so that patients were kept safe.
- Children's services considered guidance from the Royal College of Nursing and the Royal College of Paediatrics and Child Health in relation to paediatric nurse staffing levels. We saw from rotas that the ward was appropriately staffed.
- The service reported no staffing challenges, we saw that there were six permanent registered nurses in post and 13 registered paediatric nurses on the bank.
- Surgeries for children and young people were planned so that the correct staffing levels were arranged in advance to ensure there were two registered paediatric nurses on duty.
- The children and young peoples' recovery area was staffed by two registered nurses with paediatric competencies and the side room on critical care was always staffed with a registered paediatric nurse who specialised in critical care when children used the unit.
- Ward staff displayed safer staffing levels on notice boards, staffing met the Royal College of Nursing for children and young people standards. The board also displayed the number of staff who were paediatric immediate life support trained.
- The service rotated staff between the ward and the outpatient's department which meant that staff followed the full patient journey from pre-operative assessment to follow up after discharge. This gave patients good continuity of care.

Medical staffing

- All children and young people were cared for by a named consultant with paediatric practising privileges.
- There was a medical lead for children and young people's services at the hospital, the consultant paediatrician attended the paediatric steering group biannually to discuss the paediatric strategy.
- All consultant paediatricians working with practicing privileges had substantive posts within the local NHS trusts.
- There were two resident medical officers (RMO), who covered the ward when children were admitted to the ward. RMOs were not employed directly by the hospital and were sourced through an agency. The hospital policy ensured they had completed necessary training to care for children and completed a corporate and local induction.
- There was a service level agreement in place with the local NHS trust for 24-hour access to a paediatric anaesthetist and consultants. Staff reported that they felt able to contact consultants if advice was required.
- The consultant on call database provided nursing staff with contact details of consultants and their secretaries. It also detailed cross cover information when they were away.

Records

- There were systems to manage and share information that was needed to deliver effective care and treatment.
- Paper based records followed the patient through the hospital which promoted joined up care for children using different services. For example, care records were started in outpatients and accompanied the child to the ward where they were updated by nursing staff. Upon discharge a letter was sent to the GP electronically and parents were given paper copies of the discharge summary for themselves and the school.
- We reviewed seven completed records and found that the documentation was correct, clear and legible.
- All the information needed to deliver safe care and treatment were available inpatient notes, they included test and imaging results, care and risk assessments and care plans. Risk assessments included environmental, pain and nutritional assessments, these were regularly updated in the records we reviewed.
- Patients individual care records, including clinical data were kept in a key padded trolley at the nurse's station to keep them safe and away from the public. Once the patient left the ward, records were sent to medical records department where they were archived.
- Consultants had access to the electronic imaging system, this was so that they could access results anywhere.

Medicines

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

- We checked the storage of medicines, fluids and gases on the ward we visited. The adult ward was adjacent to

the children's ward and accessed by a swipe card. We found medication was clearly labelled with "children's" and was separated from the adult drugs. To gain entry to the clinical room on the adult ward staff used an electronic keypad. All drugs were stored securely.

- We reviewed two medicine charts and found these recorded allergies, weight and height of the patient. We saw that medicines were prescribed appropriately for the age and weight of the patient
- Medication was given to children according to their height and weight. Calculations informed which prepacked paediatric emergency care system was allocated. All calculations were taken at the preoperative assessment and again on admission.
- We saw there was an up-to-date children's British National Formulary (BNF) available to staff to reference. We saw that staff were asked to complete a drug calculation quiz to ensure they were familiar and understood how to calculate medicines for children.
- All medicines and medicines-related stationery was managed ordered, transported, stored and disposed of safely and securely by the pharmacist.
- For drugs that required refrigeration, staff told us that if the fridge temperature went out of range pharmacy would be called to advise on whether any of the drugs needed replacing. The ward where the medication was kept was visited daily by the pharmacist.
- There was evidence of medicine management audit to keep patients safe.The hospital was planning to extend the scope of these audits in 2019 to further validate, and then improve the service.

Incidents

- There was a genuinely open culture in which all safety concerns raised by staff and patients who used the service were highly valued as being integral to learning and improvement.
- The hospital had a policy for the reporting and investigation of incidents, near misses and adverse events. Staff were encouraged to report incidents using the hospitals electronic reporting system.
- Staff we spoke with said feedback from incidents was shared in many ways including; staff meetings, emails and safety bulletins.
- The service reported 57 incidents between January and September 2018, of these two were categorised as moderate harm and actions were taken to address both incidents. On inspection we saw lesson learnt bulletins that were cascaded to staff to prevent the incident from happening again.
- The children and young people's service produced their own monthly safety bulletin which provided staff with key safety messages. This was a child friendly bulletin and displayed on the information board for parents and children to read.
- All staff were open and transparent, and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed staff documented a full synopsis of the incident so that the most appropriate level of harm could be attached. Staff could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.
- The children's and young people service reported no never events over the past 12 months. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.
- In accordance with the Serious Incident Framework 2015, the service reported no serious incidents (SIs) in the children and young people service which met the reporting criteria set by NHS England from November 2017 to December 2018.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood the importance of being open and honest with patients.

Safety Thermometer (or equivalent)

- The service had a sustained track record of safety supported by accurate performance information.
- Safety thermometer data for both NHS patients and private patients were recorded for audit purposes but only data from NHS patients was submitted to the NHS Safety thermometer website.

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.
- Spire Manchester Hospital submitted safety thermometer data to the NHS Safety thermometer website since August 2012 for NHS patients. From data submitted by the hospital we saw that the service reported having a period of no harm for NHS patients since March 2015.

Are services for children & young people effective?

Good

We rated it as **good.**

Evidence-based care and treatment

- The hospital had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics.All staff we spoke with could access, via the hospital's intranet, guidelines, policies and procedures relevant to their role.
- The hospital had a procedure for implementing and updating best practice guidance. For each piece of new guidance, the hospital's clinical effectiveness team completed an assessment of the hospital's compliance and this was reviewed and signed off by the senior clinical team.
- We saw that the World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery tool was used. This reflected evidence-based practice to ensure safety for surgical procedures. We saw that audits were carried out to check compliance and that the ward had achieved the hospital target.
- The service received You're Welcome Quality Accreditation. This is set quality criteria set out by the Department of Health and Social Care for young people health services to achieve. The accreditation provides a systematic framework to help providers to improve the suitability, accessibility, quality and safety of health services for young people.

Nutrition and hydration

- We found that the service had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of children and young people.
- Staff used a screening tool to assess the nutrition and hydration needs of patients. This tool was a five-step screening tool to identify children at risk of being malnourished. The outcomes of these assessments were documented in the patient's notes.
- Nursing staff recorded when patients had their first drink and the time they first ate after surgery in the nursing notes. They also documented any vomiting the child experienced so that they could monitor any dehydration.
- Patients were offered a range of child friendly meals; the menu had been updated in January 2019 after receiving feedback from children about the choice of food. The service worked collaboratively with a local school to put together a menu that considered dietary requirements, allergies, cultural and religious needs.
- When we spoke with patients and their parents they said they enjoyed the food and had plenty of choice.

Pain relief

- We found that the service had systems and processes to effectively support staff to meet the pain relief needs of patients.
- Child friendly pain charts were embedded into patient notes to assist children in expressing their pain.
- In all patient records we reviewed we saw pain assessment charts to support staff in monitoring pain relief. In addition, staff described, when doing intentional rounding they would use child friendly charts to help them assess pain hourly.
- The service undertook pain audits that included scores recorded with every set of observations when the patient was awake and pain scores in discharge summaries on the care pathway. Data provided by the hospital relating to pain audits showed some low areas of compliance for pain scores on PEWS charts, during 2017 – 2018. An action plan was in place at the time of the inspection to ensure pain relief was discussed and any issues noted. Non-compliance was from medical staff, this had been addressed at the Medical Advisory Committee.

Patient outcomes

- The service had systems and processes in place to monitor patient outcomes including various hospital-wide initiatives, and local ward-based actions.
- Staff were keen to engage with clinical audit to better patient outcomes, but they struggled to find national audits that allowed the independent provider to participate in. Instead all staff were involved in local audits to monitor and improve quality outcomes amongst the other Spire hospitals. Opportunities to participate in benchmarking and peer reviewing were proactively pursued, including participation in approved accreditation schemes.
- Patient outcomes were measured and captured on Spire's clinical scorecard. These results were benchmarked against the hospital target rate and compared against other Spire hospitals for trends. Data sets included returns to theatre, theatre starve times, transfers and surgical and site infections. Where the service did not meet the national targets, actions were put into place.
- The service did not take part in any national audits involving children and young people.
- On inspection we saw that the service had no unplanned transfers to the local NHS trust in the last 12 months for children and young people**.**

Competent staff

- The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. We saw that staff had access to the appropriate training to meet their learning needs to cover the scope of their work and training time was protected. For example, staff attended pain management skills days at a neighbouring NHS trust to improve their skills.
- The service ensured that staff were competent in their roles by providing staff with an annual appraisal, through sharing information, by email, at team meetings, in a newsletter, and by offering staff additional training.
- There was a system in place to ensure staff received an appraisal annually. At the time of inspection, the service reported all staff had an appraisal.
- Staff competency was assured through the hospital wide competency assessment documentation, undertaken by all clinical staff. Completed assessments were held in staff folders. We saw evidence of competency documentation and saw that learning was reinforced with quizzes to check the understanding and knowledge of staff. For example, medicine management and safeguarding quizzes were in folders.
- The ward manager was familiar with the process of how to identify and manage poor performance but had no concerns about the team at the time of inspection.
- Staff attended simulation learning days to evidence that they were competent and capable of leading or participating in a scenario that was either life threatening or an unfortunate event. For example, we saw the evaluation of a recent missing child scenario. Staff identified gaps in the process such as all exit points at the hospital were not covered in the policy because the hospital was bigger than other sites and immediately addressed them by amending the corporate policy to fit this location
- Data provided by the hospital showed that surgeons and anaesthetists had received the appropriate training for paediatric resuscitation and were compliant with guidelines set by the Resuscitation Council UK and the Royal College of Surgeon and Anaesthetists.
- The hospital medical advisory committee liaised with the responsible officer for the local NHS trust regarding consultants working under practicing privileges. The information shared with the responsible officer was considered during the revalidation and appraisal process. The hospital required consultants to provide information about how many paediatric cases per year in the NHS they did to evidence competencies. This was so that the service was assured they complied with the Standards for Children's surgery cited by The Royal College of Surgeons (2013).
- The resident medical officer had completed paediatric training and competencies.

Multidisciplinary working

- To ensure effective services were delivered to children and young people, we saw different teams and health professionals working with staff at the service as a multi-disciplinary team.
- The children's and young people's ward had access to paediatric pharmacist for advice 24 hours a day seven day a week.

- Staff and children had access to a qualified play specialist in areas that children were seen and treated.
- Multidisciplinary team meetings were not regularly conducted. Staff told us they only took place for a scoliosis patient.However, we observed physiotherapists reviewing children and young people following orthopaedic surgery and liaising with nursing staff. Staff reported that they had a good working relationship with the physiotherapists.

Seven-day services

- When children and young people were admitted, they had access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and pathology.
- The resident medical officer was present on site 24 hours a day, seven days a week.
- There was access to paediatric consultant cover for emergencies, 24 hours a day, seven days a week.
- The hospital pharmacy was open from 9am to 5.30pm Monday to Friday and from 9am to 1pm on Saturdays. Staff could access an out of hours pharmacist at weekends, if specialist medications were required.

Health promotion

- Staff were consistent in supporting children and families to live healthier lives, including identifying those who needed extra support, through a targeted and proactive approach to health promotion.
- We saw excellent efforts to promote a healthier lifestyle through child friendly boards, activities and leaflets. The information boards were separate for parents, children and adolescents. We saw literature was aimed at the audience they were targeting. For example, the adolescents board had information about exam stress, be smart online and the parent area had information about the Department of Health campaign change4life.
- Staff sign posted parents and carers to the weight management service for intervention and treatment if their child required weight management support. Children were referred to the service if parents requested this and this was discussed with the consultant
- The service was familiar with the national priorities to improve children's health. The health promotion boards focused on weight management, diet, mental health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Practices around consent and records were monitored and reviewed. The service audited documentation to ensure staff consented children and young people in line with guidance, results showed 100% of the records recorded consent.
- Staff knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards.
- We saw that the hospital had an up to date policy dealing with consent and mental capacity.
- Restraint had never been used on any child or young person at the service, staff said they would use other methods such as distraction, magic cream and parents holding their child.
- There was a specific consent form used for children and young people. We saw this form in all patient notes. If staff felt that the child or young person was Gillick / Fraser competent they would involve them in discussion of their care and if appropriate ask the patient to also sign the consent form alongside the signature of their parent or carer.

Are services for children & young people caring?

Outstanding ☆

We rated it as **outstanding.**

Compassionate care

- Patients were always treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs.
- Staff understood and respected the personal, cultural, social and religious needs of patients. We heard of examples where staff communicated with religious leaders to ensure they were familiar with the needs of

the communities they served. For example, the service contacted representatives of the Jewish community if they needed further information relating to circumcision carried out in the community.

- Staff took the time to interact with patients and parents in a respectful and considerate way. We saw staff helped parents when their child was distressed, the nurse stayed with mum to ensure she was supported. Interactions were jovial and friendly.
- Parents valued the relationships they had with staff. Often staff carrying out the pre-operative assessment met the child and parents on the ward on the day of surgery for continuity of care. Parents we spoke with said staff went 'the extra mile', they showed children around the ward before surgery, they contacted parents or carers prior to surgery to check they had understood the instructions before surgery. When children were upset staff acted appropriately, they were sympathetic and tried different ways to distract them.
- The importance of flexibility, informed choice and continuity of care was reflected in the service. All staff ensured that care was provided in a seamless way as soon as a child was admitted to the hospital.
- The ward collected data on patient satisfaction, we saw that the ward received 207 responses between January – September 2018, of these responses 98% said that the overall care was excellent and 100% said the staff looking after them were friendly. The remaining 2% said the service was good and commented on the food and the time they waited to go to theatre. We reviewed all the comments attached to the 207 responses whilst on inspection and found that 80% of the comments left by patients described the service as "brilliant, amazing or excellent".

Emotional support

- Staff were aware of the emotional support needs of children and showed a high level of sensitivity and understanding when providing care. Any anxieties were picked up at the pre-assessment and staff were keen to address these prior to coming to the ward to avoid emotional distress.
- Spire elephant teddies was given to the children who were distressed, the service also gave out bravery awards upon discharge to award the child for their bravery.The certificate read "for being a brave and a cheerful patient during the stay". One parent told us this was a lovely extra that made their child feel special.
- Staff
- Staff understood the need for patients to sleep, all patients were given their own room which meant there were minimal disturbances.
- Staff showed compassion and a prompt response to patients who were in pain or upset.
- Staff supported patients to reduce their nervousness, play specialists were available on the children's ward to support any child that needed distraction.We saw there was a range of toys for distraction, the older children were offered tablets that had WIFI access.
- The service had developed a patient journey video which was available via the hospital's website for both patients and their families to watch prior to admission. Staff at the pre-operative assessment sign posted parents to the link. This enabled children to understand and visualise being in hospital so that they didn't feel anxious or scared. A child we spoke with told us the video helped reduce anxieties because they were able to understand what to expect when they came to hospital.
- To reduce anxieties and emotional upset, staff allowed children attending for day case or in-patient surgery to be accompanied by their parents into the anaesthetic room.

Understanding and involvement of patients and those close to them

- Patients who used services and those close to them were active partners in their care. Staff were fully committed to working in partnership with patients and parents.
- Staff communicated appropriately with children and young people and their relatives. Results from the patient survey showed that 97% of patients said the service told them everything they needed to know.
- Information and support were provided in a child friendly format to help children and young people make decisions about their care and treatment.

- Parents we spoke with said they felt involved in decisions about their child's treatment and care. They told us that communication was clear and that staff helped with answering queries they had. We observed both parent and child were involved in the "next steps" discussions with the consultant post-surgery.
- Parents were provided with the contact number for the ward on discharge in case they needed advice once they left. During out of hours the phone was diverted to the main hospital.

Are services for children & young people responsive?

Outstanding ☆

We rated it as **outstanding.**

Service delivery to meet the needs of local people

- Patient's individual needs and preferences were central to the delivery of tailored services. The services engaged with external organisations such as commissioners, the local authority and neighbouring trusts to provide a flexible service that allowed patients to make informed choices.
- The hospital had strong links with neighbouring hospitals, we saw that feedback from surveys were used to improve the service and fuelled collaborative working with neighbouring NHS hospitals to reduce waiting times for endoscopy.
- The hospital had systems and processes in place to ensure that the needs of local people were considered when planning the service. For example, staff had contacted the Crohn's society for leaflets on managing and treating Crohn's in children because they had identified an increase of children admitted to the ward with this disease.
- The environment on the children's ward was suitable for children and young people. It was bright and colourfully decorated. This provided a warm and welcoming experience for children who required admission to the ward.
- Individual rooms with en-suite bathrooms meant children and adolescents were in separate areas. Children had access to a play room and adolescents had access to WIFI so that they could use their social media.
- A fold up bed in each child room was available for parents and relatives if they needed to stay overnight. Parents could go to the café for refreshments or staff were happy to make them hot drinks.
- Systems were in place to ensure staff had access to children and adolescent's mental health services, general practitioners, health visitors, school nurses and social care providers to support patients. For example, we saw that the service developed a referral guidance document to assist staff on how to refer to the local children and adolescent's mental health service. The guidance detailed an emergency response during working hours and the process for staff to follow during out of hours.

Meeting people's individual needs

- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. This included patients with protected characteristics under the Equality Act or who had complex needs.
- We saw that staff cared for patients as individuals and strived to meet their individual needs. This was so that they could deliver person centred care.
- There were wide facilities available for children and young people on the ward, encouraging them to play and relax. The play room colours and design met the needs of children. Children could
- The children play room was perfect for children to distract themselves from the anxieties of surgery. There was a wide selection of toys and games including books, role play toys action figures.
- Play specialists were available seven days a week, staff requested them to support children with learning disabilities, needle phobia or those they thought may benefit from play input to help prepare for a surgery.

- Staff told us that they could access language interpretation services and we saw posters displayed across the ward informing patients and families of this service.
- The service identified and met the information and communication needs of people with a disability or sensory loss. We saw that they had provisions in place to support this group of patients, these included sensory equipment and communication story cards and a quiet room if children needed time away from the ward.
- Verbal and written information was given to the patient and their families in age appropriate formats. Patient information booklets, including admission, surgery specific and infection prevention and control were tailored to support parents and their expectations. Children and young people were provided with bespoke information leaflets about their visit to hospital. The information was bright, child friendly and well written.
- We also reviewed the child friendly "your visit to hospital" booklet. This booklet comprehensively described what to bring to hospital, and the new things you will see and hear. Descriptions were targeted at children. For example, "your temperature will be taken with a thermometer that the nurse puts into your ear and this may tickle".
- Parents were encouraged to stay with their child on the ward, each room had a pull-out bed available for parents to rest next to their child's bed.
- Patients who were referred to the service with specific needs were risk assessed to determine if they were eligible for treatment at the hospital. Those who did have specific needs were offered the tulip room in outpatients, so that they could be in a more calming and quiet area away from other patients if they found it too loud.
- Room six on the ward was larger than the other rooms, bathroom facilities were appropriate for patients requiring a hoist or those who used a wheelchair.

Access and flow

- Patients could access services and appointments in a way and at a time that suited them. For example, appointments were made after school or in the school holidays.
- Patients were offered timely access to initial assessment, test results, diagnosis, or treatment.Referrals were made into the service by the general practitioner or by self-referral.
- Patients did not wait long for surgery, consultants ran clinics and theatre lists regularly.
- There was access to psychiatric services for children, we saw that there was a local service agreement for children and adolescent mental services that staff could contact
- The service set out strict criteria for admission of children on the paediatric pathways.
- Children were admitted under the care of a named paediatric consultant with paediatric practising privileges.
- The paediatric scorecard measured the number of cancelled appointments, unplanned transfers and readmissions. Each cancelled appointment was also incident reported so any trends could be identified.
- The service reported 0.24% of avoidable cancellations, 0 unplanned returns to theatre, 0 unplanned transfers to another hospital and 0 readmissions within 31 days between the reporting period of November 2017 and December 2018.

Learning from complaints and concerns

- The service had a system to encourage complaints and compliments with a view to improve the service for patients and communicate praise to staff.
- The service used the Spire group-wide complaints policy. The policy set out a two-stage process for complaints from NHS patients and a three-stage process for complaints from self-paying patients
- The Compliance and Patient Experience Manager was responsible for the monitoring and management of the complaint process. Complaints were managed in line with the Independent Sector Complaints Adjudication Service code and were discussed weekly with members of the senior leadership team.
- All complaints were reviewed at the senior management team meeting and as a standing agenda item at every hospital management team meeting, alongside patient satisfaction data and other patient feedback.

Complaints, emerging trends or themes and learning were discussed by the patient experience group, at various assurance committees and during the ward team meetings when they were relevant to children.

- Complaints for children's services were low there were two complaints over a 12-month period, one related to the choice of food and the other related to the delay to theatre. Both complaints were handled appropriately. On the back of the complaint relating to food, staff told us that the menu was changed.
- Staff told us they would seek to resolve a concern informally first, but complaints were dealt with formally if necessary. The governance arrangements in place ensured that lessons from complaints were shared amongst all staff.
- Staff learnt from complaints and tried to improve the service as a result.

Are services for children & young people well-led?

Outstanding ☆

We rated it as **outstanding.**

Leadership

- The service was led by the ward manager who reported to the matron.
- There was compassionate, inclusive and effective leadership at all levels across the children and young people service. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- Staff spoke highly of the executive team and told us they felt extremely valued by senior managers. It was evident from discussions that leaders strived to provide and encourage staff to succeed and to continue to improve.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired leadership culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.

Vision and strategy

- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. The hospital had a vision 'toThis was displayed in on the welcome board as you entered the hospital.
- Staff recognised their roles in delivering high quality in line with the hospital wide vision but also worked to the local paediatric vision. They spoke of the importance of the local vision which was to "treat each child as an individual"
- The strategic children's and young people framework was reviewed biannually at the paediatric steering group. Staff on the paediatric ward were engaged in agreeing the children's and young people's strategy so the service provided patient centred care. Senior managers understood what priorities the service needed to achieve.
- The strategy for children and young people's services at the hospital was aligned with the Spire Healthcare corporate strategy. There were systems to monitor, review and provide evidence of progress against the strategy and plans.
- The values and the vision of the service were aligned to staff objectives, these were discussed at yearly reviews.
- Leaders of the children and young people service were invited to a leadership forum where they put forward priorities for the new year. All priorities were captured on the department's plan and added to the heads of department priorities before they were all consolidated into a single strategy.

Culture

- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns.
- We found no evidence of hierarchal importance between senior and junior staff. All staff felt leaders valued their opinions and were approachable. Staff felt comfortable to raise concerns with clinical leads and said their concerns would be acted upon. All staff we spoke with mentioned in their discussion that they felt there was a supportive 'no blame culture'.

- We heard of how leaders celebrated positive achievements on the ward, we saw evidence of staff receiving awards and incentives for going over and beyond.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and children's experiences. The open and honest culture within the service was exceptional; staff we spoke with were sincere throughout our inspection about their service and the areas where they wanted to develop.
- Throughout the service we found that staff were friendly and worked together as a team across all areas of the patient journey. Staff we spoke with described having a good team ethos.
- Staff were very passionate about working in the organisation and were highly committed individuals that worked their best to provide patient focused care. Staff all said they enjoyed working across children and young people services and would not move jobs. This was supported by low sickness and staff turnover levels.
- Staff had various forums in which they could express their views and be heard including one to ones, and team meetings. The hospital ran a staff survey each year, the latest figures from 2018, showed 87% of staff felt engaged, the hospital saw improvements across all areas of the survey including; management, team work and job satisfaction.
- The hospital's freedom to Speak Up Guardian was available to staff if needed. Staff were aware of how to access the guardian.

Governance

- Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.
- The paediatric consulting body was represented at the hospital medical advisory committee meetings which were held quarterly.
- Any consultant wanting to perform new procedures at the hospital had to go through the medical advisory committee for approval. This was known as a staged introduction of new practice, whereby consultants completed a form that demonstrated the number of procedures they had completed in the NHS.
- There were monthly ward and department meetings and daily heads of department safety huddles in which key issues were discussed and information shared amongst staff. These meetings were used to coordinate all functions of the children and young people service. Staff were held accountable for action plans and those who were given responsibilities for certain functions were asked to report at the meeting they attended.
- Senior managers discussed safety and performance, patient experience and training. Meetings were discussed with all staff at monthly staff meetings and the minutes were readily available.
- The clear governance structure meant that incidents could be quickly acted upon. For example, high PEWS scores had been actioned and escalated to the paediatric consultant lead.
- An incident action log was used to track all incidents and ensure that learning was developed when necessary. The action log could be accessed by any member of the team to identify and track trends.
- There were service level agreements in place for all third-party providers. We saw evidence of these SLA's being checked against agreed key performance indicators on a regular basis. There had been no issues that had required escalation.

Managing risks, issues and performance

- There was a demonstrated commitment to best practice performance and risk management systems and processes.
- A quarterly governance report was completed for the children and young people's service and shared with relevant committees and the Medical Advisory Committee.
- The lead nurse for the service was represented in other relevant committees, for example, health and safety, risk, infection, prevention and control and medicines management.
- There was a specific children and young people audit schedule which included resuscitation, dashboard measures (audit and outcome data), infection, prevention and control and anaesthetics.

- The service submitted data for children and young people's safety thermometer externally. The leadership team received information to support them in managing risk, recognising issues, and measuring performance.
- The hospital held an overarching risk register and all risks were entered on the register by ward managers or the matron. Risks were reviewed and updated monthly. We saw that there were no paediatric associated risks on the hospital-wide risk register. Staff said any previous risks on the register were supported with a brief description of the risk, control measures, an owner, risk level and a review date.
- All local risks were recorded on the electronic risk library. These were underpinned with risk assessments which detailed the risk, the mitigation, actions and the responsible individual.
- Risks were identified through a variety of sources including the risk assessment process, feedback, incident reporting, external accreditation/assessments, audit and national recommendations. Information was analysed, discussed and actions were put in place at the paediatric steering group.
- Measures and information relating to quality and safety was provided to the leadership team. We saw examples of this in the children and young person's report. Leaders were provided assurance through audit.

Managing information

- The hospital ensured that all staff had a Spire Healthcare email account (including consultants provided by the partner NHS provider) and used an electronic encryption system to enable the sharing of secure information between healthcare professionals when necessary.
- Staff had unique profiles to access the hospital's computer systems.
- There were adequate numbers of computers for staff, which supported their daily functions.
- Images from scans could be reviewed remotely by doctors so that interpretation was timely.

Engagement

- There were consistently high levels of constructive engagement with staff and people who used services. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.
- There was a proactive approach in engaging with external stakeholders to deliver patient focused care. Ongoing discussions with the local commissioning groups aimed to explore ways in which the provider could support children in the surrounding communities and local NHS hospitals. For example, we saw that the service had recently taken up an NHS contract to reduce waiting lists for endoscopic procedures and were looking to support ear nose and throat work.
- The children and young people service actively sought the views of patients and their relatives by asking them to complete satisfaction surveys following treatment to help shape future improvements. Results were displayed on the ward notice boards and updated regularly.
- The service demonstrated learning from patient feedback. This included the development of a new child friendly menu and colouring book that was designed by children from local schools.
- Patient satisfaction survey results showed that patients were very satisfied with the facilities and care they received. Feedback received was related to the menu choice which had been changed in response to the comments.
- Another way of engaging with patients was the feedback chart on the ward corridor. This detailed comments from patients who visited the ward "what's hot and what's not". Where children had identified areas, which were 'not hot' the service had responded and made changes for example to the menu.
- There were monthly staff meetings when more detailed information was cascaded from senior management meetings. We heard examples of how staff were encouraged to participate in meetings, so that they could get the maximum out of their meeting.
- The service invited children and their parent or carer to advisory groups but unfortunately, they did not attend. We saw that the service had held eight events which were opened to children and young people, data showed that no children had attended.

- The hospital wide staff survey results had showed improvements, overall 81% of staff said they felt engaged, 81% enjoyed work and 84% said they were happy with their manager.
- The service engaged with local universities to provide work placements to nursing and physiotherapist students. We saw there was a big drive to provide a productive and informative placement to these students.

Learning, continuous improvement and innovation

- There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. For example, the service implemented plan, do, study act cycles to demonstrate change. The example given on inspection related to child friendly information booklets. All phases of the booklet were sent for feedback and changes were made from recommendations.
- Improvement was seen as the way to deal with performance and for the service to learn. The service did this by introducing child friendly feedback surveys, children and young people forums and attending national work streams to gain information on best practice so that they could deliver care that was patient focused to this age group.
- Leaders and staff strived for continuous learning, improvement and innovation, they participated in accreditation schemes to align their service to ensure patients received national standards for children and young people. For example, the service made use of technology to make it more accessible to young people. An online preoperative assessment option was introduced for children who were not able to get into the hospital and were appropriate for this. This meant they did not have to miss time off school.
- We saw that the team regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance. This led to collaborative working to improve menus, processes and cross working with the children's outpatient department.
- Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. We saw that there were systems to support improvement and innovation work. For example, Spire Manchester were involved in the design and piloting of a children and young people's survey which had now been rolled out across the whole organisation.

Outstanding ☆

Outpatients

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

Are outpatients services safe?

Good

We rated it as **good.**

Mandatory training

- Spire Manchester provided staff with training in safety systems, processes and practices and staff had a high level of compliance. Training was monitored by local managers and nationally by Spire.
- Staff received support and training in 10 core modules including fire safety, safeguarding adults and children, moving and handling and infection control.
- The service provided mandatory training to staff, either face to face or on- line in key skills. Staff told us they could access training when needed.
- Between 1 January and 31 December 2018 outpatients staff met the hospital target for compliance with mandatory training. The mandatory training log showed all 45 clinical and non-clinical staff within the department had completed 100% of their required training.
- Completion of mandatory training was a requirement to obtaining increment increases in pay. Staff we interviewed told us they were fully informed about their mandatory training position by managers before increment dates so that training could be completed before increments were due.

Safeguarding

- Spire Manchester provided staff with polices and training to keep people safe from abuse and this was monitored by managers and Spire nationally. Staff had a high compliance rate for training. There were comprehensive systems to keep people safe, which took account of current best practice.
- There was an in-date safeguarding policy and staff we talked to had access to it and were aware of how it supported decision making.
- Staff in the department could seek advice from a paediatric lead nurse, safeguarding lead nurse and matron. Staff told us all the safeguarding leads were accessible and based in the hospital.
- The paediatric lead nurse supported the outpatient's department by overseeing children's outpatient's appointments in conjunction with consultants. The paediatric nurse was responsible for co ordinating care between the hospital's paediatric and outpatient's department.
- The nurse safeguarding lead supervised and supported the paediatric lead nurse in outpatients. The nurse safeguarding lead was trained at Level 4 children's safeguarding.
- The matron was also trained at Level 4 children's safeguarding and linked into the local safeguarding governance structures in the hospital in conjunction with the nurse safeguarding lead.
- The safeguarding structure included a local safeguarding group which was attended by different

departments and professions in the hospital. The matron also sat on the senior managers clinical governance groups as well as the medical advisory committee.

- Mandatory training for safeguarding children for clinical and non-clinical staff was at 100%
- Mandatory training at level three in safeguarding adults for clinical and non-clinical staff was 100%.
- The paediatric team in the hospital had developed a safeguarding competency framework which outpatients staff had to complete. All staff had completed the framework as part of their yearly cycle of training.
- Staff in the outpatient's department received training on vulnerability and mental capacity and training levels were at 100% for clinical and non-clinical staff.
- The outpatient's department had no safeguarding referrals to the local authority in the last year.

Cleanliness, infection control and hygiene

- We found staff were aware of infection, prevention and control issues. Staff were proactive in control measures
- Spire Manchester had procedures and a policy in place for its staff to manage infection control to minimise the risk to patients. Staff we spoke with knew about the policy.
- Health care assistants and nurses in the department told us they took ownership of cleaning clinical areas and stated that they felt their role was vital in making sure the environment was safe and hygienic. It was clear that all staff we talked to were fully committed to maintaining high standards of infection control.
- All staff had received training in infection control measures and there was a 100% compliance rate.
- We observed hand gel being used by staff in all clinical areas and hand gel was accessible across the department.
- Best practice handwashing techniques were displayed above sinks in every treatment room. Staff followed 'bare below the elbow' guidance to minimise the risk of infection spreading.
- Personal protective equipment such as aprons and gloves were available for staff to use in every clinical room. Sharps bins containing used needles and syringes were secure and safely stored.
- We reviewed records that showed all clinical rooms we inspected were cleaned by staff on an ongoing daily basis. Non-clinical areas we visited were visibly clean and tidy and had completed cleaning checklists.
- Equipment in the rooms had been tagged to show cleaning dates and all the stickers indicated that cleaning dates had been complied with.
- Records showed that clinical areas were deep cleaned as required.
- Clinical waste bins were used by staff to dispose of clinical waste across the unit daily. Policies and procedures were in place to remove clinical waste safely.
- Staff in outpatients had access to a hospital lead nurse on infection control and the lead nurse had developed a programme of staff training events.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- We visited three large patient waiting areas, seven consultation rooms, two treatment rooms and a store room and sluice area.
- The premises were modern and accessible, consisting of one ground floor department with a reception area entrance. There were 24 consulting rooms with dedicated separate examination rooms. The department had four treatment rooms, one of which had its own recovery area. All rooms had locks for privacy and security.
- Consulting and treatment rooms were of high specification and suitably sized. They contained the necessary patient equipment and stock, which was clean, in date and regularly checked by staff.
- The service used oxygen when needed and this was piped through to clinical rooms. Extra oxygen cylinders

were available, and these were attached against secure surfaces, on the walls, inside the treatment room. We checked the cylinders and found adequate oxygen supply for the treatment of patients.

- The head of service reviewed all specialist equipment with the maintenance department in the hospital. We saw evidence that this was carried out on a yearly basis with the support of the maintenance department.
- Staff checked equipment daily to ensure that it was correct, and stock was replenished
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired, and we saw evidence this had occurred.
- The head of service showed us examples of environmental improvements which were made in the last year in response to staff and patient feedback. Due to an increase in numbers of children accessing outpatients the department had developed several child friendly initiatives. The initiatives included additional baby changing facilities in the paediatric area and a play area for children.
- The toys in outpatients were stored and kept clean by staff in the hospital. In addition, wooden mobiles had been attached to walls where children were waiting to be seen.
- Patients with mobility problems had given feedback about access to the department. The hospital had widened entrances to the department for ease of access. The height of some chairs in waiting areas had been raised to help with mobility of patients.
- New dementia friendly toilets and waiting areas had been introduced. The department had recently developed the “tulip room”, which was a multi-purpose private room and could be used for patients with additional needs or as a private area.

Assessing and responding to patient risk

- Staff had the ability to assess and respond to patient risk and were aware of who to contact if a patient deteriorated.
- A resident medical officer or the emergency team depending on the nature of the illness were available If a patient required hospital admission following review and treatment by medical staff.
- A blog had been developed by the hospital director to show staff a new resuscitation system and staff were able to describe the procedure if a patient became unwell in their department.

Nurse staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The outpatient department had 13.3 full time nurses and 7.4 full time health care assistants. The outpatient department had many senior nursing staff who provided staffing support. Nursing staff reported to the head of service who reported to the matron.
- The outpatient department had no vacancies as at the end of the reporting period, December 2017-November 2018.
- In the last three months of 2018 the department had no unfilled shifts for its clinics.
- Sickness and vacancy rates were low. We reviewed sickness rates for nursing and healthcare assistants in the period December 2017- November 2018. Nursing sickness was relatively low for the full year at under 4%. Health care assistant sickness spiked to 8% in two months due to long term sickness but was generally under 3% for the rest of the year. The national target for Spire was 3%.
- Nurse staffing in the outpatient department was planned by managers on a weekly and daily basis. Administration managers and clinical managers worked together to assess workload and capacity. The review included the number of nurse and consultant clinics taking place and the numbers of patients expected.
- Information provided by Spire showed that annual nurse turnover rates had significantly reduced in the last year from 55% to 13%. We were told by staff and managers that staff had been encouraged to develop in the department so that leaving the department was

seen as a career setback rather than an opportunity. Staff had been encouraged to go to managers with proposals and ideas about change in the department and staff had gained access to management courses and other qualifications.

- The nursing team used an acuity dependency tool with staffing calculated daily and staffing was discussed during a daily huddle.

Medical staffing

- There was adequate medical staffing to meet the demands of the outpatient clinics.
- Spire Manchester employed consultants with practising privileges who undertook outpatient clinics as well as surgery at the hospital. Patients were seen generally for consultation, pre- surgery assessment and post-surgery discharge. A large proportion of patients attending Spire wanted to see the same consultant and did so on request.
- Consultants maintained responsibility for their caseload and we were told by three patients that medical staff were accessible, and appointments could be made almost daily. Consultants were available for advice by telephone if they were not on-site.
- We interviewed two consultants, they told us that clinics were manageable. Spire had introduced a new clinic viewing system which allowed consultants to review patients lists booked into their clinics off site using a secure server, before attending clinic. The system allowed consultants to add or decrease proposed clinics depending on the complexity of patients.
- A resident medical officer was on site for 24 hours a day, seven days a week. All consultants told us that they received support or supervision either through Spire or their NHS employer.

Records

- Records of patient care were not always completed correctly. Staff did not always keep detailed records of patient care clear and up to date.
- In 2017 Spire introduced a single patient record. This was in response to feedback from the CQC that we expected all patients admitted to independent hospitals to have a full and contemporaneous medical record available on the site where the patient was given advice and treatment.
- The hospital director had written to all consultants asking for compliance to our request. The request was then followed up by two record audits in outpatients. The audits were undertaken over many areas. We reviewed these audits as part of our inspection.
- In April 2018, two of the consultants in the audit reached only 25% and 38% compliance rates. A further audit undertaken in June 2018 showed improvement moving to 82% and 73% compliance rates. The department did a follow on review in June 2018 and the audit results showed that most files contained copies of referral letters, outpatient clinic notes and outcome letters, as well as all other relevant correspondence and diagnostic test results.
- During our inspection we reviewed 17 sets of notes. We found only four sets of the notes were completed without any recording issues. Several of the files were not dated We also found some notes were not signed by consultants and in some cases handwriting in files was illegible. Following these findings, we escalated these concerns to senior managers who immediately discussed the issues with consultants and clinical leads in the hospital. The following day Spire sent us a comprehensive action plan which included auditing and compliance letters to consultants.
- Records in the outpatient's department were paper based. There were plans to introduce a fully electronic system. Files were kept securely and were placed in clinics by health care assistants before consultant clinics started.
- Spire had an in-date records management policy.
- The service provided electronic access to diagnostic results for consultants in outpatients. Results could be sent to other hospitals if needed.

Medicines

- The service had systemsthat were in place for the safe storage, administration, prescribing and disposal of medicines,

- Spire nationally had a medicines management policy, and this was followed by clinical staff.
- The outpatient's department did not store controlled drugs.
- The medicine cupboard had access keys which were held by qualified staff. Keys were kept separately and were tracked by an electronic system on the cupboard so that access was secure.
- We saw a record for the ordering, receipt and disposal of general medicines and all medicines and supplies were in date of safe use.

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

Incidents

- The outpatient's department managed patient safety incidents well. Staff had an open culture where safety incidents and concerns raised in the department were valued as being integral to learning and improvement.
- Incidents in Spire Manchester were recorded using a nationally used electronic incident reporting system. All staff we interviewed told us that they were trained to use the system and could gain access to the online system.
- The outpatient's department had no never events in 2018.
- Staff told us that they were encouraged to report incidents and they reported receiving feedback from managers on incidents on the unit and across the hospital.
- There were 288 clinical incidents between October 2017 and September 2018. The rate of incidents had fallen in the last two quarters and incident levels were down on the year before. The outpatient's department also had 49 non-clinical incidents in the same year.
- Spire Manchester had developed a story-board detailing how a never event had occurred in the hospital. The story board showed how the event happened and what those involved were thinking at the time of the incident. All the staff we interviewed in the outpatient's department were aware of the incident and the findings had been shared using the story board.
- Staff were aware of duty of candour and we were shown evidence of letters to patients which included duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The senior managers met in a safety huddle every morning with heads of department to review issues and incidents which had occurred across the hospital in the last 24 hours. The senior management safety huddle meeting findings were then sent to all teams in the hospital via a poster.
- The outpatient's department undertook a similar daily multi-disciplinary safety huddle after the senior manager meetings to discuss safe staffing and any concerns or issues that needed to be resolved.
- Spire Manchester had developed a series of video blogs/communications to help get key messages over to staff regarding incident reporting. The video blogs covered duty of candour, risk management, and had a video recording encouraging escalation of concerns which was presented by the hospital director.

Safety Thermometer (or equivalent)

- The outpatient's department monitored safety results. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The service reported thermometer outcomes on a national clinical scorecard which was published on a quarterly basis. The score card showed the hospital's performance across several safety targets. The score card was green throughout 2018, with good outcomes for transfers out, venous thromboembolism incidence, re-admissions and falls.

Are outpatients services effective?

Not sufficient evidence to rate

Inspected but not rated. We do not rate the effective domain in outpatient departments.

Outpatients

Evidence-based care and treatment

- The outpatient's department provided care and treatment using evidence-based practice. Spire as a national organisation and the hospitals managers checked to make sure staff followed guidance.
- The hospital participated in a national audit awareness week with other Spire hospitals across the country. Following the awareness week every department in the hospital presented an audit they had conducted. The audits findings were shared with the hospitals staff group. The senior management team then voted on the best submission and awarded a prize to the winning department.
- Spire Manchester had a yearly clinical audit plan. The plan included sharps, waste, cleaning schedules anti-microbial, hand hygiene, asepsis and environment audits. We reviewed the results from audits and these were showing nearly 100% compliance.
- Care and treatment within the outpatient department was delivered using evidence-based practice. Staff and managers described the use of The National Institute for Health and Care Excellence (NICE) guidelines in outpatients and outpatient's physiotherapy. A monthly safety bulletin was issued centrally by Spire which included updates on NICE guidance. The evidence was reviewed by the clinical audit team and shared with managers and teams across departments.
  - Patient pathways were in place for a wide range of treatments and this incorporated both inpatient and outpatient treatment pathways.
  - We reviewed minutes from staff meetings in the outpatient's department which were held to share best practice information and promote shared learning between staff and managers. Staff received clinical updates electronically and policy updates were discussed at staff briefings.

Nutrition and hydration

- Free refreshments were available in outpatient waiting areas.

Pain relief

- The staff in outpatients assessed and monitored patients at appropriate times to see if they were in pain using organisational guidelines.
- The hospital had pain relief guidelines, a pain relief assessment form and a pain relief group.
- Analgesia was prescribed for individual patients to take home in outpatient's clinics following some procedures.
- The Spire Manchester patient satisfaction survey asked all patients how well their pain was managed throughout their stay. The 2018 survey stated that 96% of patients reported that the staff did everything they could to control their pain.

Patient outcomes

- Staff monitored and compared the effectiveness of care and treatment with other hospitals nationally across Spire.
- Spire used a national clinical scorecard to benchmark its performance against targets and other Spire hospitals. The scorecard had several quality indicators such as infection rates, falls and patient satisfaction. The score card was green in 2018 showing positive performance when compared nationally to other Spire hospitals.
- We reviewed a yearly action plan which was developed to improve areas of the score card. The areas of improvement were minimal and mainly related to hospital wide processes, rather than issues in the outpatient's department.

Competent staff

- Staff performance was monitored using supervision which supported managers to assess the effectiveness of staff and the department.
- Appraisal assessments were in place for outpatient staff and they directly related to the hospitals and outpatient departments business strategy.
- Staff appraisals had increased in the last year. Nursing appraisals had increased from 83% in 2017 to 93% in 2018. Health care assistant's appraisals rates were at 100% in both years.
- Staff told us they had a full induction and a buddy who supported them whilst the induction process occurred.

Outstanding ☆

Outpatients

- Outpatient staff told us they felt supported by managers and the organisation to develop in their roles and staff described numerous development opportunities which included managerial, clinical and the development of current staff.
- Managers described how they managed poor performance including the development of improvement plans for both consultants and other clinical staff when required.

Multidisciplinary working

- A daily hospital huddle of staff from various disciplines was held and attended by senior representatives from each hospital department. This was then replicated by departments, to ensure planned staffing levels were appropriate to meet the needs of patients. In addition, it allowed identification and forward planning for patients with additional requirements such as children, vulnerable adults or those with complex care needs.
- Monthly team meetings were held within the staff in the department which were also attended by physiotherapy staff to exchange information.
- Regular team meetings were held in the outpatient's department which complimented the daily huddles.
- Letters were sent from the outpatient's department to patient's GPs to provide a summary of the consultation.

Seven-day services

- The department provided services Monday to Friday 8am-8pm and provided services on Saturday morning.
- A 24-hour hospital on call service was available seven days per week.

Health promotion

- Several health improvement days were open to the public to promote healthy living and well-being and an opportunity to discuss various topics such as cardiac disease, hip and knee replacements.
- The physiotherapy department carried out fitness checks on patients both pre- and post-surgery.
- Spire offered patients open forums on differing illnesses and injuries. The service had provided patient open evenings on avoiding sports injuries.
- The service provided health promotion leaflets which were readily available throughout the outpatient's department.Leaflets in different formats and languages were also available.

Consent and Mental Capacity Act

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards
- Spire had a national consent policy in place which was in date. Mandatory training levels were high for both mental capacity, vulnerability and safeguarding.
- Staff in outpatients worked on the principle of implied consent but if written consent was needed it was obtained by the consultants in the outpatient clinics. Spire used a specific consent form relating to investigation or treatment for a child or young person.
- Staff told us they would involve the safeguarding lead if they had concerns regarding a patient's capacity while attending the department.
- Staff understood legislation and how it related to decision making in young people such as the Children's Acts 1989 and 2004, Gillick competence 1985 and Fraser guidelines 2006

Are outpatients services caring?

Outstanding ☆

We rated it as **outstanding.**

Compassionate care

- We observed all staff treating patients with compassion, dignity and respect. We spoke with 11 patients and carers who confirmed how well staff treated them. We listened to staff being sensitive in their communications with patients and they

respected their individual needs. We listened to reception staff, nursing and care staff introducing themselves, 'Hello my name is…'. Patients told us they were given time to ask staff any questions they had.

- We were told how the outpatient staff visited breast care patients on the ward when they had received treatment because they had built up a relationship with them over a period following their attendance at the breast care clinic. We observed a patient receiving immediate assistance with mobility as they arrived in the outpatient's department.
- The reception staff and nurses in outpatients promoted confidentiality as we observed patients being able to speak with the reception staff without being overheard. We observed patients and family members being welcomed to the department prior to their appointments by the reception staff. Confidential personal information was not discussed for others to hear. The pharmacy department had in
- Staff understood and respected the personal, cultural, social and religious needs of patients. A staff member had considered alternative ways of communicating. The staff gave us an example of how they took a patient aside to the Tulip room with a pad and pen as they recognised at reception they had difficulty expressing their needs verbally. This made them feel more comfortable and able to express their needs.
- The hospital had a multi-faith prayer room which was open 24 hours a day and available for use by patients, carers and staff.
- Staff told us they had received dementia friendly training and additional training had been provided by a representative from the Stroke Association who talked about how people with a disability accessed healthcare services. This had assisted the staff to make amendments to their environment, for example they had introduced a red toilet seat in the toilet as a visual aid for people living with dementia, removed the mirrors in one area and had lowered the mirror in the bathroom for wheelchair users.
- We observed many interactions where the staff responded with compassion in a supportive way to patients who were evidently experiencing physical discomfort. The receptionist escorted a patient to sit down whilst checking the patient's registration form, rather than leave them to stand up with their mobility aid. One patient told us they had always been made to feel as 'comfortable' as they possibly could by 'excellent, professional and caring staff' throughout their course of treatment which had involved several visits to the bariatric clinic. They had valued their relationship with their lead nurse.
- We observed and listened to staff actively promoting patients' dignity in the outpatient's department. For example, one patient had requested to attend the unit in their nightwear otherwise they would not attend. To ensure their dignity was met, staff thought to advise the patient they should bring a blanket and checked they were being accompanied. Upon arrival staff asked the patient if they wanted to sit in the quiet room (the Tulip room) with their next of kin.
- Feedback from people who used the service, and those who were close to them was continually positive about the way staff treated people. We saw several thank you cards from patients and relatives who were appreciative of the care and service they had received. Three patients told us their consultants had provided them with the best care they had ever had.
- Patient satisfaction data was collected. Spire Manchester were one 8 in 10 outpatients would be highly likely to consider the hospital as their first-choice next time they needed to visit a hospital.
- In addition, an online physiotherapy survey was available for patients to complete on a tablet in the department following their physiotherapy appointments.
- The environment in the outpatient department allowed for confidential conversations. The consultation rooms were private, additional curtains were in place for the treatment area to maintain patients' privacy and dignity.
- A chaperone policy was in place for staff to access. All patients had access to a chaperone. Patients were offered this service on their initial letter and a clearly displayed reminder notice was available in each consultation and treatment room.

Emotional support

- Staff provided emotional support to patients to minimise their distress and demonstrated an

understanding of their condition on their wellbeing. For example, we observed physiotherapy staff actively encouraging patients to carry out their treatment programme. One patient told us how their family had been included in their treatment plan.

- We heard examples of where staff told us their experiences at the hospital were positive. Comments made included; "I felt really involved in the decisions about my care and planned treatment" and "the consultant and specialist nurse have been wonderful. They have explained everything clearly to me". With the patient's permission, we observed a member of staff undertaking a procedure. We observed they were provided with appropriate information and were given time to ask any questions. Three other patients confirmed their procedure had been clearly explained to them.
- In addition, we sat with a patient during their final follow up consultation. The patient explained their care and treatment had been 'second to none and staff were always very professional'. Staff were proud of their Tulip room, a multi-purpose space to promote privacy and dignity for any patients who wished to use it. Staff told us they had used it to break bad news to patients and relatives, for privacy for breastfeeding mothers and for patients with challenging behaviour.
- Staff had access to psychological therapies to support them in their roles.
- One staff member we spoke with had received the Inspiring People's Award due to the positive feedback from patients they dealt with. This is a recognition scheme the hospital used to reward those who deliver great care to inspire others to want to deliver the same. The patient had required an injection in their eye and the support and action taken by the administrator had reassured the patient immensely. The staff member had received a thank you card as the patient felt they had gone 'above and beyond' to support them. The staff member told us 'I am proud to work for Spire. I am the first point of contact and I get satisfaction from giving my best to patients. This showed how staff were provided the time and resources to ensure patient centred care occurred and staff demonstrated the core hospital values of 'Caring is our Passion' and 'Looking after all patients with dignity, concern and kindness"
- During 2019 the hospital had plans to run at least four patient forums to involve patients in developing and improving patient care. In addition, plans were in place to run targeted forums for specific patient groups including children and young people and self-funding patients.

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 told us they had been involved in decisions regarding their care. The results of the hospital outpatients pilot survey in November 2018 showed that 96% of respondents would recommend the hospital to friends and family if they needed similar care or treatment. One respondent in the survey had stated, 'the staff are very friendly and welcoming. The hospital is very clean. The hospital appears to want to continually improve itself, and this is shown around the hospital, using feedback, and what improvements they have made. The staff were understanding, explained everything well, and are very assuring.'
- Information was provided to patients before admission from the hospital bookings team.
- Reception staff told us if they identified a patient with communication needs, these were recorded during the pre-assessment process and an additional alert would be put on the patients file at this stage so staff providing care were aware of any individual needs.
- A process was in place to inform patients on arrival of any delay to their clinic appointment and staff told us that they would contact patients by telephone prior to their arrival to advise of any significant delay. This enabled patients and staff to work together and allowed patients to reschedule their appointment if it was more convenient.
- Patients told us their follow up appointments and post diagnostic investigations were made with minimum delay and they were clearly told what the next step in their treatment would be. They were advised they could contact the hospital whilst awaiting results if they needed to. We observed patients being prepared for their outpatient treatment and given information

prior to their discharge. GP's were sent letters following patients' consultations to advise them of the outcomes, examples of these were seen in their records.

Are outpatients services responsive?

Outstanding ☆

We rated it as **outstanding.**

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people the hospital worked collaboratively with local commissioners of services and local providers, including hospital managers and GP's. This was to enable NHS patients to access care and treatment without delay, and to allow people to have a choice where they received their care. The hospital website included information for patients and visitors about the outpatient's department.
- The environment was appropriate, and patient centred. We observed clear signposting within the hospital guiding patients to the outpatient's department, physiotherapy and hydrotherapy pool. Signage was clear for refreshments, toilets and baby changing facilities. Refreshments were available from vending machines and access to the hospital restaurant was close by on the ground floor.
- We observed the reception staff guiding patients to the appropriate waiting areas where they were met by nursing staff. The waiting areas were clean and comfortable with adequate seating, televisions and magazines provided.
- There was a soft play area in the paediatric clinic waiting area. In addition, children's toys were available in other consulting waiting areas.
- Free car parking was available. In the November 2018 outpatient survey, parking was one of the lowest areas on the patient journey as a concern. However, it appeared to be a time of day issue as some patients reported struggling at certain times. The hospital reacted positively to car parking by securing some additional parking for staff close by.
- Patients told us they received instructions with their appointment letters and we saw the information provided to both private and NHS patients. NHS patients could choose their appointment date and time through the NHS referrals scheme. Self-funded and insured patients had a choice of consultant as well as the date and time of their appointment.
- We observed where the use of alternatives to face to face appointments were carried out.In the physiotherapy department we saw where a patient, their consultant and the physiotherapist had held a skype call with the patient who had gone abroad following their surgery.
- The department had introduced a hysteroscopy service which enabled patients to be treated without requiring a day case bed. The new procedure had followed a detailed policy and risk assessment check prior to commencement.
- The hospital was working to establish a volunteer programme learning from the positive experiences of other Spire Hospitals.
- Certain clinics were held on Saturdays and in the evenings to provide flexibility for patients. Since 2018 extending Saturday opening for consultations, diagnostic imaging and physiotherapy had commenced.
- Patients we spoke with told us their test, examinations and follow up appointments were planned in a timely way.
- The hospital monitored the number of patients who did not attend (DNA) for their pre- booked appointments. Physiotherapy, NHS, self-paying and insured patient's DNA rates were less than 10% of their overall scheduled appointments with NHS being the highest at 9.78% of patients. Following missed appointments staff followed a procedure. This involved contact by phone or a letter to rearrange an appointment and patients would be discharged if they did not attend a second time. In addition, cancellations were monitored and used as an opportunity for learning.
- Feedback was encouraged through various means with responses publicised on 'You said we did' section of noticeboards.

Outpatients

Meeting people's individual needs

- The service took account of patients' individual needs.
- The outpatients service took a proactive approach to understanding the needs and preferences of different groups of people, including those with protected characteristics or complex needs, and in a way, that met those needs. One of the commissioning targets allocated to the hospital was focussed on access for those people with protected characteristics.
- The department was located on the ground floor and was accessible for patients with a disability. Mobility scooters and wheelchairs were made available for patients or relatives with mobility problems.
- Staff told us they had received dementia friendly training and additional training had been provided by a representative from the Stroke Association who talked about how people with a disability accessed healthcare services. This had assisted the staff to make amendments to their environment, for example they had introduced a red toilet seat in the toilet as a visual aid for people living with dementia, removed the mirrors in one area and had lowered the mirror in the bathroom for wheelchair users.
- Patients were encouraged to provide feedback on their experiences and wherever possible, services were tailored to the needs of individual patients. The outpatient's department had been involved in the redesign of an admission and discharge booklet. This was based on the feedback from past patients and included new information such as queries raised by patients.
- The administration manager told us how the staffing requirements and shift patterns were adapted according to the consultants lists so patients' needs could be planned for. If staff identified any additional needs for individual patients during their initial referral or during the pre-assessment process. An alert sheet was completed prior to admission detailing if the patient had any physical, sensory or mental impairments, allergies, or communication needs. The alert sheet was then filed at the front of the patient individual records. In addition, an alert sticker was placed on the cover to remind staff to check the alert sheet.
- The service had clear policies in place supporting patients with mental capacity issues.
- The department had a wide-range of patient information leaflets explaining the services. Staff could access and print copies of the standard leaflets in a range of other languages for patients whose first language was not English. Telephone and face-to-face translation services were available to staff; this included access to British Sign Language interpreters.
- All permanent staff had undertaken dementia awareness training and were dementia friends. A dementia friendly clock was available at the reception area.
- Equipment to meet the needs of individual patients was available including, chairs and treatment couches for bariatric patients.
- The hospital had ensured it was accessible to patients within the requirements of the Disability Discrimination Act. This meant that in addition to adapted toilets, parking facilities and wheelchair access was available at the main entrance of the hospital.
- The physiotherapy and hydrotherapy department were located on the ground floor and provided physiotherapy services for post-surgery patients including those whose care involved special exercises undertaken in a warm-water pool.
- There was a full physiotherapy service within a gym environment which included pre-operative assessment clinics, Pilates classes, hand therapy and multi-disciplinary clinics where the consultant and the physiotherapist jointly assessed and planned care for patients undergoing hip surgery.
- Since 2018 the hospital promoted the hospitals public health days by using social media to help patients and others to provide feedback and help people with a variety of conditions find out more about their condition and possible treatment options. In March the service was holding a heart disease event.

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 offered flexibility of choice of consultants in most specialties and of appointment times which included evenings and weekends.

- One-stop clinics were available for patients with breast or bowel symptoms, reducing the number of appointments.
- The results of the hospital outpatients survey in November 2018 showed that 8 in 10 appointments happened on time in November 2018. In answer to the outpatient's survey question, 'why did you choose Spire Manchester?' 21% said it was the speed at which they could be seen and 12% said it had the best choice of appointment times.
- The national standard for referral to treatment time stated that 95% of patients should start consultant led treatment within 18 weeks of referral. In the reporting period November 2018 to February 2019 the outpatient's department data showed that the hospital exceeded the target by achieving an average of 98.6% of patients waiting 18 weeks or less.
- The national standard from referral to diagnostic test stated that 99% of patients should wait less than 6 weeks from referral to diagnostic test. In the reporting period November 2018 to February 2019 the outpatient's department data showed that the hospital exceeded the target as 100% of patients waited less than 6 weeks.

Learning from complaints and concerns

- The service treated complaints and concerns seriously, investigated them and learned lessons from the results. Lessons learned were shared with staff. Sixteen complaints were received from patients regarding the outpatient department from January to December 2018. Nine complaints related to the nursing team and 7 were related to outpatient administration.
- There was a transparent and proactive complaints policy available for staff.
- Complaints leaflets were available within the department. The leaflets provided details about how to complain, the stages of a complaint, and how to request an independent review of complaints through the relevant NHS health service ombudsman and independent healthcare complaints handling organisations. In the same reporting period no complaints had been progressed in this way.
- The manager had a high visible presence in the outpatient's department and a strong commitment to resolving issues locally where possible. The manager told us, "It's about trying to anticipate patients fears and worries. We aim to make it better for the patients at all times where possible". Staff told us they attempted to resolve any patients verbal concerns at the time they were raised. All staff were aware of how to signpost patients to the hospital's complaints policy.
- We discussed two outpatient complaints with the hospital's dedicated patient experience manager. This manager's role included analysing feedback from patients and ensuring the hospital acted on patient satisfaction and complaint data to improve the service they provided in line with their patient engagement and experience strategy.
- We saw evidence of the learning from the two complaints received. One had led to additional staff training in relation to sleep study. We saw the letter to the complainant which offered the option to arrange to speak with the manager of the department if they were dissatisfied with the outcome.
- In line with the hospital's complaints procedure, the complaints were acknowledged within two working days. The written responses were sent within 20 working days following investigation.
- Outcomes of complaints were shared at senior management meetings and learning from complaints was shared with staff at staff meetings and during staff briefings.

Are outpatients services well-led?

Outstanding ☆

We rated it as **outstanding.**

See surgery section for main findings.

Leadership

Outpatients

- Managers had the right skills and abilities to run the service providing high-quality sustainable care. The department was led by a head of service and team leaders who managed all staff. The department had an outpatient administration lead who had a similar structure of administration leads.
- Spire Manchester had gone through a significant change in leadership in the last 12 months and this had been coupled with an entirely new hospital and new hospital site. The outpatient staff told us a new hospital director and head of service had been appointed just after the hospital moved location and new working structures and practices had been initiated in the outpatient department.
- The hospital director, matron and head of service updated outpatient staff on progress against plans and sought direct feedback from all staff. This included quarterly face to face updates, staff inclusion in business planning with the hospital director and the leadership team. Staff, including consultants had also participated in a hospital feedback which had provide positive feedback from a survey.
- Spire Manchester had introduced quarterly leadership forums to help develop strategy, improve engagement and deliver regular leadership training.
- Managers and staff told us how succession planning and development had prospered in the organisation. Thirty-six staff including those from outpatients had been through a four-day management programme in 2018 so that they could support their teams to deliver care. Staff spoke highly of the hospital for allowing them to attend management training, the quality of this training and how this had benefitted them in their role.
- We found a compassionate, inclusive and effective leadership team both at senior management and team management level. Staff we spoke with said that Spire was the best organisation they had worked for in their career.
- We were told by staff that managers went out of their way to thank them and reward them for work they had undertaken. It was clear that this had a real impact on morale within the unit. Turnover of nursing staff in outpatients had reduced by 42% in one year, from 55% in 2017 to 13% in 2018. Staff told us that they felt this was down to managers taking active interest in retaining staff by creating an environment they wanted to work in.
- Members of staff who aspired to develop clinical skills were provided with support and training to do so in the organisation. The department had a clear policy of growing its own workforce. In collaboration with Bucks New University Spire are sponsoring a health care assistant to train as an apprentice student nurse. The department have plans to develop this in the future with a further apprentice student nurse.
- We interviewed a health care assistant who had been encouraged and supported to apply successfully to a nursing course and gain a nursing qualification. The member of staff told us they were fully supported by the hospital and the outpatient manager and felt that the organisation had transformed her future job prospects.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Staff including consultants spoke highly of line managers and the senior management team.
- Senior managers participated in sleepovers and weekend cover, so they had first-hand experience of the hospitals patient's experience and observed how teams cared for patients.
- Every staff member we interviewed felt supported by their local managers and we observed good team working within the outpatient's department. All staff shared a sense of pride in working for Spire Manchester and working with their colleagues.
- The hospital managers had changed the way they communicated with staff and had produced a series of video blogs/communications to help get key messages over to staff.
- Hospital staff had access to all the physiotherapy departments amenities, including gym and exercise classes. In addition, staff had access to yearly wellbeing checks that were carried out by an independent health care organisation.

Vision and strategy

Outpatients

- The vision of Spire Manchester was, "To be the first choice for private healthcare for patients, consultants and GP's in Greater Manchester".
- Spires vision, values and promises were displayed prominently around the outpatients' department.
- Each department in Spire had its own strategy which was developed in conjunction with staff and senior leaders. The outpatient departments strategy for 2019 focussed on three key headings namely, fix, build and grow. The fix element of the strategy related to rectifying issues which had underperformed in the last year or had been identified as a problem area. The build element was focussed on developing areas of business and the final element, grow was expanding processes that were succeeding.
- Staff were aware that a new vision had been developed and their input had been actively sought in its development. The vision promoted a sense of belonging to a wider health care community. Staff told us how they had started to integrate into GP and hospital networks and shared information and good practice.
- The hospital and outpatient strategy were developed in both a bottom-up and top-down process. Staff told us they were asked to reflect on the successes and the things that needed to improve from the previous year through staff seminars. Team leaders were then invited to a leadership forum where priorities, including those identified by the staff, were included in a business strategy for the new year.
- Heads of department then met with the senior management team to consolidate team findings with the national strategy.
- Staff told us that the business strategy (along with the departmental strategy) was used as a foundation for building individual objectives. This ensured that everyone could relate their job role with the wider objectives and strategy of the hospital.
- The vision and the strategy had been discussed at the quarterly hospital director roadshows with staff. Progress was then discussed with staff and the leadership forums.

Culture

- The senior management team was visible, approachable and hands on in their management of the service and this was repeatedly evidenced by staff in outpatients. There were high levels of satisfaction regarding working at Spire Manchester across all staff groups, including consultants.
- There was a deeply embedded culture of openness from leaders at all levels. Staff told us that middle and senior managers were very visible and accessible. There was an open-door policy with all managers and staff spoke very highly of the head of service and the senior management team.
- Managers across the service promoted positivity and this was reflected in the staff's attitude to working in the department. Staff told us that it was a pleasure to come into work every day.
- Staff told us that the culture of the department was that it was "everybody's business" which implied that the organisation and department were a team where everybody mattered. We were told by lower grade staff that senior managers sat and had lunch with them in the canteen and spoke to staff about how they felt working for the organisation.
- Staff were aware of the organisations Freedom to Speak Up Guardian and how to contact them.
- There was a staff recognition award scheme which had recently been awarded to a member of the outpatient service.

Governance

See information under this sub-heading in the surgery section for the main findings.

- We saw clinical governance committee meeting minutes and reports, which took place quarterly to discuss risks, incidents and key issues.
- Outpatients contributed to the hospital's quality report every three months which set targets for compliance. The report included reporting on infection control measures, incidents across the hospital, mandatory training, staffing and complaints.

Managing risks, issues and performance

Outpatients

- Outpatients had systems to identify and manage risk and provided controls and assurances for the risks that were identified.
- Managers in the department could identify what their local risks were, and they shared these risks with staff and senior managers during meetings.
- Outpatients monitored risk using a scorecard which had key performance indicators. The score card reflected domains which were used by the Care Quality Commission. We were told by managers that action plans were developed if performance dipped or did not meet national performance figures.
- Daily huddles were held with clinical leads and the hospital director so that teams understood the day to day risks in the hospital which were shared with departmental staff.
- The hospital produced a document for staff that identified its top 10 risks with an appropriate risk rating. The document was well laid out and helped staff recognise risks in their own areas of work.

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 collected performance measures and data which enabled managers to understand areas of improvement. The data included patient and staff questionnaires which were shared with staff by managers and actioned on.
- Policies and procedures were readily available on the hospitals intranet site and all staff told us that they had access to it.

Engagement

- We observed high levels of constructive engagement with staff and people who used services, including all equality groups.
- Spire Manchester had a patient engagement strategy which included commissioning targets for engaging with patients with protected characteristics.
- The views of patients and staff were actively sought within outpatients using the NHS Friends and Family Test and patient and staff satisfaction surveys. The friends and families test showed that 96% of patients were likely to recommend Spire Manchester.
- The outpatients and physiotherapy department have been involved in the design and piloting of new patient surveys which are now being rolled out across the whole organisation. We observed a digital patient survey which was accessible to patients within the physiotherapy department where they could access this immediately following treatment.
- A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future patients. Consultants and staff had been involved in receiving feedback and had made adaptations to the environment to improve access to the department.
- The service was open and rigorous and constructive in acting on feedback. The public staff and stakeholders were welcomed and seen as a vital way of holding services to account.
- Staff we spoke with told us there had been a significant increase in staff engagement at Spire. This was reinforced by the 2018 staff engagement survey which 81% of Spire Manchester staff had completed.
- Patient representatives will also be asked to review complaints which have been anonymised and review Spires responses to provide an objective assessment from the patient's perspective.

Learning, continuous improvement and innovation

- Spire Manchester developed a story-board detailing exactly how a never event occurred which has been shared with outpatient staff. The story board showed how the event happened and what those involved were thinking at the time of the incident.
- Spire Manchester have developed a series of video blogs/communications to help get key messages over to staff. The video blogs covered duty of candour, risk management, encouraging escalation of concerns.
- Spire Manchester had employed its first two apprentice nurse associates from its outpatient health care assistant staff group.

Outstanding ☆

Outpatients

- Spire Manchester have produced a health and equalities plan in conjunction with its staff group and commissioning group.
- The Imam from Manchester Royal Infirmary had agreed to run cultural awareness sessions for staff to raise awareness of the Islamic religion in March 2019.
- Patient representatives were asked to review complaints which have been anonymised and review Spires responses to provide an objective assessment from the patient's perspective.
- During 2019, Spire Manchester are running four patient forums to involve patients in developing various aspects of patient experience, including catering service and fee information provided to outpatients in advance of their initial appointment. Spire Manchester also provide patients with open forums on differing illnesses and injuries. The service had provided patient open evenings on avoiding sports injuries.
- Spire Manchester developed a staff awareness workshop led by a representative from the Stroke Association. The workshops shared personal experiences of accessing healthcare using a wheelchair.
- The hospital had also introduced other staff workshops such as one on sepsis and infection control which were led by an individual with experience of developing sepsis.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

We had not rated this service before. We rated it as **good.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff received training in areas relevant to their role, such as health and safety, equality and diversity, information governance, moving and handling and resuscitation.
- Mandatory training was delivered using a mixture of face-to-face training and e-learning.
- In December 2018 training compliance was 96% with a hospital target of 95%. Staff were notified on the electronic system when their mandatory training was due to expire.
- The service had an induction programme for agency staff.
- Staff working with radiation were trained in the regulations, risks and use of radiation and had signed the local rules relating to the appropriate areas in which they worked

Safeguarding

- Staff understood how to protect patients from abuse, staff had training on how to recognise and report abuse, and they knew how to apply it.
- There were no safeguarding incidents between October 2017 and September 2018.
- Organisational policies included a safeguarding vulnerable adult's policy and safeguarding the care of children and young people and chaperone policy, all were in date. There were flow charts for safeguarding children and adults with relevant information and contact numbers.
- Mandatory training included safeguarding training at the appropriate levels that staff needed for their job role. There was 96% compliance with safeguarding training. The training included awareness of female genital mutilation and child sexual exploitation.
- Five radiographers were trained to level three for safeguarding for children and young people. When children were brought in to the department for diagnostic scans they were accompanied by their parents and sometimes by a paediatric nurse.
- Staff we spoke with were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately. Staff told us they could contact the hospital lead for safeguarding adults and the hospital lead for safeguarding children for advice.

Cleanliness, infection control and hygiene

- The service controlled infection risk well, all areas were visibly clean and tidy.
- There was no MRSA, methicillin-sensitive staphylococcus aureus, Clostridium difficile or Escherichia coli reported by the service between October 2017 to September 2018.

Good

Diagnostic imaging

- The waiting areas, corridors, examination areas and changing rooms were visibly clean and well organised. There were rotas for cleaning the areas and rooms. We saw completed cleaning schedules and provisions were in place for patients with an infection.
- Radiographers cleaned scanning equipment after each use with sanitising wipes. Paper covers were used on the scanning couch. They were disposed and replaced after each patient.
- Staff used orange clinical waste bags, with foot-operated waste bins. Sharps bins were correctly assembled, signed, dated, and not over-filled.
- Staff adhered to the hospital's hand hygiene and "bare below the elbow" policy. Personal protective equipment such as gloves and aprons were available to wear during care and treatment. There were instructions for washing hands above the sinks. There were wall-mounted hand gel sanitizers readily available in all areas. Staff we observed used sanitizing hand gels before providing patient care
- Infection control was included in mandatory training for staff. There was 100% completion of this training

Environment and equipment

- Equipment in the department was new and there were servicing contracts in place.
- The service was in a purpose-built unit on the ground floor of the hospital. It was accessible and was clearly signposted.
- The service had a radiation protection supervisor (RPS) who was the head of the department and a radiation protection advisor (RPA) who was from an external company, there was also a medical physicist attached to the service. The RPA was responsible for issues such as calibration of equipment, risk assessments and dose assessment and recording.
- The RPS told us that they had a good relationship with the RPA and had worked closely with them since coming into post.
- Staff and patients accessed the radiology department into a waiting area with a reception desk.Staff signed in patients for their diagnostic imaging examinations. The reception area was shared with physiotherapy patients. All other areas of the radiology department were restricted to staff access only. These areas included offices, patient areas and diagnostic imaging areas. Fire exits were clearly marked and accessible.
- In the computerised tomography (CT) scanning room and magnetic resonance imaging (MRI) scanning room ceiling tiles had been replaced with scenic images for patients to look at when undergoing a scan.
- Diagnostic imaging staff used lead aprons to protect themselves against radiation exposure. Lead aprons we saw were in good condition and were checked on a regular basis and replaced when not fit for purpose. Thyroid protection shields were available in line with Ionising Radiation (Medical Exposure) Regulations (2000) (IR(ME)R) recommendations.
- The service audited their lead aprons and they were scanned every year and rated as to their quality. Any apron rated as red was scanned every three months, any apron rated as amber was scanned every six months and any apron rated as green was scanned every year.
- Risk assessments had been completed for all the modalities of radiation and the risk assessments addressed occupational safety to radiographers and to patients.
- Local rules for radiation were displayed on the walls of the treatment area for each modality of radiation and had been signed by appropriate members of staff.
- Equipment had been purchased from new when the hospital had opened in 2017, this meant that dose reference levels of radiation were generally low. Each piece of equipment included a risk assessment and any mitigating actions in place to reduce radiation risk.
- Maintenance arrangements were in place to ensure that specialist equipment was serviced and maintained as needed. All equipment seen during the inspection included evidence of a maintenance check within the last 12 months. All equipment was checked every year and there was a mock IRMER inspection every two years.
- Staff completed daily warm up quality assurance tests on the equipment to monitor and check that it was safe to use.

- Staff wore dosimeters so that managers knew how much radiation the staff had been exposed to.
- There were signs and warning lights outside controlled areas where radiation was used to make it clear when it was safe to enter.
- There were resuscitation trolleys around the radiological imaging department. We observed they were checked daily by the radiographers and this was recorded. There was oxygen available on the trolleys, though piped oxygen was available in most clinical areas including the MRI room. There was paediatric resuscitation equipment available on the unit.
- There were generators that could be used in case of power failure during a scan, so the scan could be completed.

Assessing and responding to patient risk

- There were systems and processes in place to reduce the risks to patients and staff.
- The service had processes to confirm the right person got the right radiological scan at the right time. The imaging department had implemented the pause and check process before every patient examination to confirm the delivery of safe and effective patient care. This included a six-point check. The six-point check included examination justification, patient's recent imaging, patient's identity (name, date of birth, postcode), pregnancy status, confirmation that the patient expected the diagnostic testing procedure and a check as to whether the patient had had a similar procedure recently. This enabled staff to check patient understanding about the radiological procedure and to reduce duplication and possible over exposure to radiation.
- The service conducted observational audits of Ionising Radiation (Medical Exposure) Regulations. IR(ME)R requirements. Computerised tomography IR(ME)R audit for November 2018 showed 100% compliance with pause and check processes including examination justification of the procedure, checking patient recent imaging and patient name, date of birth and address.
- Staff recorded cannulation attempts and this was stored in the patient record. This was used to assess staff competency in cannulation technique.
- The service had safety questionnaires that patients completed before they underwent radiological testing. The service had a magnetic resonance imaging (MRI) safety questionnaire and a computerised tomography (CT) questionnaire. For radiological examinations requiring contrast, patients completed a specific questionnaire to identify if they had any renal problems which may prevent them receiving contrast. This was scanned into patient records.
- Staff checked the pregnancy status of female patients. One member of staff was pregnant at the time of the inspection and a risk assessment had been completed to identify and negate any potential risks. There were signs in the department advising women of child bearing age about radiation risk. This was audited as part of the IRMER audit and the audit showed 100% compliance with the checking of pregnancy status.
- The recovery room located next to the MRI scanner room was purpose built to be used in the event of a medical emergency in the MRI scanner. The MRI scanning table decoupled so that staff could take the patient out, straight into the recovery room where there was all the appropriate equipment required to address the medical emergency. Piped oxygen was available in the MRI scanning room.
- Staff completed point of care testing to measure the glomerular filtration rate of patients before administering contrast. The filtration rate would show whether the patient's renal function was adequate to receive contrast for their imaging otherwise it would only be given under the direct supervision of a radiologist.
- Staff we spoke with told us that the resident medical officer was supportive and available to offer medical support when required. During our inspection a patient had received contrast and had a slight reaction to it, staff contacted the resident medical officer who responded quickly and provided medical support. Adrenaline was always available in the department in case of an anaphylactic emergency.
- Mammography staff told us what they would do if they found something of concern on a breast scan. They would contact the person who had made the referral to the service as soon as possible.

Good

Diagnostic imaging

- There were protocols that required the presence of a radiologist for the procedure, these would not take place if appropriate staff were not present.
- There were emergency call buttons all around the department so that help could be summoned quickly if necessary.
- Staff knew how to manage a patient who suddenly became unwell. This included basic observations, contacting the resident medical officer and emergency treatment as required.
- All staff including non-clinical attended team huddles which helped contribute to continuity of care. This meant that all staff could manage potential safety risks for the day. Staff felt supported by their colleagues.
- There was a policy for extravasations and these would be reported as an incident. Extravasation is the leakage of fluid or a medicine from a blood vessel into the tissue around it.
- All allergies were noted on the electronic record and flagged up before any scanning started.
- The reception staff were trained in basic life support and said that they kept an eye on patients in the waiting room, if they became unwell they would use the emergency call buttons in the waiting area to summon appropriate support. The system was tested regularly.

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 service included radiographers of different gradings, health-care assistants and non-clinical administration staff. The service sometimes used agency staff to meet the demands of the service. Some agency staff were used frequently to cover specific areas of competence in the department and the same bank and agency staff worked in the department and knew the systems and processes.
- There had been a reduction in staffing when the hospital moved sites as there was a reduction in demand, this was increasing, and the department was advertising for two additional radiographers.
- The hospital did not generally recruit newly qualified radiographers.
- Staff told us they never worked alone, this was for patient and staff safety.
- A paediatric nurse trained in advanced paediatric life support attended when a child was scanned.
- A noticeboard, in the waiting area, displayed photos of staff uniforms for the service so patients understood different staff roles.

Medical staffing

- There were several radiologists who worked at the hospital who had practising privileges.
- All consultants had to nominate a standby who would cover for them during periods of absence or annual leave.
- For our detailed findings on medical staffing please see the safe section in the surgery report.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. These were mainly electronic though referral forms were paper, these were audited to check that they were appropriate for the imaging and any risks to patients were identified.
- The service used several electronic systems for storage and transfer of images. This included the picture archiving and communications systems (PACS). There was 24 hour, seven days a week, PACS support available. There was IT support that could be contacted in the event of IT failure.
- The service provided electronic access to diagnostic results. The service could send images to other hospital sites.
- The service used an electronic patient record system. Any additional needs of the patient (such as mental health needs, learning disability needs and physical

health needs) were detailed in the justification comments or by using a logo on the patient record system. The referral form included additional information that may impact on the examination.

- Staff would scan completed safety questionnaires and consent forms for examinations into the electronic record system.
- Staff told us that if a patient had a blood test in the hospital, they could access the results in the database and use this to inform care. This would save the staff needing to conduct an additional blood test before the scan.

Medicines

- There were effective systems in place for the storage and management of medicines, and they were prescribed and administered appropriately.
- Rooms where medicines were stored were accessed by key pads and the cupboards were accessed by key pads. There were no controlled drugs in the department.
- Room temperatures were taken daily and recorded. All rooms in the department were air-conditioned so it was unlikely that room temperatures would rise enough to affect any medicines stored in the storage rooms.Fridge temperatures and the warming cabinet temperatures were recorded daily.
- The service used patient specific directives (PSD's) for the administration of radiology contrast dye. A PSD is an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by that prescriber. The radiographers had worked with the lead pharmacist to develop the PSD and their competencies to administer the medicines.
- There was a comprehensive audit of storage and security of medicines in the radiological imaging department on 23rd August 2018, the department scored 100%.
- During the period between September 2018 to December 2018 there were no incidents involving medicines reported.
- When contrast was used for patient imaging the batch numbers from the contrast was recorded in the patient record.

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.
- All radiographers, health-care assistants and non-clinical staff we spoke with knew how to report incidents using the hospital electronic reporting system. One member of staff gave an example of using the system to report a contrast reaction.
- There have been no never events or serious incidents reported for the imaging service between October 2017 to September 2018. Never events are serious incidents that are wholly preventable.
- Alerts from the central alerting system were passed on to staff during routine briefings.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (2000) IR(ME)R. The service had procedures in place to report incidents to the appropriate regulators, for example the Care Quality Commission (CQC). There had been three incidents involving radiation though none of these had been reportable to IR(ME)R in the past 12 months.
- The service had radiation protection local rules and IR(ME)R employer procedures in place. This was updated in January 2019 and was due for review in January 2021. This detailed arrangements in case of a radiation incident occurring.
- There had been 48 incidents in the reporting period, these were either low harm or no harm. Most incidents were when a patient had an unnecessary X-ray on a body part or where a repeat image was required. None of these incidents were IRMER reportable.

Good

Diagnostic imaging

- Staff had received awareness training on incident management and processes and all incidents were discussed at the daily departmental meetings.
- Staff had access to a monthly update of the hospital's incidents and complaints and what actions were taken and lessons learnt.
- All staff we spoke with within the department knew their responsibility and the process relating to Duty of Candour. The Duty of Candour is a legal duty that relates to openness and transparency and requires providers of health and social care services to inform patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

Inspected but not rated. We do not rate the effective domain in diagnostic imaging.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- We saw that the service used guidance from the National Institute of Health and Care Excellence and from the Royal College of Radiologists and the Royal College of Radiographers.
- The service had determined their dose reference levels for most procedures, these were generally lower than national levels, this was because the equipment was new and generally required less radiation for images. There were also processes in place for appropriate dose reference levels for children and young people. Dose reference levels were audited as part of the Ionising Radiation (Medical Exposure) Regulations requirements audit and there was 100% compliance with the audit in November 2018.
- The service used pathways and protocols for procedures that were evidence based and available on the hospital intranet.
- Any deviation from a protocol would need the permission of a radiologist, this would be scanned into the patient record.
- There was a national steering group for radiographers at Spire who met regularly, the group comprised of the managers at the sites where there were diagnostic services. This group would make recommendations about new guidance and shared best practice across all the hospitals.

Patient outcomes

- Managers and staff monitored the effectiveness of diagnostic services and compared the outcomes of their services both internally and within the Spire hospital group.
- There was an extensive programme of 16 audits every month in the department. These included infection control, safety checklists, referral audits, consent, World Health organisation checklists and Ionising Radiation (Medical Exposure) Regulations. Each member of staff was responsible for several audits and any action plans arising from the audit.
- Protocols for each procedure had to be signed off by the chair of the Medical Advisory Committee. Any new protocols had to be agreed with the chair.
- Each consultant had their own protocols for different parts of the body and we saw that these were recorded and stored by the radiographers. This was because different consultants came from different NHS trusts that used different protocols.
- The mammographers would undertake a peer review of their images every six months to assure on going quality of the images. The mammographers were mentoring a new member of staff.

Competent staff

- The service made sure staff were competent for their roles.
- Staff told us that they had completed additional courses and training to enhance their skills and knowledge.
- All staff we spoke with told us that they had an appraisal.

Good

Diagnostic imaging

- There were clinical competency frameworks and one of the radiographers told us they had completed appropriate competency training for their grade.
- Radiographers told us they learned from the radiologists who were always available for advice.
- Although staff did not currently receive protected time for continuous professional development the manager told us this would be built into job roles in the future.
- Agency staff had to complete competency training before being able to conduct scans. There was an induction checklist for radiographers.
- The hospital put on teaching and learning sessions for local GP's, these were open to all staff at the hospital.
- There were continuous professional development sessions and lunch and learn sessions for staff development.
- There were study days and training for the radiation protection supervisors, there were also updates every two years.
- There were corporate conferences every year for radiology managers.

Multidisciplinary working

- Staff of different professions worked together to produce the best outcomes for patients.
- Radiographers told us they had good relationships with the radiologists at the hospital. The administration staff who booked patient appointments also told us the radiologists were always happy to answer queries about patients and their appointments.
- We saw that there was good working between the cardiology nurses and the radiographers at the hospital.

Seven-day services

- Computerised tomography scanning was available 8.00am to 8.00pm and magnetic resonance imaging (MRI) was available 8.00am to 8.00pm six days a week but there was an on-call service out of hours. This was mainly used to facilitate patient discharge. Staff said that services were moving towards six days a week.

Health promotion

- We saw that there were health promotion leaflets around the department. There were leaflets about giving up smoking and the hospital ran free events for people including heart health events.

Consent and Mental Capacity Act

- The service did scan patients who lacked capacity and staff used the appropriate consent forms.
- Staff said that patients without capacity were usually accompanied by a carer or there were dementia friendly advocates at the hospital.
- Staff had received training in the mental capacity act and staff we spoke with described what they would do to support a patient who lacked capacity.
- There were several ongoing trials that required imaging, these had received ethical approval.

Are diagnostic imaging services caring?

Good

We had not rated this domain before. We rated it as **good.**

Compassionate care

- We saw the staff treated patients with compassion and respected privacy and dignity.
- In the control room for magnetic imaging scanning and computerised tomography there were blinds so that staff could protect the privacy and dignity of patients undergoing a personal procedure. We saw that these were used during our inspection.
- Staff were respectful of patients as they brought them from changing areas into treatment rooms.
- Staff told us about an unwell patient who needed a whole-body scan and there was no availability as the treatment slots were full. Staff came in at 6.30 am so they could complete the scan before the days list started.

Emotional support

Good

Diagnostic imaging

- Staff provided emotional support for patients when they needed it.
- There was a one stop breast clinic and staff told us how they supported patients who were attending the clinic and waiting for results.
- Staff said that some patients attended the hospital regularly and welcomed them by name into the department.
- We observed that the radiographers kept in touch with patients through the intercom system during their magnetic resonance imaging and computerised tomography scans to reassure them. Patients were able to choose music to listen to, whilst having their scan, this would calm and distract them.
- Radiographers tried to see the same patients when they attended for multiple scans to give continuity of care.

Understanding and involvement of patients and those close to them

- Staff involved patients and their relatives in decisions about their care.
- Staff involved parents and carers to help when children were having a diagnostic procedure.
- Carers could stay with relatives or children when they were having a magnetic resonance imaging scan if they completed the safety questionnaire.
- We observed a radiographer telling a patient about a procedure, this was well communicated in a very caring way. The radiographer told us that they had been involved in an audit about good communication skills. This was part of the Ionising Radiation (Medical Exposure) Regulations and the audit showed 100% compliance in November 2018.

Are diagnostic imaging services responsive?

Good

We had not rated this service before. We rated it 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 who used the hospital.
- There were a range of diagnostic services available to support patients who required treatment both NHS and self-funding patients. The diagnostic suite was located on the ground floor of the hospital and shared a spacious waiting room with physiotherapy services.
- The waiting area was pleasant and there were refreshments available. The chairs in the waiting area were of different heights and some had arms. This was useful for patients who had recently had joint replacement to help them get in and out of the chairs.
- There were several imaging services available at the hospital including magnetic imaging resonance scanning (MRI), computerised tomography scanning (CT), digital X-ray, digital mammography and fluoroscopy.
- Access from the waiting room into diagnostic areas was controlled so that staff had to let patients in from the waiting room. There were seating areas near the different diagnostic modalities.
- In the computerised tomography (CT) scanning room and magnetic resonance imaging (MRI) scanning room, ceiling tiles had been replaced with scenic images for patients to look at when undergoing a scan.
- Although there were not a lot of windows in the diagnostic department, waiting areas were light and airy and uncluttered. There was comfortable seating and art work throughout the department that was appealing.
- There was a small play area for children with a selection of toys in the play area in the main waiting room.

Meeting people's individual needs

- The service met the individual needs of patients
- The magnetic resonance imaging scanner had a 70 cm bore which was wider than most scanners. Because of this, patients sometimes attended the service who had claustrophobia issues from NHS trusts. Staff worked with patients to support them in the scanner.

Good

Diagnostic imaging

- There was a one stop clinic for patients with breast lumps and staff worked with consultants and other hospital staff so that patients received their results in a timely manner to get a prompt diagnosis.
- The mammography staff were happy to scan patients who had breast implants and had appropriate techniques for this.
- There were translation services available for patients, these were flagged on the electronic booking system. Patients with a learning disability or cognitive impairment were also flagged on the system.
- Patients with a learning disability were invited in before their appointment to look round the scanner, longer appointment times were allowed for patients. We saw there was a trial of scanning for patients with dementia and staff told us they allowed an hour for these patient's appointments instead of 20 minutes.
- Children who attended for scanning were accompanied by a paediatric nurse who used play techniques and distraction techniques to relax children during scanning.
- There was a private toilet for patients undergoing scanning for urodynamic to ensure privacy and dignity.

Access and flow

- People could access the service when they needed it and results were available in an appropriate time frame.
- The administration team arranged appointments for patients who were having diagnostic imaging tests. This was complicated, and the allocation of the appointment time depended on the procedure. To support the administration team, one of the radiographers had started working in the booking office on a daily rota. This helped the administration team so that they could quickly respond to any patient queries. This was a new initiative that the new manager had put in place and the administration staff said that this worked well.
- The reporting times for images were approximately two days for self-funding patients and five days for NHS patients, though any urgent images could be reported sooner. Consultants could log onto the systems at home to report on images.
- The hospital was achieving imaging times and 99% of patients waited less than six weeks from referral to diagnostic test in November and December 2018 and January 2019.
- We saw the service accommodated a patient who needed to catch a plane, staff said that they always tried to do this if possible.
- The hospital would undertake computerised tomography scans for other Spire hospitals and would help if there were equipment failures at other hospitals or NHS trusts.
- The department audited waiting times to scanning for patients, sometimes there were delays if a specific radiologist had been requested for a procedure.
- The department saw about 26 patients a day, six days a week for magnetic resonance imaging scanning.

Learning from complaints and concerns

- There was a patient experience manager who notified the hospital director of all complaints and the hospital matron of all clinical complaints as soon as they were received by the hospital.
- The wider management team were informed of new complaints at the daily huddle as well as updates on ongoing complaints. Complaints were discussed at the senior team meetings and management team meetings. Compliance with complaints targets was monitored through the clinical scorecard and at a national level.
- The hospital aimed to respond to complaints within 20 working days of receipt and had a target of 75% for this.
- There had been six complaints about diagnostic imaging in the period June 2018 to November 2018. This had been addressed within the appropriate time frames.
- There was information around the department about how to complain or raise concerns.

Good

Diagnostic imaging

Are diagnostic imaging services well-led?

Good

We had not rated this service before. We rated it as **good.**

Leadership

- Managers at all levels of the service had the right skills and abilities to run the service.
- The service had recently appointed a new head of department. They told us their plans for the department and had begun to implement these including mentoring staff for management development.
- Staff in the department told us that leadership had improved since the new head of department had come into post, staff said they felt the appointment of the head of department was good for the department and for their own development.
- Radiographers in the department said that the new head of department was looking to establish new roles and responsibilities in the department and to develop leadership skills of staff.
- There had been a gap in employment for the head of department of several months and during this time the department had been managed well by the deputy manager. Several other senior staff had also left during this period and so all the staff were looking forward to a period of management stability.

Vision and strategy

- The service was developing a vision and strategy for what it wanted to achieve and had started to develop this vision with its staff. They wanted to develop their cardiology services and there were plans being developed to achieve this
- The vision and values for the hospital were displayed at various places around the hospital.
- The week before the inspection took place there had been a strategy day for the department, the manager said this had been very positive and that they had some good ideas from the day.

Culture

- Managers and staff across the service created a positive culture that supported and valued staff.
- There was an open culture in the department and staff said they were happy to work there. Several staff had moved from the old hospital and were adjusting to the new hospital.
- The staff told us the senior team at the hospital were visible and accessible if they needed them. Staff all spoke very highly of the senior team.
- The administration staff said they were much happier since their reorganisation and that they now received compliments from senior managers and from the public.
- Staff were paid overtime or given time in lieu if they came in early or worked late.

Governance

- The hospital produced a governance and quality report every three months with targets for compliance. There were several measures including hand hygiene, times for closing incidents, mandatory training, agency staffing numbers and complaints.
- There was a clinical leadership group which was attended by the manager of the department, the role was to review new policies and procedures, look at incidents and complaints and all aspects of patient safety in the hospital.
- The department manager was reviewing all departmental policies and told us that they would be introducing “policy of the month” at the radiography leads meetings.
- There were daily departmental meetings in the department to highlight any safety issues, incidents or complaints. These were documented.

Managing risks, issues and performance

- The service managed risk well and there were systems in place to identify and provide controls and assurances for identified risk.
- The risk register dated December 2018 identified that staffing in magnetic resonance imaging services was a problem and was rated as nine on the risk register.

Good

Diagnostic imaging

- There was a hospital risk register which stated that there was a risk with documentation and processes within the diagnostic imaging department were not up to date and in line with the latest Spire policy due to the absence of a substantive head of department for a prolonged period. This was rated as 12 on the risk register. We saw that there were controls and assurances in place and gaps in controls had been identified with assurances and action.
- The hospital produced a document for staff that identified its top five risks with an appropriate risk rating. The document was well laid out and helped staff to recognise risks in their own areas of work.
- The radiologists had 10% of their reports audited to maintain their practising privileges. We saw that practising privileges had been restricted for one of the radiologists following a complaint and issues about their competency.
- The radiology manager had appointed an audit lead for the department, this was recent, but they had established a comprehensive programme of audit in a short time.
- Radiographers told us that they would challenge the radiologists if they were unhappy about a protocol or procedure, we were given an example of when a radiographer had challenged a radiologist and refused to compromise about the protocol.

Managing information

- Radiographers could access other scans that had been undertaken at Spire hospitals, this helped to reduce duplication.
- Images could be transferred securely to NHS trusts.
- Information governance was part of mandatory training.

Engagement

- There were events when patients and members of the public came into the hospital to talk about their issues, an example was about a patient who used a wheelchair.
- There were examples of how the service had engaged with representatives from the stroke association and a patient who had hearing loss to improve their services.

Learning, continuous improvement and innovation

- There was a culture of learning and improvement in the department and a vision that the new management would improve services in the future. There was an appetite for more collaborative working for example with cardiology to develop new services.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had excellent ways to share learning and best practice, including 48-hour flash reports and various daily huddles one of which was led by the hospital director. This included feedback from relevant incidents that occurred in other parts of the hospital.
- The hospital was a 'quality data provider' to the National Joint Registry and had been awarded a certificate for this.
- The hospital had a dementia champion and numerous volunteers to provide advice to staff and carers. Staff provided adjustments and tools to distract patients. They also provided patients living with dementia with a blue pillow case to help staff easily identify them without having to refer to their notes.
- The hospital held several free health information sessions for patients to listen to, and ask questions about, various health conditions including causes and treatment options for hip pain, robotic surgery for knee pain and the management of back and neck pain.
- The hospital held a staff awareness workshop led by a representative from the Stroke Association who shared personal experiences of accessing healthcare using a wheelchair. The representative was asked to carry out an environmental audit and tweeted about the positive feedback and engagement from staff who attended.
- The hospital secured the service of the Deaf Sign Academy to run sessions for staff on British Sign Language to improve the team's ability to communicate with patients, families, visitors and colleagues with hearing loss.
- Spire Manchester had developed a story-board detailing how a never event had occurred in the hospital. The story board showed how the event happened and what those involved were thinking at the time of the incident.
- Spire Manchester have developed a series of video blogs/communications to help get key messages over to staff. The video blogs covered duty of candour, risk management and encouraging escalation of concerns.
- During 2019, Spire Manchester are running four patient forums to involve patients in developing various aspects of patient experience, including catering service and fee information provided to outpatients in advance of their initial appointment.
- Patients having complex spinal surgery would have a dry run to help the theatre team ensure they could properly position them to reduce the risk of surgery. It helped operating department practitioners prepare the medical trays and understand the equipment the surgeons required and to plan for any unforeseen emergencies.
- The medical devices team had introduced electronic scanning of prostheses to improve stock and financial controls, and more efficient access to the required equipment by consultants.
- The children and young people service used a paediatric emergency care system to assess and manage children during an emergency. On admission children were given a coloured wrist band, which alerted staff to use a pre packed bag of that colour in an emergency. The packs contained a pre-calculated drug chart according to the patient's weight so that staff could act quickly.
- Spire elephant teddies were given to children who were distressed, the service also gave out bravery awards upon discharge to award the child for their bravery.
- Seventy-four per cent of the permanent and bank nursing staff had achieved the post-graduate award in critical care nursing.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff in the outpatient department keep detailed records of patient consultations and these are clear and up to date.
- The provider should ensure that all patients undergoing endoscopy are asked about their pain according to the core standards for pain management in the United Kingdom.
- The provider should ensure it continues to roll out its audit programme to validate and improve the medicine reconciliation target in children and young people services.
- The provider should consider further steps to achieve 100% compliance with infection control procedures in theatres.
- The provider should consider looking at maintaining privacy and dignity in the reception area at the main entrance to the hospital.
- The provider should consider an audit of patient outcomes on the insufflation of carbon dioxide.
- The provider should consider an audit of patient outcomes on the use of Entonox.
- The provider should consider if there would be a future benefit to recording and monitoring the time between the decision that a patient could be discharged from the critical care unit and when the patient was discharged to the ward.