Spire Hartswood 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Hartswood Hospital is part of Spire Healthcare Limited. Spire Hartswood offers comprehensive private and NHS hospital services to patients from Essex and surrounding areas. The hospital is located with easy access to main driving routes such as the M25 and A12 and is in close proximity to three NHS Trusts.

Healthcare is provided to patients with private medical insurance, those who self-pay and patients referred through NHS contracts. Hospital facilities include an outpatient service, diagnostic imaging service, a 25 bed inpatient ward which includes two extended recovery beds and a 26 bedded day case ward which includes five endoscopy pods. Theatre provision consists of three theatres, two with laminar flow and a sterile services department. From January to December 2015 there were 7,220 visits to theatre.

We inspected this hospital as part of our independent hospital inspection programme. This was the first comprehensive inspection of Spire Hartswood Hospital. The inspection was conducted using the Care Quality Commission's comprehensive inspection methodology.

We carried out an announced inspection of Spire Hartswood Hospital on 3 May 2016. We also undertook an unannounced inspection on the 13 May 2016, to follow up on some additional information.

The inspection team inspected the following core services:

- Medicine (specifically oncology services)
- Surgery
- Outpatients and Diagnostic Imaging

During 2015, the hospital had provided in patient services for children and young people. However, at the time of our inspection, these services had been suspended pending a full quality review. We therefore did not inspect these services.

We rated Spire Hartswood Hospital as requires improvement overall, with core services achieving good overall in medicine and requires improvement overall in surgery and outpatient and diagnostic services.

Our key findings were as follows:

Are services safe at this hospital/service

- Staff were aware of the incident reporting system however incident investigation and route cause analysis' (RCA) following incidents were often lacking detail.
- Adult and Child Safeguarding training was completed by 95% of all staff including bank staff across the hospital in 2015.Training records showed that 27% of Spire Hartswood hospital staff in February 2016 had completed the annual update of adult safeguarding training and 20.6 % for child safeguarding training against a quarterly target of 25%. The hospitals safeguarding policy had not been adapted for local use. Effective systems were in place for the management of medicines and the prevention and control of infectious diseases.
- Infection control and prevention mandatory training compliance for January and February 2016 were 33%, which is higher than the quarterly target of 25%. The hospital infection control lead carried out annual on-site refresher hand hygiene training for all staff and regular audits, including patient perception of healthcare workers hand hygiene. Reports were monitored through the Infection Control Committee, Clinical Governance Committee, Clinical Effectiveness Committee.
- Mandatory training compliance for 2015 at quarter four was 84%. This was below the target of 100% based on the trusts 25% quarterly target compliance. Between January 2016 and February 2016 overall mandatory training compliance was 18% (against quarterly target of 25%).

Summary of findings

- The levels of compliance of multidisciplinary team (MDT) discussions for oncology patients were poor, ranging between 5% and 10%.However since the introduction of the new information technology system in December 2015, compliance for quarter four had increased to 100% for breast cancer patients.
- Documentation in nursing care pathways was not robust. Medical review details were often limited, lacked detail or not present.
- The hospital did not have a single or unified patient record. Consultants kept their own patient records to which the hospital did not have unrestricted access.
- The hospital collected data to support the safe running of the service. The clinical scorecard showed the hospital group target for aspects of care across all five domains. The hospitals clinical score card data was predominantly positive. Compliance with national early warning score (NEWS) completion and pain assessments were above Spire target.

Are services effective at this hospital/service

- Hospital clinical policies were evidenced based and used national best practice guidance and staff attended network events, such as infection control, to share learning and promote best practice.
- Patient reported outcome measures (PROMS) from April 2014 to March 2015 and National Joint Registry data was positive, with 93% of patients undergoing hip and knee surgery reporting an improvement in their health.
- New national guidance were discussed and minuted within clinical governance meetings and circulated to relevant clinicians, but not formally minuted for relevance to implementation within the hospital.
- Appraisal rates amongst staff exceeded the hospitals target of 75%. The Enhanced Recovery Unit (ERU) lead nurse was using an adapted and shortened National Competency Framework for Critical Care Nurses (NCFCCN) to up skill ward staff in the care of level one patients.
- Pain assessments were undertaken on patients and pain relief prescribed and administered as required.
- Patient's had access to food and drink throughout their stay and dietary requirements were taken into consideration and provided for.
- Staff had good knowledge and understanding of Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- Local audits were conducted for service improvements however there was a lack of scrutiny or challenge.
- The majority of consent was undertaken on the day of surgery. This followed an outpatient consultation where risks and benefits of treatment options are initially discussed and in line with Spire's consent policy (FIN 07).
- Local audits were undertaken by individual areas own lead staff which meant that there was the lack of challenge or peer review.

Are services caring at this hospital/service

- Patient rating excellent for overall care and attention provided by staff in the patient experience data for 2015 was above the Spire target of 85%.
- Between July 2015 and December 2015, the hospitals Friends and Family Test (FFT) results were 100%.
- Patient feedback during the inspection was all positive with patients speaking highly of the care and treatment received. Patients and relatives felt involved in decision making and felt supported.
- Chaperone services were available and utilised to support patients when required.
- Videos and podcasts were available on the hospital website demonstrating what patients could expect when coming into hospital and providing consultant discussions about various conditions.

Are services responsive at this hospital/service

- Patients had access to care when they required it with referral to treatment time (RTT) for admitted patients consistent for the majority of 2015. RTT times were met for 11 of the 12 months of 2015 for outpatient and diagnostic imaging patients.

Summary of findings

- Services were available for patients with additional needs and in house dementia training was being run by a member of staff who was also a 'dementia friend'. However support for patients with pre-existing mental health conditions was lacking.
- Information could be obtained in other languages via a translation service, however staff were unsure how to utilise this.
- There had been a decreasing number of patient complaints, from 72 complaints in 2013 to 47 in 2015. Staff were unable to provide a specific example of when practice or procedures had changed following patient feedback, however posters entitled "you said, we did" were displayed in the patient waiting areas showing changes in practice which had happened as a result of complaints of incidents reported to the hospital.
- The Spire target for compliance with the pre-operative fasting guidelines was 45%. The hospitals clinical scorecard for 2015 showed results that ranged between 50% and 60% compliance. This meant that at least 40% of patients were at risk of extended periods of fasting prior to surgery.

Local audits on start and finish times in outpatients had been introduced in February 2016 to monitor delays and over runs. At the time of inspection ten weeks data had been collected, but data was not available for any themes or trends to be identified.

Are services well led at this hospital/service

- Whilst governance processes were in place at the hospital they did not work effectively or support a continuous learning and improvement culture. There was an inconsistent approach to learning from incidents and the quality of root cause analysis (RCAs) were poor. This meant that appropriate learning was not being identified in order to drive improvement.
- Senior management oversight of the hospital's governance arrangements was limited. Formal processes for information sharing around governance issues were not well established and a key member of the leadership team was not well informed about pertinent issues facing the hospital.
- We reviewed minutes from the clinical governance committee and medical advisory committee and noted a lack of challenge and scrutiny at senior level.
- Risk management systems were not used appropriately. From the risk register dated March 2016 we found that controls to mitigate risk had not been identified. This meant that the effectiveness of mitigating actions could not be monitored.
- The 2015 staff survey showed a lack of staff confidence in senior leadership, working together, and service quality.
- Within oncology, audits were in place to monitor multidisciplinary meetings, as well as patient feedback surveys. There were a number of quality indicators that were in process of being introduced which included chemotherapy workload and scalp cooling audits. However, these were not in place at the time of our inspection.
- There were good processes to monitor consultants practicing privileges
- Staff felt engaged in the running of the hospital and were rewarded via the hospitals recognition scheme "Inspiring People" which gave staff the opportunity to be recognised and valued for their work.
- There were examples of innovation and sustainability such as plans to build a new hospital locally to deliver a modern, spacious and well-designed hospital.

We saw several areas of good practice including:

- Participation with networks to promote best practice. The hospital implemented and hosted the Essex group discussion of complex knee surgery.
- Pod-casts presentations were available for patient and public access in relation to a variety of clinical procedures offered, via the hospital website.
- It should be noted that the hospital responded to areas of concerns raised during the inspection and undertook some immediate responses. An action plan was produced however changes need to be embedded and monitored

Summary of findings

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Adopt a single patient record system, ensuring that all patient records are up to date, contain relevant information, include medical and nursing notes, patient risk assessments and administration pathway records. The hospital must also make sure records are available and legible.

In addition the provider should:

- Review governance process to ensure a greater level of management oversight. Including the role of the MAC
- Review the process for root cause analysis (RCA) and ensure a robust, consistent approach to analysing incidents and identifying lessons to be learnt. Improve process for sharing lessons and actions following incidents.
- Ensure completion of refurbishment to remove all carpets from areas where clinical interventions may take place such as patient rooms.
- Review the methodology currently in use for monitoring hand hygiene and consider undertaking hand hygiene audits to evidence effectiveness of hand washing.
- Ensure the quality of records is improved and monitor to ensure documentation content is clear, legible and accurate. Improve the recording of review by medical staff within the patient care record.
- Review preoperative fasting arrangements for patients and ensure regular monitoring to evidence improvement.
- Ensure fire escapes are left clear and review storage options for mobile imaging equipment to ensure these are not a hazard.

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Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	The oncology service was rated as requires improvement overall. Safe and well led required improvement, with effective, caring and responsive all rated as good. Spire Hartswood hospital maintained their own patient records, but did not have access to records held by individual consultants. Spire has a national Multi-disciplinary team (MDT) which has a full quorum of Breast cancer MDT members including specialist surgeon, medical and/or clinical oncologist, with histopathologist and consultant radiologist input. Patients' privacy and dignity was not always respected in the oncology service. For example, a patient was being weighed in the corridor on the day we inspected. There was a lack of governance and oversight with monitoring and updating risks. Audit information was limited and lacked specific measures and actions to promote quality improvement. New local leadership had taken place and whilst improvements had begun, such as regular team meetings and updating of risk assessments, these were in their infancy and needed to be embedded. However, there were no adverse incidents relating to the oncology service and staff were aware of how to report and escalate adverse incidents. The oncology service was provided in an environment that was endorsed through the MacMillan Cancer Support Quality Environment Mark and was visibly clean and cleaning schedules were in place. Staff were trained, qualified, competency assessed, and supported to undertake regular updates. Consent to chemotherapy was consistently recorded in patient notes. Friends and Family test results for January to March 2016 showed that 100% of day case patients who responded were likely or highly likely to recommend the hospital. Day case patients accounted for around 20% of the respondents.

Summary of findings

Patients stated that they had been involved in their care planning and they felt supported. Staff provided caring and emotional support and patients confirmed they felt well-cared for by compassionate nurses.

Surgery

Requires improvement 

Surgery services at Spire Hartswood Hospital were rated requires improvement overall, with effective, caring and responsive rated as good and safety and well-led rated as requires improvement.
Staff were aware of how and when to report incidents, however route cause analysis (RCA) often lacked detail and were not conducive to learning.
Single patient records were not fully embedded within the hospital. Documentation and record keeping, particularly from consultants, was at times limited. One set of notes reviewed had pre-assessment documentation missing and two sets had no detailed plan of care documented following surgery.
There was evidence to show that care planning for patients with pre-existing mental health conditions did not happen
Medicines management was in place and pain relief was readily prescribed for patients post-operatively and to take home
Patient Reported Outcome Measures (PROMs), National Joint Registry and NHS CQUIN data showed positive results in the majority of areas.
Knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was good amongst nursing staff. Staff were able to give appropriate examples and uses of the MCA and DoLS.
Staff provided compassionate, respectful care to patients. The latest Friends and Family Test (FFT) results were 100% between July 2015 and December 2015. Patients who required additional support throughout their stay were highlighted at pre-assessment. Patients highlighted as being at a greater risk were reviewed by either the consultant or anaesthetist prior to admission.
A clear vision and a set of values were in place for staff to work to. A governance structure was in place; however evidence gathered did not support that this was cohesive, robust or used to promote a

Summary of findings

continuous learning and improvement culture. Oversight by the medical advisory committee (MAC) was limited in relation to understanding of the challenges facing the hospital.

Outpatients and diagnostic imaging

Requires improvement

Outpatient and Diagnostic Imaging services were rated as requires improvement overall. Safe and well-led were rated as requires improvement with caring and responsive rated good.
The hospital did not have a single or unified patient record, however there was an action plan in progress for the implementation of an electronic single patient record.
Staff knowledge of local risks was limited. Assessment and monitoring of risks was not robust. Identified risks were not included on the risk register and risk assessments were overdue for review.
There was a hospital on call rota for radiographers in place.
Staff supported openness and transparency following incidents. Staff were aware of the system for reporting incidents and understood their responsibilities under duty of candour to explain and apologise to patients went things went wrong.
There was evidence of staff sharing lessons learnt following incident investigations. The hospital displayed: “You said, we did” posters in patient waiting areas showing changes in practice which had happened as a result of complaints or incidents reported to the hospital.
Staff were aware of national best practice guidance and local network links were established by the infection prevention and control lead to share information and benchmark against other local providers.
There was a robust system for ensuring that consultants operated within their scope of practice. The hospital provided figures to demonstrate that medical notes were available for outpatient appointments in 98% of cases.
Information governance systems included a secure electronic system for sharing diagnostic patient images. Referral to treatment time figures for all outpatient and diagnostic imaging patients were met in 11 out of 12 months in 2015.

Summary of findings

Medication management was monitored and reviewed regularly within the diagnostic imaging service.
Patients were treated with dignity and respect by hospital staff and spoke very highly of the care they received. March 2016 patient survey data demonstrated that between 97% - 100% of patients felt that the care and treatment they received was 'excellent' for outpatient and diagnostic imaging departments.
There were registered nurses, (child branch) available to support children and their families attending appointments in the outpatient and diagnostic imaging departments.

Summary of findings

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Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Spire Hartswood Hospital

Spire Hartswood Hospital is a purpose built private hospital which was opened in 1984. Since then there have been a number of developments and a significant growth in volumes of patients treated year on year. In 2007 a private equity company called Cinven bought the company from BUPA Hospitals LTD, and Spire Healthcare was established.

Spire Healthcare became a public limited company when it floated on the London Stock Exchange in July 2014. The hospital is located close to the M25, A12 and A127 and provides access to a wide geographical area including; Barking, Dagenham, Havering, Romford and Redbridge to the West; Basildon, Billericay, Southend and Wickford to the East; Chelmsford, Colchester, Doddinghurst, and Shenfield to the North, and Dartford, Grays and Thurrock to the South.

The main hospital comprised of three theatres, two wards containing single patient rooms, an endoscopy suite, outpatients department, diagnostic imaging facilities, extended recovery beds, medical care (Including older people's care), oncology, refractive eye surgery and surgery services (including cosmetic surgery and gynaecology).

In November 2015 the hospital opened a new specialist cancer centre in the Essex Healthcare Park in Chelmsford. The centre provides the latest technologies in cancer care, including external beam radiography to patients of Brentwood, Billericay, Chelmsford and the surrounding areas of Essex and East London.

In recent years the hospital has benefited from various equipment upgrades, including a full field digital mammogram scanner. Plans were in place to extend the services on offer at the hospital with an ambulatory care service due to open in November 2016.

The Registered Manager is Mark Gilmour, Hospital Director, who has been in post for five years and six months. Mark is also the hospital's controlled drugs accountable officer. The nominated individual for the hospital is Dr JJ De Gorter who has also been in post for five years and six months.

Our inspection team

Our inspection team was led by:

Inspection Manager: Tracey Wickington, Care Quality Commission

The team on site included five CQC inspectors, one assistant inspector and four specialist advisors: two surgical consultants and two specialist nurses.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection was announced and took place on 3 May 2016. We also undertook an unannounced inspection on 13 May 2016.

Before visiting, we reviewed a range of information including information held by us and information provided by the hospital. In addition to private healthcare services the hospital treats NHS funded patients and we contacted the main clinical commissioning groups (CCG) for their views on the hospital.

Summary of this inspection

We talked with patients and staff from the ward and operating theatre areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' records. We also undertook a focus group at the hospital, on 3 May 2016, for a variety of staff to attend.

Patient views were also collected by means of comment cards in the immediate weeks running up to and immediately following the inspection.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Spire Hartswood Hospital.

Information about Spire Hartswood Hospital

There were 51 beds at the hospital which included 25 inpatient (overnight) beds and 26 day case beds (which incorporated 5 day-case pods used for Endoscopy procedures and minor day-case procedures).

The hospital workforce was made up of a variety of staff which included:

- 231 Medical doctors or dentists working under rules or privileges. No doctors or dentists were directly employed by the hospital.
- 31 Nurses.
- 9 Operating department practitioners (OPD).
- 22 Care assistants.
- 84 other members of staff which included administrative and clerical staff, allied
- health professionals (AHPs) and support staff.

There were 8,074 inpatient stays between January and December 2015 made up of the following:

- 307 NHS overnight inpatient stays;
- 1,294 privately or other funded overnight inpatient stays;
- 1,358 NHS inpatient day case contacts; and
- 5,115 privately or other funded inpatient day case contacts.

There were 52,500 outpatient appointments attended between January and December 2015 made up of the following:

- 2,419 NHS first attendances;
- 15,605 NHS follow up appointments;
- 6,144 privately or other funded first attendances; and
- 28,332 privately or other funded follow up appointments.

The hospital had three theatres, two with laminar flow, and an endoscopy suite.

There were 7,220 visits to the theatre between January and December 2015. The five most common procedures performed were:

- Primary phacoemulsification of cataract with lens implant – unilateral (including topical or local anaesthetic) (415)
- Secondary phacoemulsification of cataract with lens implant (348)
- Diagnostic colonoscopy, includes forceps biopsy of colon or ileum (347)
- Diagnostic oesopgago-gastro-duodenoscopy (OGD) includes forceps biopsy, biopsy urease test and dye spray (338)
- Medial branch block or facet joint injection (under x-ray control) – 5 to 6 joints (258).

Diagnostic Imaging facilities on site include:

- 64 slice computer tomography (CT) scanner;
- 1.5T Magnetic Resonance imaging (MRI) scanner;
- A full field digital mammogram scanner;
- X-ray;
- Ultrasound; and
- Dexa Scanning.

The hospital holds the following accreditations:

- The Macmillan MQEM (Macmillan Quality Environment Mark) Charter Mark for Chemotherapy and Breast Care pathways;
- An SGS accreditation for Sterile Services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Medical care

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

Information about the service

Spire Hartswood hospital provides treatment for breast, colorectal, gastrointestinal, gynaecological, lung, peri-ocular eye, prostate, renal, skin, and urological cancers. The hospital provided an overarching oncology consultation and treatment for cancer service to private patients. 591 patients were seen between January and December 2015.

The Spire Hartswood was awarded the Macmillan Quality Environment Mark (MQEM) accreditation in 2011. This is a quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. In November 2015 the hospital opened a new centre in the Essex Healthcare Park in Chelmsford. The centre provides the latest technologies in cancer care, including external beam radiography to patients of Brentwood, Billericay, Chelmsford and the surrounding areas of Essex and East London.

The chemotherapy service was provided four days a week within the oncology suite. Chemotherapy patients were treated in one of five individual en-suite rooms each of which had a shower room, seating for three people and a television within the day case unit on the ground floor.

During this inspection we visited the oncology suite at the hospital, spoke with four members of the oncology team, the resident medical officer (RMO) and two support services staff. We spoke with four patients receiving chemotherapy, observed the environment and reviewed five sets of chemotherapy patients' notes. We did not inspect the specialist care centre at Chelmsford.

Summary of findings

The oncology service was rated as requires improvement overall. Safe and well-led required improvement with effective, caring and responsive all rated as good.

Spire Hartswood hospital maintained their own patient records, but did not have access to records held by individual consultants. Patients' privacy and dignity was not always respected in the oncology service. For example a patient was being weighed in the corridor on the day we inspected.

There was a lack of governance and oversight with monitoring and updating risks. Audit information was limited and lack specific measures and actions to promote quality improvement.

New local leadership had taken place and whilst improvements, such as regular team meetings and updating of risk assessments, had begun these were in their infancy and needed to be embedded.

Staff survey feedback showed that senior management were less respected than local leaders.

However, there were no adverse incidents relating to the oncology service and staff were aware of how to report and escalate adverse incidents. The oncology service was provided in an environment that was endorsed through the MacMillan Cancer Support Quality Environment Mark and was visibly clean and cleaning schedules were in place.

Staff were trained, qualified, competency assessed, and supported to undertake regular updates. Consent to

chemotherapy was consistently recorded in patient notes. Friends and Family test results for January to March 2016 showed that 100% of day case patients who responded were likely or highly likely to recommend the hospital. Day case patients accounted for around 20% of the respondents.

Patients stated that they had been involved in their care planning and they felt supported. Staff provided caring and emotional support and patients confirmed they felt well-cared for by compassionate nurses.

Are medical care services safe?

Requires improvement

Medical oncology services were rated as requires improvement for safe because;

- The hospital did not have a single or unified patient record. Consultants kept their own patient records to which the hospital did not have unrestricted access.

However;

- Staff were able to identify how to escalate an adverse event using the hospital electronic record system.
- The oncology environment and equipment was visibly clean, cleaning schedules were in place and were monitored by the housekeeping team leaders.
- Medicines were stored securely and safely.
- The chemotherapy lead nurse was proactive in reviewing and updating risk assessment documentation.
- The chemotherapy lead nurse had identified areas where the service could be developed including improving chemotherapy staff's understanding of the lead nurse role.

Incidents

- There was one reported adverse incident for an oncology patient who passed away at home whilst still undergoing a course of treatment.
- A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. There were no never events related to the oncology service in the between January and December 2015.
- We spoke with four members of oncology staff and all were able to identify how incidents were escalated and reported using the electronic adverse incident reporting system.
- There had been one recorded incident in April 2016 where a chemotherapy drug order had not been dispatched and therefore this delayed patient treatment. Despite all attempts to source from an alternative supplier the appointment had to be

rescheduled and the incident was reported. The pharmacy manager fully investigated the incident and as a result implemented online trackable deliveries from all suppliers.
- Staff were aware of duty of candour and the responsibility of open discussions with patients and relatives to inform and apologise when things go wrong. Following the chemotherapy drug incident the pharmacist manager spoke personally with the patient to explain the circumstance and wrote to the consultant oncologist to explain the delay.
- Incidents were discussed at team meetings. Staff stated that the team met once or twice a month depending on workload and circumstances. However, minutes from the meetings had not been recorded to document discussions and ensure issues were taken forward.

Safety thermometer or equivalent

- Patient outcomes were measured against a fixed set of criteria using the Spire clinical scorecard. Outcomes were compared nationally against other Spire hospitals on a quarterly basis.
- The lead oncology nurse had recently reviewed and updated the risk assessments for the oncology service. For example neutropenic sepsis and storage of chemotherapy medication.
- Venous thrombo-embolism VTE risk assessments had been completed appropriately in all patient notes reviewed. Compliance on the clinical scorecard was 95-100% between January and December 2015.

Cleanliness, infection control and hygiene

- There were no reported incidences of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile since 2008. The oncology suite was cleaned by housekeeping staff and checks were completed daily by the housekeeping team leaders with cleaning schedules and checklists for completion in place.
- Personal protective equipment such as gloves and aprons were available in the open store room located in the nurses' office.
- Hand hygiene foam dispensers were available at the entry to ward areas.
- Hygiene audits, for example of hand sanitizer usage, were completed. Results of the quarterly hand sanitizer audit showed that whilst the hospital were exceeding the target of 18%, (Q1 22%, Q2 31%, Q3 35% and Q4 30%).The hospital used alternative methods of audit, such as the use of an ultraviolet light box, to assess the effectiveness of the hand washing techniques used by staff as part of the annual mandatory training as well as staff induction..
- Clinical chemotherapy waste was disposed of in line with national guidance, with appropriate coloured (purple) sharps containers to signify cytotoxic waste.

Environment and equipment

- The oncology suite did not have separate resuscitation equipment but shared the emergency equipment on the ground floor. Staff knew where to access this equipment.
- The resuscitation trolley, including oxygen cylinders, were checked and were satisfactory.
- Equipment seen was within service dates and had been potable appliance tested (PAT) prior to use.

Medicines

- Management of medicines was safe and storage was secure. Medicines were stored within a locked cupboard inside the nurses' office. A keypad lock had recently been fitted to ensure security of access. The oncology nurses were responsible for rotating medicines and dated equipment. Stock was frequently rotated to ensure the medication with the shorter shelf life was used.
- Chemotherapy drugs were kept in a fridge in pharmacy until patients' test results were checked. Nursing staff then collected the medication from pharmacy when required.
- Patients' blood was tested prior to chemotherapy doses being calculated and treatment delivered to ensure appropriate levels of medication were prescribed.
- Protocols were in place to ensure prescription of chemotherapy was monitored.
- There was a three point check to ensure the correct drug was ordered. Pharmacist technicians inputted the order then saved as a pending order, the pharmacist then checked this and placed the order on hold, whilst the patient's blood test results were updated and the specialist oncology nurse checked and confirmed the order. Medication orders that had been confirmed by midday should have arrived arrive by 9am the next morning to be dispensed.
- A new electronic prescribing system, was in the process of being trialled at the time of our inspection. The pilot

scheme had been started in November 2015. Oncologist consultants could access the system remotely and prescribe directly. Patients' blood results were inputted into the system and the system worked out the correct dosage.

- Not all drug pathways were inputted into the electronic system during the pilot stage which meant that two systems were in use including hard copy prescriptions for long term chemotherapy patients.
- The hospital had a corporate 'safe management of systemic anti-cancer therapy policy and procedure' dated April 2015 which covered prescribing, preparation for treatment, spillages, risk management and precautions including personal protective wear and disposal of unused chemotherapy medication

Records

- Five sets of chemotherapy patient notes were reviewed. These were completed clearly, were legible and included individual patient risk assessments.
- However, one set of notes did not have the patient's named consultant identified. We drew this to the chemotherapy lead nurse's attention who stated that they would address this with the consultant.
- The hospital did not currently have a single patient record because consultants kept their own records to which the hospital did not have unrestricted access to. An action plan to address this had recently been implemented. The action plan had time bound actions with key staff allocated to lead completion of the tasks by October 2016.

Safeguarding

- Training data submitted by the hospital was not separated into specific teams. Adult and children safeguarding training was provided via an e-learning system that combined both level 1 and 2 together. Training records showed that 27% of Spire Hartswood hospital staff in February 2016 had completed the annual update of adult safeguarding training and 20.6 % for child safeguarding training against a quarterly target of 25% In 2015 95% of staff had completed the annual safeguarding training.
- One oncology nurse stated they would report suspected abuse to the matron as the designated safeguarding lead.
- From January 2015 to April 2016 no safeguarding concerns had been raised The hospital had a corporate safeguarding vulnerable adults policy dated January 2016. A safeguarding flow chart was displayed in staff areas and detailed the escalation process should staff have a concern, including contact numbers for the relevant local authority.

Mandatory training

- Staff were aware of their responsibility to undertake and complete mandatory training. Mandatory training was delivered via the Spire electronic system. Between March 2015 to February 2016, an average of 89% of staff had completed all required mandatory training, with the exception of adult and child safeguarding modules.
- The hospital's target for compliance with mandatory training is 100%. The hospital had achieved an average of 84% compliance across all nine mandatory training modules during 2015, which was below target

Assessing and responding to patient risk

- The oncology service used the tools provided by the UK Oncology Nursing Society guidelines (UKONS) 'Management of Deteriorating Patients'. The UKONS tools had been developed to rapidly and consistently identify oncology and haematology side effects that may or may not require attendance for further symptom management at short notice.
- The service had a policy for extravasation. Extravasation is the process by which any liquid (fluid or drug) accidentally leaks into the surrounding tissue. In terms of cancer therapy, extravasation refers to the inadvertent infiltration of chemotherapy into the subcutaneous or subdermal tissues surrounding the intravenous or intra-arterial administration site. Nursing staff were able to recognise when this happened and could describe actions required to manage this.

Nursing staffing

- The oncology nursing team consisted of five nurses in total; one lead chemotherapy nurse, a lead breast care nurse, and three additional staff with oncology training.
- Staffing requirement was calculated according to the numbers of patients receiving care at Spire Hartswood hospital and at the specialist cancer centre at Chelmsford. There were regularly two oncology nurses plus the lead nurse on site during chemotherapy treatment which was sufficient to provide adequate care.

Requires improvement

Medical care

- The lead oncology nurse stated they were currently reviewing staff rotas to ensure continuity of staff for the patients. They stated that planning staff was sometimes a challenge as some patients were currently attending the Chelmsford centre. Nurse staffing was allocated according to patient numbers and requirements at both sites.

Medical staffing

- There was a consultant on-call rota and consultants also had nominated medical colleagues to take calls, should the first medical staff member from the on-call rota not be available.
- Consultants did not routinely attend when patients were receiving chemotherapy. An oncology nurse told us the consultants reviewed patients in the outpatient department the day before administration of chemotherapy.

Are medical care services effective?

Requires improvement

Medical oncology services were rated as requires improvement for effectiveness because;

- There was no evidence that the service benchmarked outcomes to local or national guidelines. Audits completed did not have clear actions identified to ensure improved practice.
- Results for MDT review had been poor in the first three quarters of 2015 but had improved with the implementation of a new system.

However;

- Evidence based treatment templates were in place and the oncology service followed National Institute for Health and Care Excellence (NICE) guidelines in the treatment of cancer.
- Patients' nutrition and hydration needs were met.
- Staff were specially trained in oncology, had regular evidence based updates and were competency assessed.
- Evidence based assessment tools were used to assess oncology patients who contacted the service out of normal business hours.

Evidence-based care and treatment

- The hospital used protocol driven chemotherapy record keeping templates jointly agreed by another Spire site and a local acute NHS trust for each specific type of chemotherapy medication prescribed and administered.
- In 2015, the hospital implemented a new Sentinel Lymph Node Biopsy service line with National Institute for Health and Care Excellence (NICE) guideline NG14 - Melanoma: assessment and management of skin cancer. This enabled doctors to carry out a test to see if skin melanomas (skin cancer) had spread to nearby lymph nodes so they could remove those lymph nodes
- The hospital had a local audit compliance and activity plan for January to December 2016. There were no oncology outcome based activities identified as part of this plan and no information of how the hospital benchmarks their success against other oncology services.

Pain relief

- Administration of chemotherapy pathway documents included prompts for staff to ask patients about pain relief requirements.
- None of the patients seen during the inspection had painful conditions. One patient stated that his condition would deteriorate and become painful, but he was satisfied the nurses would help him manage any pain.

Nutrition and hydration

- The four patients spoken with during the inspection said they had enough to eat and drink and could choose from the menu. One patient told us they did not normally eat much during treatment but nurses made sure they had plenty to drink.

Patient outcomes

- Evidence of participation in local and national audits relating to cancer services was limited.

The hospital's 2016 audit plan included a quarterly multidisciplinary team (MDT) audit to ensure that all patients have been discussed at MDT with documented evidence in the medical notes. The hospital scorecard demonstrated a poor compliance at the beginning of 2015 with Q1 to Q3 showing 5%, 5% and 10% compliance against a Spire target of 65%.

- There had been a chemotherapy patient audit completed in Q1 2016The audit was to identify the workload in oncology, and review staffing levels .At the time of the inspection there was not enough data collated to develop an specific actions.

Competent staff

- All five oncology nurses had been specially trained and attended annual oncology updates run at Leicester University. The annual update training course included an update on bladder cancer, Mitomycin C medication and a practical session.
- Staff kept individual training records and one nurse showed us their training folder which included evidence of qualifications, annual update training attended and competency assessments.
- Four of the five oncology nurses had a completed appraisal in the last year. The fifth member of staff was still in their induction period.

Multidisciplinary working

- Oncology team meetings were planned as a service development but not yet implemented.
- The lead breast care nurse stated they had links with local NHS trusts and other cancer care hospitals in the Spire group, and shared information about infection rates and head cooling techniques.
- The hospital had introduced an information technology eMDT workflow system in 2015.This facilitated multi-disciplinary team (MDT) discussions for patients with breast cancer and ensured that patients were placed on the most appropriate care pathway for their care. The lead clinician was responsible in uploading the treatment plan and patient information onto the system. The MDT was convened weekly. The proposed treatment plan was then returned to the lead clinician via the system. In Q4 the hospital had scored 100% compliance. Data provided by the hospital demonstrated that all patients from January 2016who were newly diagnosed with cancer had been entered onto the network system.

Seven-day services

- The chemotherapy service was provided Monday to Thursday and used the UKONS triage tools to assess patients who contacted the hospital outside of these times. The unit was only open for three days however there was a chemotherapy competent nurse on duty Monday to Friday, 9am to 5pm, for patients to call for advice. The resident medical officer (RMO) was available on site for immediate medical advice and the pharmacy service was provided during the hours patients were receiving chemotherapy.
- The pharmacy manager was on call, out of hours and weekends, to provide telephone advice and support where necessary. Cover for annual leave and sickness was provided by either a pharmacy technician or bank pharmacist. Funding had been approved and recruitment was underway at the time of inspection for a second pharmacist.

Access to information

- Nursing staff had access to the patient records maintained by Spire and these were securely stored in a locked room. All nursing and medical documentation was in paper form.
- Test results, including x-rays, were held electronically with medical staff having access as required. IQemo was at the pilot stage and therefore only certain pathways were held electronically. This was a secure system with appropriate staff having log on access to IQemo.
- Data provided by the hospital demonstrated that an MDT discussion form had been developed and introduced in May 2016. This was to be given to all consultants to complete following any MDT meeting that took place in an NHS provider regarding any Spire patients. This ensured that the hospital maintained a comprehensive copy of that discussion within its network system to ensure consistency of care for the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Four sets of the patient notes reviewed were fully completed including consent to treatment.
- Staff stated that they felt confident supporting patients who lacked capacity and could provide an example of how a patient's treatment had to be withdrawn because the patient lacked capacity to understand and consent to the treatment.

Requires improvement

Medical care

Are medical care services caring?

Good

Medical oncology services were rated as good for caring because;

- Friends and Family test results for January to March 2016 showed that 100% of day case patients who responded were likely or highly likely to recommend the hospital.
- Staff had time to care and provided emotional support. The oncology service received commendations from friends and relatives of patients.
- Patients said they and their relatives had been involved in their care planning and they felt supported.

Compassionate care

- Staff were observed to interact positively with patients and their colleagues during this inspection Staff were welcoming and introduced themselves to patients and colleagues.
- Mandatory training included a module entitled 'compassion in practice' with a target of 95% of staff to complete this; 89% of hospital staff had completed this training.
- The four chemotherapy patients we spoke with described staff as "friendly, efficient", "friendly courteous and helpful" or "superb".
- Friends and Family test results for January to March 2016 showed that 100% of day case patients who responded were likely or highly likely to recommend the hospital. The sample sizes were small for January at16 respondents; February 10 respondents and March eight patient respondents.

Understanding and involvement of patients and those close to them

- The four patients we spoke with told us they had been involved in their care planning; two specifically stated that their families had also been included and were well looked after.
- Staff provided examples of positive feedback that had been received via email from a relative and a friend of two patients that had received care at the hospital. Unfortunately both patients had passed away however the feedback thanked the chemotherapy staff for the care they had given. Both emails acknowledged how staff had supported patients through a difficult time and in one email how staff had made it possible for a chemotherapy patient to have one last holiday.

Emotional support

- One oncology nurse said: "We are lucky with the time we get to spend with patients". Staff had time to care and provided emotional support. For example, a patient spoken with said: "Staff always have time to chat and deal with worries and concerns".
- When required, the oncology nursing team liaised with Macmillan service and the patient's own GP to ensure continuity of care and information regarding support at home or within a hospice setting.

Are medical care services responsive?

Good

Medical oncology services were rated as good for responsiveness because;

- Two patients told us how the service responded quickly when side effects of treatment were identified. This showed the chemotherapy nurses were aware of side effects and pro-actively identified and managed these.
- There had been no complaints made about the oncology service. Patients stated they did not have reason to complain but felt they could discuss concerns with nurses as they arose.

However;

- The practice of weighing patients in a corridor did not provide them with sufficient privacy or dignity.
- There was no documented information from the treating consultants identifying which NHS hospital patients should be transferred to in an emergency.

Service planning and delivery to meet the needs of local people

- The lead chemotherapy nurse had recently been employed to work across the hospital and the new specialist cancer centre in Chelmsford. Patients had been reluctant to attend the Chelmsford centre for treatment and many of the patients, including two we spoke with during the inspection, had attended at this

hospital for many appointments spanning up to five years. The hospital was providing new cancer patients the choice of site for treatment but were trying to develop the service in Chelmsford due to lack of available space to expand at Spire Hartswood hospital.
- Exclusion criteria included patients under 18 years of age, patients with unstable mental health problems or a body mass index (BMI) of above 40. This meant that patients were assessed to lower the risk to patient safety.

Access and flow

- The service treated patients who were funded through insurance policies or self-funded. The hospital did not offer NHS cancer services. The oncology service could accommodate up to 12 patients on any one day, however the lead nurse stated that regular numbers were around six chemotherapy patients daily.
- Oncologists reviewed their patients in the outpatient clinic the day before chemotherapy treatment was given. Appointments were also attended by one of the oncology nurses to ensure seamless communication between the patient, consultant and chemotherapy service.
- Independent hospitals are not subject to the same performance indicators around waiting times and waiting times for treatment were not collected as part of the hospital's clinical scorecard.

Meeting people's individual needs

- Four patients receiving chemotherapy all stated they had been involved in their care planning, had no complaints and felt staff were available to chat or to answer questions.
- Within the oncology suite there were five individual en-suite rooms, each of which had a shower room, seating for three people and a TV within the day case unit on the ground floor.
- Two patients stated they received sufficient information about their treatment. One patient said they preferred to have face to face conversations with their consultant whilst another patient said that the volume of information could be a bit overwhelming
- One patient said that their consultant regularly discussed the balance of quality of life versus treatment. They stated that their medication had regularly been adjusted to strike the best balance between treatment and management of side effects.
- One of the patients described how the hospital responded quickly when they became unwell late one Friday evening. When they had telephoned the out of hours service, they were advised to come to the hospital and were met by a member of the nursing team; tests were performed and the patient was sent home with treatment within a matter of hours the same evening.
- During the inspection a nurse was observed to weigh a patient in the corridor of the ward area. This practice did not provide sufficient privacy of dignity for patients and this was raised to the senior hospital management team, who removed the scales immediately and practice was amended. The service had a privacy and dignity policy dated October 2014, which stated 'Spire Hartswood Hospital only has single patient's rooms with en-suite facilities and therefore does not breach any privacy and dignity standards.'

Learning from complaints and concerns

- The hospital received 47 complaints between January and December 2015, none of which related to the chemotherapy service.
- One non-clinical manager informed the inspection team that the most frequent complaints related to waiting times when patients attended for their outpatient appointments. This manager had been supported to develop a customer care training workshop for staff. Not all staff had attended the workshop, but those who had provided positive feedback.
- None of the patients spoken with said they had cause to complain. They said that the nurses were very responsive and felt they would speak freely to them with any concerns.
- Staff provided a copy of the cancer patient survey form that was given to patients on discharge.. The results of completed surveys were not available which meant that demonstrable evidence was lacking as to whether chemotherapy patients were satisfied with the service.

Are medical care services well-led?

Requires improvement

Medical oncology services were rated as requires improvement for well-led because;

- There was a lack of oversight with monitoring and updating risks.
- Audit information was limited and lacked specific measures and actions to promote quality improvement.
- New leadership had occurred and whilst improvements, such as regular team meetings and updating of risk assessments, had begun, these were in their infancy and needed to be embedded.

However;

- The chemotherapy nursing team were observed demonstrating the values of succeeding together, driving excellence and caring.

Vision and strategy for this this core service

- The Spire hospital group had a vision and set of values: 'To be recognised as a world class healthcare provider.' There was no separately defined strategy, vision of values for the oncology service.
- The values of the hospital included: 'Caring is our passion, Succeeding together, Driving Excellence, Doing the right thing, Keeping it simple, Keeping our promises'.
- Staff were observed demonstrating the values of succeeding together, driving excellence and caring. For example, the lead nurse had identified where the service needed to develop and was making sure the team understood what was involved in the lead nurse role.

Governance, risk management and quality measurement for this core service

- The lead chemotherapy nurse had reviewed and was updating the risk assessments for the service since they took up the post in November 2015. Examples dated 2 May 2016 included storage of chemotherapy medication and neutropenic sepsis or other acute oncology emergency.
- The risk assessment for oncology emergencies was based upon the UK Oncology Nursing Society guidelines (UKONS). There was one outstanding task on the risk assessment. This required new consultants who treated patients privately at the hospital to provide details in writing of the preferred NHS place of transfer should a patient deteriorate and require urgent transfer to an NHS oncology service.
- The hospital risk register identified nine concerns relating to the oncology service. The hospital had indicated that the mitigation steps being taken were adequate., however the risk register for the service was not maintained as a live document. There was one example rated red on the register, which related to the lack of documented multi-disciplinary discussions. The mitigating action indicated this issue would be addressed through expansion of the electronic recording system. Evidence provided demonstrated that this had been implemented in September 2015 and results in Q4 had improved to 100% for breast cancer patients. The roll out of the new system aimed to replicate the same level of compliance for all cancers with a target date of December 2016.
- Audit information was limited with actions identified, nominated individual and timeframes not reported. There were no up to date processes to seek patient feedback for the oncology service to ensure patient outcomes or satisfaction for the service was monitored, measured or steps taken to improve.
- Minutes from team meetings were not recorded. This meant that there was no formal recording of concerns or evidence of how actions and improvements had been implemented

Leadership and culture of service

- There was an open culture amongst the staff working within the service .The lead chemotherapy nurse had taken over the running of the service when the previous incumbent retired in November 2015.The lead nurse said that they aimed to improve staff knowledge to both develop individuals but also ensure smooth running of the service in their absence.
- One of the chemotherapy nurses confirmed that the new lead nurse communicated and was improving shared information.
- The staff within the oncology service were observed being friendly, respectful and supportive of each other. For example, negotiating tasks with each other to ensure patients were well looked after whilst one of the nurses took a blood sample to the pathology service on the first floor.

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Public and staff engagement

Requires improvement

Medical care

- Staff were happy and proud to be working at the hospital. They felt their efforts were acknowledged and there was a staff award scheme in place. Staff were nominated by colleagues and received a gift voucher and thanks from the hospital senior management team.
- One staff member stated that "It feels like a family".
- Results of the 2015 staff survey showed 63% of staff took part and 93% of these 'get personal satisfaction from the work they do'. 89% of respondents were positive to the question 'I respect my manager'.

Innovation, improvement and sustainability

- The lead chemotherapy nurse wanted to develop the service and had set tasks to achieve service development. The list of tasks included the establishment of regular team meetings, reviewing the end of life documentation and establishing links with local hospices.
- The Macmillan Quality Environment Mark (MQEM) is a quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. The hospital was awarded MQEM accreditation.

Requires improvement

Surgery

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

Information about the service

At Spire Hartswood Hospital, there is one inpatient ward, one day surgery ward, a pre-assessment unit and four operating theatres, which includes one endoscopy theatre. There are also two extended recovery (ERU) beds.

The hospital saw a total of 1,601 inpatient stays, 6,572 day case patients and 7,220 visits to theatre in 2015.

During the inspection, we spoke with 20 staff members including consultants, nursing staff, operating department practitioners, care assistants and senior managers. We also spoke with six patients, one relative and reviewed six patient records. We reviewed policies, procedures and compliance with national guidance and legislation throughout all areas of the hospital.

Spire Healthcare gather information based on calendar years, with quarter one being January to March. At the time of inspection data for quarter one of 2016 was not fully ratified or partially complete, therefore the majority of data used as supporting evidence is from 2015.

Summary of findings

Surgery at Spire Hartswood Hospital was rated requires improvement overall, with effective, caring and responsive rated as good and safety and well-led rated as requires improvement.

We found surgical services required improvement. Staff were aware of how to report incidents and when this should be done. However, route cause analysis (RCA) following incidents often lacked detail and were not conducive to learning. There was a clear escalation pathway for safeguarding concerns.

Medication was stored appropriately and in line with manufacturer's guidance. Mandatory training compliance was above 83% for all modules for the period March 2015 to February 2016, with the exception of both adult and children safeguarding modules. Documentation, particularly from consultants was sometimes limited. Single patient records were not fully embedded within the hospital at the time of inspection. One set of notes reviewed had pre-assessment documentation missing and two sets had no detailed plan of care documented following surgery.

Hospital policies were evidence based and referenced national guidance and legislation where applicable. Staff were seen to comply with local policies and national guidance. Pain relief was readily prescribed for patients post-operatively and to take home. Food and drink was available throughout the day and patients' dietary requirements were taken into consideration and provided for. The latest Patient Reported Outcome Measures (PROMs), National Joint Registry and NHS

Requires improvement

Surgery

CQUIN data showed positive results in the majority of areas. There was evidence to show that care planning for patients with pre-existing mental health conditions did not happen.

Knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was good amongst nursing staff. Staff were able to give appropriate examples and uses of the MCA and DoLS.

Staff provided compassionate, respectful care to patients. We observed staff being understanding and maintaining patient dignity. However, in the latest patient led assessment of the care environment (PLACE) data, the hospital scored below the national average for maintaining the privacy, dignity and wellbeing of patients. The latest Friends and Family Test (FFT) results were 100% between July 2015 and December 2015.

Patients who required additional support throughout their stay were highlighted at pre-assessment. Either the consultant or anaesthetist reviewed patients highlighted as being at a greater risk prior to admission. Services were in place to accommodate patients whose first language was not English using a translation service. However, staff were unsure how to use the translation services in place and were unaware how to obtain written information in other languages.

A clear vision and a set of values were in place. Staff were fully aware of these and promoted them in day to day working. Questionnaires and annual PLACE assessments were used to gather patient feedback. A governance structure was in place; however, evidence gathered did not support that this was cohesive, robust or used to promote a continuous learning and improvement culture. Oversight by the medical advisory committee (MAC) was limited with the MAC chair unable to demonstrate a clear understanding of the challenges facing the hospital.

Are surgery services safe?

Requires improvement

Safe has been rated requires improvement because:

- Route cause analysis' (RCA) following incidents were often lacking detail.
- Carpeted flooring was in half of patient bedrooms. The hospitals risk assessment lacked detail and actions to mitigate the risk. Cleaning schedules lacked detail, including which areas had been cleaned and how.
- Compliance of infection control process (bare below the elbows) amongst medical staff was not always in place.
- There was no system in place to record decontamination of the fibreoptic laryngoscopy used in theatre for difficult intubations.
- Documentation in nursing care pathways was not robust. Medical review details were often limited, lacked detail or not present.
- The hospitals safeguarding policy had not been adapted for local use.
- Mandatory training compliance was 84% in 2015 against a target of100%.

However:

- The hospitals clinical score card data was predominantly positive. Compliance with national early warning score (NEWS) completion and pain assessments were above Spire target.
- The latest Patient Led Assessment of the Care Environment (PLACE) scored above the national average for the condition, appearance and maintenance of the hospital.
- Equipment was PAT tested and serviced when needed and in line with manufacturers guidance.
- Medication management processes were in place; however door codes to medication rooms were not regularly changed and senior staff were unsure who had access.

Incidents

- From January 2015 to December 2015, the hospital reported one never event (serious incidents that are

wholly preventable), one unexpected death, one serious injury and two further serious incidents. The hospital reported a further 252 clinical incidents in the same period.

- Staff were aware of incident reporting requirements. This included identifying incidents and the subsequent reporting of them.
- When a serious incident, or other incident requiring investigation, occurred, a root cause analysis (RCA) was carried out and we saw evidence of information and outcomes being disseminated to staff in email and hardcopy form. Serious incidents were also discussed at team meetings and escalated through the hospitals governance system.
- However, on review of a selection of RCAs we found that these lacked in certain detail. Important information had not been included or picked up upon during the investigation process. For example, in one case we found that a patient had suffered a cardiac arrest, been successfully resuscitated and transferred to a local NHS provider. However, no lessons learnt or recommendations had been made. The patient had a previous heart attack yet the RCA had only considered the events of the incident and not those leading up to the arrest. There had been no review regarding pre-assessment arrangements or tests undertaken prior to admission. This meant that any lessons regarding effectively assessing patient risk and acuity prior to admission had not been considered.
- In another RCA it was documented that a patient had become unwell at 4.30am, however when the timeline and detailed information was provided this did not correlate. Nothing had been documented between 1.40 am and 6.30am when the patient's observations had due to be recorded, such as blood pressure, pulse and temperature. The information demonstrated a lack of monitoring and documentation, a delay in responding to patient deterioration and escalation to the medical team. The patient had required a return to theatre due to bleeding. Actions to prevent reoccurrence were vague with no date for completion. For example, the two identified actions were staff to attend a documentation workshop and attend acute illness management training with no dates specified, simply in progress and immediate.
- This was followed up during our unannounced inspection and new root cause analysis guideline had been introduced outlying that current RCA lacked depth of detail and did not always identify all learning opportunities. The new guideline stipulated a structure, process and outcome procedure with oversight from the Spire national clinical team, hospital management team, clinical governance committee and medical advisory committee. The hospitals clinical governance lead would lead future RCAs would be led by the hospital clinical governance lead, however at the time of inspection the hospital did not have a governance lead in post and therefor this responsibility sat with the hospital Matron. A decision had been made to appoint a governance lead following the inspection and recruitment was beginning.
- However, one member of staff was able to give an example of practice changing following an incident. This involved the degrading of walking frames within showers when getting wet. Information had been disseminated to staff and walking or standing frames are now removed prior to patients being showered.

Safety thermometer (Spire clinical scorecard)

- Patient outcomes were measured against a fixed set of criteria using the Spire clinical scorecard. Outcomes were compared nationally against other Spire hospitals on a quarterly basis. The hospital also submitted data to the NHS Safety Thermometer for NHS patients.
- Compliance with national early warning score (NEWS) completion was above 98% throughout 2015, with the hospitals target being 95% or above.
- In 2015, the hospital did not meet its target for inpatient falls in quarters three and four, scoring 2.65 and 2.0 respectively. The hospital did meet its target in quarter one, recording no falls, and quarter two, scoring 1.87. The hospitals target for inpatient falls was less than 1.9. The data is based on the number of falls per 1000 bed days.
- Surgical site infection (SSI) data for 2015 showed that the hospital recorded no incidents of SSI for hip and knee arthroplasty operations.
- The hospital recorded no incidents of venous thromboembolism (VTE) in patients undergoing hip and knee arthroplasty operations during 2015 and no incidents of pulmonary embolism (PE) in 2015.
- The hospital recorded no incidents of pressure ulcers of grade two or above during 2015.
- The hospital contributed to NHS Commissioning for Quality and Innovation CQUIN data collection. CQUIN is

a national initiative that enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
- The hospital submitted data for pressure ulcers, falls, urinary tract infections (UTI), venous thromboembolism (VTE) and harm free care rates. The hospital reported no pressure ulcers and no falls with harm between June 2012 and April 2016.

Cleanliness, infection control and hygiene

- Housekeeping staff undertook domestic cleaning. Patient rooms, corridors, ward areas, waiting areas and en-suite facilities were all visibly clean. Corridors were carpeted and half of patient bedrooms were carpeted. The hospital had a rolling program of improvements underway to replace all carpet in patient bedrooms by the end of 2016.
- The hospital provided a risk assessment in respect to the carpeted areas. This was completed in March 2015 and due for review in March 2018. The risk assessment was brief and lacked detail, for example, one action was in place to mitigate the risk, which was to replace bedroom and examination area flooring with laminate. The target date for completion was "following refurbishment". The risk assessment does not mention a refurbishment anywhere else, and no dates detailed on the risk assessment.
- Housekeeping staff held cleaning records; however, these lacked detail and did not specify the areas that had been cleaned.
- Clinical staff were responsible for cleaning clinical equipment, for example monitors, dressing trolleys and blood pressure machines. Equipment was labelled with a green sticker and dated once cleaned. All clinical equipment observed during our inspection was visibly clean.
- Staff completed annual infection control training in electronic format as part of their annual mandatory training program. compliance for infection control across the hospital was 87% in 2015. from January 2016 59.5% of staff had completed the infection control e learning module
- Processes were in place for decontamination and sterilisation of equipment. The central sterile services department (CSSD) cleaned, packed and sterilised surgical instrumentation on site. The CSSD was compliant with regulation and had recently undergone SGS audit in February 2016. There was a clear process for tracking and traceability of theatre instrumentation. Staff knowledge and awareness of their responsibilities in relation to the use of sterile equipment was good.
- There was no system in place to record decontamination of the flexible fibre optic laryngoscope used in theatre for difficult intubations. Theatre staff could not state when it was last processed and confirmed that should there be an emergency, the scope would be used directly from the storage case, which meant that patients could be at risk of cross contamination. We raised this as a concern with the theatre manager. A risk assessment was undertaken during the inspection with the plan to implement a three-point decontamination wipe system.
- Staff were aware of when and how to use appropriate personal protective equipment (PPE) such as gloves and aprons. Staff were observed to use PPE appropriately throughout the inspection.
- Staff used hand sanitiser before and after patient contact and nursing staff followed a 'bare below the elbows' policy. However, the hospital did not monitor medical staff's adherence to this. During the inspection, a consultant wore a wristwatch whilst undertaking endoscopy procedures. We brought this to the attention of senior managers on site. The hospital director contacted the individual consultant. A standing item for 'soft intelligence' such as challenging consultant practice was added to the hospital management team (HMT) meeting agenda.
- From January 2015 to March 2016, the hospital identified no MRSA, MSSA or clostridium difficile (C. Diff.) cases.
- The infection control lead nurse carried out hand sanitiser use audits. This was done by weighing the bottles of sanitiser within each patient bedroom to estimate how much sanitiser had been used. Hand hygiene is monitored quarterly as part of Spire's quarterly audit data set and reported via the national scorecard. Annual training for staff includes hand hygiene procedures with competence tested with a light box.

Environment and equipment

- Waste management was compliant with DH Health Technical Memorandum 07-01: Safe Management of Healthcare Waste (2011). An external contractor undertook the removal of waste.

- All equipment checked across the hospital was within its service date and clearly labelled with the next date of service. All equipment was stored appropriately and safely. Contemporaneous records were held by the engineering department detailing the service history of all equipment, when equipment was next due for service and by which contractor.
- There were four theatres at the hospital. Two of the theatres had laminar flow systems installed to ensure high-pressure air ventilation changes and two had the ability for laser surgery to be undertaken.
- The Central Sterile Services Department (CSSD) had a contingency plan with another hospital within the Spire group. This meant that should major failure of washers or autoclaves occur the instrumentation could be processed at the other hospital and service to patients could be continued
- Work requisition books were in each ward area. An engineer checked these twice a day.
- Resuscitation equipment was available on the day case unit, inpatient ward and within theatres. The hospital only treated patients over the age of 16 as inpatients. The resuscitation trolleys contained full adult advanced life support equipment and paediatric basic life support equipment. We saw evidence of completed daily and monthly checks of the resuscitation equipment.
- The difficult intubation trolley within theatres did not have a specific checklist; however, a list of daily jobs was signed to say it had been checked.
- The ERU was equipped with wall mounted monitoring equipment, non-invasive ventilation and patient transfer bag. The transfer bag contained equipment required to transfer a deteriorating patient between ERU and theatres or to a waiting ambulance for transfer to an intensive care unit.
- The most recent patient led assessment of the care environment (PLACE) for the hospital was published on 11th August 2015. The hospital scored 94.5% for the condition, appearance and maintenance part of the assessment, which was better than the national average of 74.5%.

Medicines

- Controlled drugs (CD) were managed appropriately. Two registered nurses checked CD registers daily. We reviewed the register, along with three randomly selected CDs, and saw it was accurate and correlated with the stock within the inpatient ward. The patients' own CD register was also checked, however, no patient's own medication was present at the time of inspection.
- Treatment rooms within the day case and inpatient wards were locked using numerical key pads. All medication was stored appropriately in locked cupboards or fridges, in accordance with manufacturer guidance.
- The nurse in charge holding keys controlled access to medication. However, senior nursing staff were unaware of when the code was last changed to access the treatment room. We brought this to the attention of senior management during our inspection who stated this would be reviewed.
- Intravenous (IV) fluids were stored safely within treatment rooms.
- We saw completed records that demonstrated fridge temperatures were checked on a daily basis and were within acceptable ranges.

Records

- We reviewed six patient records during the inspection. Staff were able to find the records requested quickly and without delay.
- Pre-operative assessments were complete and accurate in five of the six records reviewed. In one set of pre-assessment notes, there was no documentation from the consultant and no plan of care for pre and post theatre.
- We reviewed care records through the complete patient's pathway from admission, through theatre and to discharge. Documentation was completed as required throughout the process, including the World Health Organisation (WHO) safer surgery checklist.
- Single patient records were not embedded within the hospital at the time of inspection. Staff told us consultant documentation was often missing or limited within patient records. There were two endoscopic procedures performed in the day of inspection, there was no documented information from any consultant discussions within the care records of either patients. No clinical medical history notes were available which was a risk to patient safety.
- During our review of records, we found that one patient had not had a medical review for days two and three post operatively, despite the patient complaining of increasing pain. The plan as of day one post operatively

stated "continue monitoring" and "continue treatment" with no expansion or detailed explanation. The RMO was informed and the patient had a review. The RMO stated that they had reviewed the patient however had not recorded this in the patient's notes.
- We reviewed another patient's notes and found no documented plan of care from the nursing staff, consultant or RMO over two hours after surgery. Medical staff were informed and we were assured the patient would be reviewed and a plan of care documented.

Safeguarding

- From January 2015 to April 2016, no safeguarding concerns had been raised.
- Staff were able to describe the local arrangements in place to report safeguarding concerns. Support was available from the ward manager or the Matron.
- However, outside of normal working hours when support was not available staff were unsure as to how to escalate concerns. This meant that safeguarding referrals could be delayed placing patients at risk.
- The hospital submitted the Spire national safeguarding vulnerable adults policy as their active safeguarding policy. Within the policy it stated that matron, or their deputy, should be the responsible person for safeguarding concerns, which was the case at Spire Hartswood. A local safeguarding flow chart detailed the process to follow if a safeguarding issue was suspected, including details of the local authority to contact in emergencies. Nursing staff completed Prevent training (radicalisation recognition and prevention) and female genital mutilation (FGM) as part of the hospitals adult and child safeguarding modules. (FGM)..
- The adult and child safeguarding modules were introduced in January 2016. By February 2016, 20.6% of staff had undertaken child safeguarding and 27.3% had undertaken the adult safeguarding module. This was in line with the trusts quarterly target of 25%.

Mandatory training

- Staff were aware of their responsibility to undertake and complete mandatory training. Mandatory training was delivered via the Spire electronic system.
- From March 2015 to February 2016, an average of 89% of staff had completed all required mandatory training, with the exception of adult and child safeguarding modules.
- The hospital's target for compliance with mandatory training is 95%. The hospital had achieved an average of 84% compliance across all mandatory training during 2015, which was below target.
- All registered and non-registered clinical staff were trained to a minimum of basic life support (BLS) for resuscitation. Six nurses held current advanced life support (ALS) certificates.

Assessing and responding to patient risk

- The World Health Organisation (WHO) Safer Surgery Checklist was in use at the hospital. The five steps to safer surgery incorporates a briefing before surgery commences at the beginning of the list and debrief at the end. Huddles were taking place before each list and with each change of consultant to ensure safety and a coordinated approach to the surgery.
- Monitoring of the WHO checklist and compliance was not always robust. On the day of inspection, a patient had not had their operation site marked before going to theatre. Surgical staff identified and rectified this in the anaesthetic room.
- Staff completion of instrument checklists was not consistent to clearly demonstrate and provide assurance that all items of surgical instrumentation were accounted for at every stage, e.g. at packing, first count, final count and receipt into the wash area in the sterilising department. Five checklists were reviewed, two had been completed in full, two had been scored through and one had not been completed at all.
- In the event of a cardiac arrest, there was a dedicated crash number for staff to page relevant members of the medical team. The resident medical officer (RMO), theatre staff and senior nursing staff made up the cardiac arrest team. Emergency call bells were available in each patient bedroom and consulting rooms.
- The hospital used the National Early Warning Score (NEWS) to assess patients. NEWS is a nationally recognised scoring system to establish the stability and deterioration of a patient based on predetermined parameters for observations such as pulse, temperature, pain and blood sugar.
- NEWS were completed appropriately in accordance with hospital guidance. Escalation plans accompanied the NEWS assessments and were appropriately implemented.
- National Institute for Health and Care Excellence (NICE) QS81 Pressure Ulcers states that a pressure ulcer risk

assessment should be undertaken within six hours of a patient being admitted into a hospital. The use of the Waterlow Score system is a common assessment tool used in hospitals. A Waterlow Score provides a risk based score against a set of predetermined standards to establish the likelihood of pressure damage occurring.

- During the inspection, the use of Waterlow Scores was seen. Patients were assessed at pre-admission; however, no evidence of follow up or care planning resulting from a high Waterlow Score was seen.
- Patients were routinely nursed on pressure relieving mattresses deigned to accommodate patient with a high risk of developing tissue damage. A repositioning chart was used for patients who were unable to mobilise as per physiotherapy plan of care. At the time of the inspection there were no patients who required a repositioning care plan.
- .
- All patients were pre operatively screened initially using a postal questionnaire assessment. The returned questionnaires were reviewed by the registered nurse who would triage the patients accordingly. Patient brought in their completed questionnaires on the day of admission. If any specialist requirements or concerns were highlighted patients were referred to either he consultant of anaesthetist. .
- The environment and equipment within the extended recovery unit (ERU) was sufficient and appropriate to care for a level one patient requiring additional monitoring and closer observation.
- Criteria was in place for escalation of deteriorating patients, including transfer to the nearest NHS hospital for level two or level three intensive care. Staff were aware of the process and examples were given of its effective implementation.
- In 2015, there were five unplanned transfers of care to another hospital. The unplanned transfers of care had been reported as incidents and investigated. In quarter one of 2016, there had been no unplanned transfers of care to a level two or level three facility.

Nursing staffing

- There were 53 beds at the hospital split between day case (21 beds), endoscopy (five beds), inpatient (25 beds) and ERU (two beds) that required nurse staffing.
- In total, there were 25.1 whole time equivalent (WTE) registered nurses, 9.3 WTE operating department practitioners (ODP) and 17.3 WTE care assistants covering theatres and inpatient beds.
- Nurse staffing was split over three shifts in a 24 hour period; the 'early shift' 7am to 3pm, 'late shift' 1pm to 9pm and 'night shift' 8:30pm to 7:30am. This meant that there was a handover between each shift to ensure continuity of care.
- The number of staff on each shift was dependant on the expected number and acuity of patients. Senior nursing staff monitored patient acuity on a daily basis and additional staff brought in when required. No formal acuity tool was in use at the hospital; however, the ward manager and ERU lead nurse had a good understanding of the needs of the ward and demands on the service based on the planned procedures.
- From January 2015 to December 2015, the use of agency registered nurses ranged between zero and 12%, with the exception of July 2015, which saw an agency use for registered nurses of 20%. Information was not provided to explain the isolated rise. There was a small use of healthcare assistant agency use between February and April 2015 of around 3%.

Surgical staffing

- There was a resident medical officer (RMO), at the hospital 24 hours a day, seven days a week. The RMO's worked seven 24 hour shifts in a row, with facilities on site for them to sleep over night.
- The RMO was available 8am-5pm on the wards, and was on call 5pm-8am.
- The provider of RMOs, completed surveys of the RMOs sleep disturbance, and provided reports to the hospital. Results showed that sleep disturbances were rare, and when they did occur were for justified clinical need. If the RMO had a disturbed night, or unwell, an alternative RMO would be provided.
- Individual consultants, responsible for patients' care, were contactable 24 hours a day whilst the patient was an inpatient for advice and guidance should this be required. The RMO was aware of how to contact consultants and was happy to do this when necessary. During times of absence, consultants were required to nominate and provide details of another consultant who was available for support and guidance with patients.

Requires improvement

Surgery

Major incident awareness and training

- The hospital had procedures in place in the event of a major incident occurring on site. The engineering manager spoke of the process for power failure. Backup generators were in place to provide power. Essential equipment, for example within theatres and endoscopy, ran from separate backup generators. Emergency lighting would come on in the event of a power failure.
- An engineer was on call 24 hours to provide support and advice in the event of a major incident or power failure. The on call rota was managed effectively with one telephone number staying with the engineer on call. This meant staff around the hospital required one emergency number to be displayed.
- Appropriate procedures were in place in the event of a fire or flood. Records showing the service history of the fire alarm system were seen during the inspection. The procedure in the event of a fire was explained fully by the engineer and was proportionate to the needs of the hospital.

Are surgery services effective?

Good

Effective has been rated good for surgery because:

- Staff undertook pain assessments on patients and pain relief prescribed and administered as required.
- Patients had access to food and drink throughout their stay.
- The latest PROMS and National Joint Registry data was positive, with 93% of patients undergoing hip and knee surgery reporting an improvement in their health, and 10 out of an eligible 17 patients who underwent groin hernia repairs reported an improvement in their health.
- Appraisal rates amongst staff exceeded the hospital's target of 75%.
- Staff had good knowledge and understanding of Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- The Enhanced Recovery Unit (ERU) lead nurse was using an adapted and shortened National Competency Framework for Critical Care Nurses (NCFCCN) to up skill ward staff in the care of a level one patient.

However:

- The ability to achieve and maintain full competence of Step One skills would be difficult due to the lack of exposure and suitable patients.
- Individual areas lead staff undertook local audits, which meant that there was the lack of challenge or peer review.

Evidence-based care and treatment

- Staff were aware of, and worked in line with, local policies and procedures. For example, infection prevention and control and medicine management
- Staff followed relevant National Institute of Health and Clinical Excellence (NICE) guidance. For example, in relation to the administration of intravenous (IV) medication (NICE QS66).
- Within theatres, staff were aware of the World Health Organisation (WHO) safer surgery checklist. The WHO checklist was observed being used within theatre and was embedded into the routine of the patient's pathway. The hospital undertook audit of completion of all aspects of the checklist and observational audits to confirm the quality of the checks. Data from Q1 2016 demonstrated that documentation completion was completed on average in 88% of cases and observational compliance was at 91%. The hospital had identified several areas of action to improve results in the time out and sign out aspects of the safer surgery checklist.
- Hospital policies were appropriately referenced and signposted to the evidence base. For example, the resuscitation policy references the Resuscitation Council, and the Vulnerable Adults Policy references the Department of Health, Care Act 2014 and the Equality Act 2010.

Pain relief

- The hospital did not have a dedicated pain team or nurse specialist for pain. There was a pharmacist on site Monday-Friday, 9am-5pm and on Saturday, 9am-1pm, to dispense and provide advice and support. There was a 24 hour on call system in place for urgent and out of hours advice.
- Evidence of pain assessments being undertaken and documented were seen in four out of the five sets of patient notes reviewed where a pain assessment would have been expected.

- Compliance with recording patients' pain scores was 100% in Q1, Q3 and Q4; however within Q2 compliance fell to 95%. The hospital's target for recording pain is 95% or above.
- Post-operative pain relief was prescribed within theatre. Ward staff stated that patients rarely come back from theatre without pain relief prescribed, which ensured patients remained comfortable post-operatively. Staff said the RMO's were supportive and available to review pain relief if requested by nursing staff.
- Prescriptions for pain medication reviewed were completed in full, legible and appropriate doses prescribed, as per the British National Formulary (BNF). Evidence of regular and appropriate administration in line with the prescription was seen in all notes reviewed.

Nutrition and hydration

- Preoperatively patients were advised regarding fasting requirements. For general anaesthetics, this was 6 hours prior to surgery for solid food and two hours for fluids. Patients were given information on fasting during the preoperative assessment or consultation.
- Patients had a daily menu to choose meals from and catering staff prepared food fresh on site. Patients had access to food between meal times as required. Water was available to all patients throughout the day.
- Patients with special dietary requirements were highlighted at pre-assessment and their needs were catered for throughout their stay. Staff informed the catering staff on admission of any dietary requirements, for example vegetarian or coeliac disease.

Patient outcomes

- The hospital submitted data for Patient Reported Outcomes Measures (PROMs) for NHS patients. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short self-completed questionnaires.
- PROMS data between April 2014 and March 2015 demonstrated positive results with 93% of patients indicating an improvement in health following both knee and hip surgery. During the same reporting period, groin hernia data shows that of 17 eligible patients, 10 reported an improvement in their health following surgery, five reported no change and two reported a worsening in their health.
- The hospital submitted data to the National Joint Registry (NJR). The NJR showed patient outcomes for revision rates for hip surgery between April 2010 and June 2015 for Spire Hartswood was at the national average.
- Between April 2010 and June 2015, patient revision rate outcomes for knee surgery were significantly better than the national average. The mortality ratio following knee surgery was also better than national average.
- Individual areas own lead staff undertook local audits, which meant that there was the lack of challenge or peer review. This was raised during the inspection and the hospital has since implemented a process that requires head of departments from other areas (or hospitals) to oversee local audits.

Competent staff

- Staff joining the hospital received both corporate and local inductions. They also completed a program of mandatory training.
- Appraisals had been completed for 100% of nursing staff (inpatient areas only), 91% of care assistants (inpatient areas only), 90% of allied health professionals, 80% of clerical staff and 98% of all other support staff in 2015. The hospital's target for appraisals was 75%.
- We reviewed five staff competency folders in theatres. All five had completed and signed documentation for appropriate competencies for the role e.g. covering anaesthetics, surgical and recovery aspects.
- Senior staff within theatre could not evidence that a documented record was in place to ensure all competency and health and safety checks had been undertaken for any staff that acted as surgical assistant as per hospital policy. We raised this with the theatre manager and matron and a form was subsequently produced.
- In 2015, out of 318 staff, six had undertaken advanced life support (ALS) training, 21 had completed intermediate life support (ILS) training and 85 members of staff had completed basic life support (BLS) training. Fifty three staff had completed paediatric BLS and 13 had undertaken acute illness management (AIM) training.
- The hospital's matron checked all RMO qualifications and suitability before commencement of employment. The RMO staff were supplied via an agency and had undertaken all required training to satisfy the agencies criteria.

- ERU staff were undertaking step one of the National Competency Framework for Critical Care Nurses (NCFCCN). Whilst this was beneficial in staff development, it was unclear how competence would be maintained due to the limited number of patients requiring ERU. ERU bed use during 2015 was on average 9%.
- The ERU lead nurse had begun to use an adapted and shortened National Competency Framework for Critical Care Nurses (NCFCCN) to up skill ward staff in the care of a level one patient. This meant that the nurses would have additional competency to assist with patients that are more complex.
- The engineering staff had yearly competency assessments carried out by the engineering manager. The two engineers had completed their yearly competencies in June 2015, and were scheduled for reassessment in June 2016.
- The engineering manager was yet to have his competencies assessed by the Spire area manager due to his recent employment at the hospital. However, evidence was seen to show this had been arranged for May 2016. Following this, the engineering manager was able to undertake the reassessment of the engineers in June 2016.

Multidisciplinary working

- Staff of all disciplines, clinical and nonclinical, worked alongside each other throughout the hospital. Physiotherapists were requested to review patients as required. Nursing staff felt empowered to ask for assistance from anaesthetists or consultants.
- Physiotherapists were observed treating patients and were involved in the discharge process for patients with mobility needs. Physiotherapists wrote discharge summaries whenever patients had continuing community needs, for example rehabilitation. No evidence was seen at the time of inspection to support physiotherapy input within the discharge process due to the patients on the ward; however, both nursing staff and physiotherapists reported physiotherapy involvement.

Seven-day services

- The onsite pharmacy was open 9am-5pm Monday to Friday and 9am-1pm Saturday. Outside these hours, a member of pharmacy staff was available via the on call system to provide pharmaceutical advice and support to the staff.
- Theatres were staffed and used Monday to Friday 8am to 9pm and Saturday 8am to 5pm. Outside of these hours there was an on call system in place to provide emergency surgical cover if required.
- The resident medical officer (RMO) was onsite 24 hours a day. The RMO was able to contact individual consultants for support and advice throughout the patient's stay. The RMO felt confident to contact consultants out of hours when needed.
- There was an engineer available between 6am to 6pm Monday to Friday. An on call system operated outside of these hours for emergencies for example radiology.

Access to information

- All nursing and medical documentation, including risk assessments, care plans and theatre documentation, was in paper form. When requested, nursing staff were able to find relevant notes for patients and these were easily accessible.
- Test results, including x-rays, were held electronically. The consultants and RMO had access to these as required.
- The hospital was looking to implement a single care record to replace the current system where documentation is held in several places, including consultant held notes. The single patient record is an ongoing project, which will improve accessibility to the most up to date information and improve patient safety.
- On discharge, patients were given a copy of their discharge summary to give to their General Practitioners (GP).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- . Consent forms were completed appropriately, in full and were legible, although some were of an older format. Consent, was taken on the day of surgery, following an outpatient consultation, where risks and benefits of treatment options were initially discussed. The practice was in line with Spire's consent policy...
- Nursing staff had a good understanding of consent, the Mental Capacity Act (MCA), mental capacity assessments and deprivation of liberty safeguards (DoLS). Staff could

provide examples of when a DoLs application may be needed. One nurse gave two examples of when a patient's capacity may be altered; these were post operatively due to anaesthetic and due to certain medications the patient may be taking.
- No DoLS applications had been made by the hospital to the local authority. Staff told us that these would be done by matron rather than by staff at ward level.
- MCA and DoLS training was delivered to all staff as part of the mandatory training program. The hospital did not provide data in relation to the numbers of staff that had undertaken the training.

Are surgery services caring?

Good

Surgery services were rated as good for caring because:

- Staff were seen to be kind and considerate to the needs of patients throughout the hospital.
- Patients rating excellent for overall care and attention provided by staff in the patient experience data for 2015 was above the Spire target of 85%.
- Between July 2015 and December 2015, the hospital's Friends and Family Test (FFT) results were 100%.
- Patient feedback during the inspection was all positive, with one patient saying they were "very happy" with the care provided and another patient stating staff had been "approachable and respectful" throughout their stay.
- A chaplaincy service was available for patients and staff were aware of how to contact the service.
- Patients felt well informed and involved in their care throughout their stay at the hospital.

However:

- The latest PLACE scores for privacy, dignity and wellbeing were 78%, which is below the national average of 86%. However, we found staff maintained patients privacy and dignity throughout the inspection.
- No specific counselling or emotional support services were available at the hospital for patients or relatives.

Compassionate care

- Staff were seen to provide compassionate, kind and considerate care. Staff interacted with patients and relatives in a professional but thoughtful manner. Staff were observed offering to escort patients to their rooms on arrival and providing assistance to those with disabilities.
- Reception staff were kind and welcoming to patients across the hospital.
- From July 2015 to December 2015, the hospital's Friends and Family Test (FFT) results were 100% throughout.
- The hospital's clinical scorecard results were positive in relation to patient experience in 2015. The percentage of patients responding excellent to the overall care and attention provided by nursing staff, ranged between 86% and 92% in 2015, against a hospital target of 85%.
- Senior nursing staff had undertaken Dementia Friends training that highlighted the physical and emotional difficulties faced by people with dementia and how a supportive network can help alleviate some of those concerns.
- The hospital scored 78% for privacy, dignity and wellbeing in August 2015 patient led assessment of the care environment (PLACE) inspection, which was below the national average of 86%. However, we found during the inspection that staff maintained patient's dignity and privacy throughout.
- Positive feedback received from patients included one patient that said they felt very lucky to have been treated at the hospital and staff had been approachable and respectful throughout their stay.
- Another patient within the endoscopy unit said they were very happy with their care at the hospital.

Understanding and involvement of patients and those close to them

- Staff involved patients throughout their pathway of care. Staff explained procedures to patients in a calm, non-rushed manner that allowed time for conversations about uncertainties or worries on the part of the patient.
- One patient within the endoscopy unit told us they felt fully informed about the care they were receiving. A patient within theatre recovery stated that they felt fully informed before and after their procedure

Emotional support

- All staff were observed to check on patients' well-being regularly and spend time with patients to discuss concerns and provide support and reassurance prior to their procedure.

- A Chaplaincy service was available to patients and relatives to access throughout their stay. Staff were aware of how to contact the Chaplaincy service however staff stated they had not used or accessed the service.
- The hospital provided no specific or targeted counselling for patients or relatives.

Are surgery services responsive?

Good

Surgery services were rated as good for responsive because:

- Patients had quick access to care when they required it with referral to treatment time (RTT) for admitted patients consistent for the majority of 2015.
- The latest PLACE results rated the ward food above the national average with a score of 92%.
- The number of patient complaints has fallen year on year from 72 complaints in 2013 to 47 in 2015.
- The hospital offered a range of amenities for patients, including a television and internet access in every bedroom. Each patient room was equipped with a nurse call button.

However:

- Throughout 2015 at least 40% of patients were at risk of extended periods of fasting prior to surgery.
- Staff were unable to provide an example of when practice or procedures had changed following patient feedback.
- Support for patients with pre-existing mental health conditions was lacking.
- Staff had access to a translation service; however staff were unsure how to use the service.

Service planning and delivery to meet the needs of local people

- From January 2015 to December 2015, the hospital had admitted 1,601 inpatients, 6,572 day case patients and 7,220 visits to theatre.
- The ERU at Spire Hartswood was staffed and equipped to deal with level 1 patients requiring additional monitoring and support. Patients requiring additional specialist care, for example above level 2 in a high dependency unit (HDU) or intensive care unit (ICU), were transferred to the nearest NHS provider. The clinical scorecard results for 2015 were below (better than) Spire target with an unplanned transfer to critical care occurring only in Q3.

Access and flow

- Patients had timely access to assessments, diagnosis and urgent treatment. There were no delays in accessing treatment once a diagnosis had been made.
- Surgery was predominantly elective. There had been 17 unplanned returns to theatre between January 2015 and December 2015, which was within the Spire target of less than 0.16% of patients.
- The hospital was within target for unplanned readmissions within 31 days of discharge. From January 2015 to December 2015, there had been nine unplanned readmissions. The target is 0.27% of patients and the hospital achieved under 0.17% throughout the year.
- The extended recovery unit (ERU) had seen a bed occupancy rate of 9% in 2015. This shows that patients who require ERU care can access a bed promptly. This meant that the majority of patients treated within the hospital had appropriate acuity for the service provided.
- Referral to treatment times for admitted patients receiving treatment within 18 weeks were consistent for most of the year with 100% achieved from February to August 2015. This started to gradually lower towards the end of the reporting period, September to December 2015,with figures reducing from 95% in September and October, 88% in November and 86% in December.

Meeting people's individual needs

- Patient information leaflets were available throughout the hospital; however, these were only available in English. Staff had access to translation services for patients who did not speak English or were hearing impaired. Staff were aware of the services; however, no evidence of the translation service being used was seen as no patients had required the use of translation services.
- Staff had an understanding of the additional needs of patients with dementia, including additional monitoring.
- The percentage of patients responding with excellent to being prepared for being at home was 72% in Q1,2 and 3 in 2015 against a target of 72%.This was missed in Q4, with the hospital scoring 67%.

Requires improvement

Surgery

- Support for patients with existing mental health conditions was lacking. We reviewed a set of notes for a patient with bipolar disorder who had no documented consideration or support for their bipolar whilst a patient at the hospital.
- The hospital was compliant with mixed sex accommodation requirements. The inpatient and day case wards were both individual patient rooms with individual bathrooms.
- The hospital operated an open visiting culture, allowing relatives to visit patients as they wanted.
- Each single room had a television, access to the internet and a nurse call button.
- Patients were asked to select their menu choices in the morning for lunchtime service and again in the afternoon for evening meal service. The latest PLACE results from August 2015 scored ward food at 92%, with the national average being 89%.
- The ward manager provided an example of when staff had responded and supported a patient's relative following cardiac arrest. The patient had been transferred to a nearby NHS hospital and non-clinical staff had supported the patient's relative throughout and then drove them to the NHS hospital. The ward manager was extremely proud of the way all staff had contributed to the situation and remained professional throughout, providing care to both the patient and the relatives.
- The Spire target for the number of patients to be fasted from fluids for no more than three hours prior to surgery was 45%. The hospitals clinical scorecard for 2015 showed results that ranged between 50% and 60% compliance. This meant between 40% and 50% of patients were at risk of having fasted for a prolonged period.

Learning from complaints and concerns

- The hospital had a complaints process in place for staff to follow. Two staff said that if a patient wanted to complain they would be offered the opportunity to speak with the ward manager or matron. Staff also stated the importance of acknowledging and listening to patients with concerns.
- The ward manager reviewed complaints and responded either by telephone or in writing. Matron responded to all significant concerns raised.
- There were a decreasing number of complaints at the hospital with 47 received in 2015 compared to 50 in 2014 and 72 in 2013.
- The hospital scorecard monitored the percentage of level 1 complaints handled within policy timescales, against a target of 75%. Data demonstrated an improving picture with Q2 results at 57%, Q3 100% and Q4 88%.
- Two nursing staff stated that information regarding complaints and any lessons learnt were shared within the team at handover. However, this was not formalised and staff did not receive all patient feedback.
- Staff were unable to provide an example of when practice had changed following a complaint from a patient or relative.

Are surgery services well-led?

Requires improvement

Well-led has been rated requires improvement for surgery because:

- Whilst governance processes were in place at the hospital, they did not work effectively or support a continuous learning and improvement culture.
- Senior management oversight of the hospital's governance was limited and lacked challenge.
- Risk management systems were not used appropriately. The medical advisory committee did not have oversight of risk and the risk register was lacking detail and scrutiny.
- The senior leadership team did not demonstrate cohesive understanding about the key risks and challenges faced by the hospital and there was no formal method to provide assurance between the team on governance decisions.
- Systems, which could demonstrate continuous learning and improvement, were not well embedded.
- Where local audits occurred, there was a lack of challenge or peer review.

However:

- The hospital had a vision and values in place, although these were the national Spire values and not specific to the hospital.
- There was evidence of public and staff engagement in service provision and improvement of the hospital.

- There was good local leadership and staff spoke positively about the ward manager.

Vision and strategy for this this core service

- The hospital's vision and values reflected Spire Healthcare national vision and values. The hospital's vision was to be recognised as a world-class healthcare business bringing together the best people to develop the best clinical environments and deliver the highest quality care.
- The hospital's values were based around six core areas: caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on our promises and keeping it simple.
- Staff demonstrated the hospital's values throughout the inspection.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place which included a clinical governance committee, medical advisory committee and clinical effectiveness committee. However, we found that this structure was not working effectively due to lack of review, senior oversight and challenge.
- Terms of reference for these governance committees had not been localised to ensure a clear purpose and role. From our review of the clinical governance meeting minutes dated October 2015 and the medical advisory committee dated November 2015, we noted a lack of challenge and scrutiny. This was discussed with a member of the senior management team who acknowledged there was, on occasion, a complacency to take information at face value.
- There was limited evidence that learning and improvement took place. We spoke with a member of the senior management team, who, whilst able to describe the systems and processes in place for learning opportunities to be identified, could not provide examples of how they had led to improvements within the hospital. There was a lack of communication from each department to ensure any learning across the hospital was shared.
- The medical advisory committee (MAC) met quarterly and had appropriate oversight of competence and proximity for consultants with practicing privileges. However, the MAC did not take responsibility for the appointment and review of RMOs.
- We reviewed the hospital's risk register dated March 2016 which detailed key risks faced by the hospital. However, mitigating actions had not been identified which meant that the monitoring or testing of controls could not take place. .
- Quality improvement measures were not robust. There was a lack of scrutiny and challenge as local audits to monitor and improve performance were undertaken by the leads from their own area.
- From our review of clinical governance minutes dated February 2015, April 2015, July 2015 and October 2015 we found that the hospital director did not attend clinical governance meetings. This was discussed with the hospital director during our inspection and they acknowledged that their attendance at these meetings was key to being appropriately appraised of matters regarding the running and safety of the hospital.
- The hospital director told us that they would attend these meetings going forward and that there would be a renewed focus to improve the governance strategy and structure. We did however note that the hospital management team had identified that it had not been ensuring improvement actions were acted on and implemented. In response to this we were told that an MAC meeting took place on 31 May 2016 to review findings, schedule monthly meetings with MAC chair, review terms of reference. A hospital action log (HAL) had been put in place to monitor actions and their outcomes.

Leadership / culture of service

- A hospital director and a matron led the hospital. The chair of the MAC, operations manager, commercial and finance manager and business development manager supported them.
- Leadership at this hospital was not effective. During our discussion with one member of this senior team, we found they demonstrated a lack of engagement and oversight in relation to their role and matters of importance for the hospital. For example, they could not describe the current performance of the hospital on either a local or a national basis. They could not describe any strategic risk for the hospital believing the biggest risk faced was slips trips or falls. This member of the leadership team could also not describe the importance of the MCA or provide assurance the hospital was working in accordance with the Act. They

could also not provide assurance about the processes in place for the recruitment or working patterns or RMOs or the on-going monitoring of any purely private consultants.

- During our discussions with other members of the leadership team, we were told that there was no formal process to communicate information and governance decisions. When we asked about how assurance was gained in relation to the safe and proper functioning of systems and processes, we were told by two members of the management team that this was based on trust between colleagues. Whilst a positive working relationship, this is not an effective way to ensure proper management of the hospital and its services.
- The hospital Matron had responsibility for multiple areas of complex work, which included RMO recruitment, safeguarding and governance. We raised concern over the extensive potfolio responsibilities of the matron at the time of the inspection. Following which a plan was put into place for the recruitment of a governance facilitator. Senior managers expressed that at times communication to staff had not been effective, possibly explanations behind decisions had been lacking, and that there were efforts being made to improve. One change was to reformat the team meeting for clinical staff so that clinical issues were discussed at the beginning of meetings and business and financial aspects at the end.
- The 2015 staff survey showed a lack of staff confidence in senior leadership, working together, and service quality. However, during the inspection staff praised the leadership within the hospital and felt there was a clear 'open door' culture at the hospital. Staff were positive about the ward manager and felt the ward manager was approachable and supportive
- The ward manager demonstrated a good understanding of the needs of staff and provided evidence of additional support structures put in place for staff. The ward manager was aware of the challenges and limitation of the ward, for example in providing level two care and the need for refurbishment of patient bedrooms.
- The MAC chair stated that very few disputes had happened amongst consultants and the hospital was a good environment to work within.

Public and staff engagement

- The hospital gathered patient opinion using patient surveys offered to all patients during their stay, friends and family test (FFT) and patient led assessment of the care environment (PLACE) which was carried out annually.
- Staff stated they felt empowered to make comments or suggestions that would improve the patient experience or staff wellbeing.
- Staff were engaged through weekly and monthly news bulletins that highlighted both departmental, hospital wide and national issues. These bulletins were also used to motivate staff by commending and celebrating good practice and improvements.
- There was a staff recognition scheme "Inspiring People" which gave staff the opportunity to be recognised and valued for their work.

Innovation, improvement and sustainability

- There was a plan in place to upgrade all patient rooms, including removing carpet and installing laminate flooring.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

The outpatient's department in Spire Hartswood is located on the ground floor of the main hospital. Services offered included general medicine and general surgery. There were 12 consultation rooms within the outpatient department.

Diagnostic services included plain film x-ray, magnetic resonance imaging (MRI), computerised tomography (CT), ultrasound, dexa scanning and digital mammography.

Of the outpatient appointments 83% of were for private patients and 17% were NHS appointments. Within the period January 2015 to December 2015, the outpatient and diagnostic imaging department held 52,500 outpatient appointments, consisting of 18,024 new appointments and 34,476 follow-up appointments. Children's outpatient appointments were supported by two specialist children's nurses (RN) and a children's specialist physiotherapist.

During the inspection we visited a number of outpatient clinics and diagnostic imaging treatment areas. We spoke with four patients, and 34 nursing, medical and allied health professionals staff members. We reviewed five patient records and reviewed information provided to us prior to and during inspection.

Summary of findings

Outpatient and Diagnostic Imaging Services were rated as requires improvement overall. Safe and well-led were rated as requires improvement with caring and responsive rated good.

The hospital did not have a single or unified patient record, however there was an action plan in progress for the implementation of an electronic single patient record.

Staff knowledge of local risks was limited. Assessment and monitoring of risks was not robust. Identified risks were not included on the risk register and risk assessments were overdue for review which meant that we were not assured risks were appropriately identified, monitored or actions taken in a timely manner

However; Staff supported openness and transparency following incidents. Staff were aware of the system for reporting incidents and understood their responsibilities under duty of candour to explain and apologise to patients went things went wrong. There was evidence of staff sharing lessons learnt following incident investigations. The hospital displayed "you said, we did" posters in patient waiting areas showing changes in practice which had happened as results of complaints or incidents reported to the hospital.

The hospital had not reported any cases of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile in the last seven years. Hand sanitizer gel was available in outpatient waiting areas and consultation rooms. Staff were aware of national

Requires improvement

Outpatients and diagnostic imaging

best practice guidance and local network links were established by the infection prevention and control lead to share information and benchmark against other local providers.

There was a robust system for ensuring that consultants operated within their scope of practice within the NHS, maintained their continued professional development, received annual appraisals and completed mandatory training. The hospital provided figures to demonstrate that medical notes were available for outpatient appointments in 98% of cases.

Information governance systems included a secure electronic system for sharing diagnostic patient images. Referral to treatment time figures for all outpatient and diagnostic imaging patients were met in 11 out of 12 months in 2015.

Medication management was monitored and reviewed regularly within the diagnostic imaging service.

Patients were treated with dignity and respect by hospital staff and spoke very highly of the care they received. March 2016 patient survey data demonstrated that between 97% - 100% of patients felt that the care and treatment they received was 'excellent' for outpatient and diagnostic imaging departments.

There were registered nurses (child branch(,available to support children and their families attending appointments in the outpatient and diagnostic imaging departments.

Are outpatients and diagnostic imaging services safe?

Requires improvement

Outpatients and diagnostic imaging services were rated as requires improvement for safe because;

- Identified equipment faults were not risk assessed or included on the risk register.
- Insufficient methods were being used for completing hand hygiene audits.
- A number of COSHH risk assessments were overdue review.
- Corporate policies were not routinely adapted for local use.

However;

- The majority of staff knew how to report an incident on the electronic incident reporting system.
- Hospital data demonstrated that medical notes were available for 98% of outpatient clinic appointments.
- Medication management was secure. Patient group directions were used within the diagnostic imaging department for routine procedures where medicines would be required to be supplied or administered.

Incidents

- There was one ophthalmology never event in July 2015. A root cause analysis had been completed and practice was subsequently changed, which included using the biometry print out as part of the final safety check prior to procedure. Trends reviewed from root causes of clinical incidents that were investigated, demonstrated that documentation needed some improvement. A documentation workshop was planned for in 2016.
- Staff were aware of their responsibilities under duty of candour to explain and apologise to patients when something went wrong. We saw that the duty of candour process was followed in the surgical never event. An outpatient nurse provided an example of a missing specimen sample for which the consultant explained and apologised to the patient. This incident was logged on the incident management system and to minimise the risk of reoccurrence the department implemented a specimen logging book.

Requires improvement

Outpatients and diagnostic imaging

- Diagnostic imaging services had correctly notified the Care Quality Commission (CQC) of an incident of unintended radiological exposure without a referral in 2016, as required by national guidelines, and this had been appropriately investigated by the hospital's radiology manager. Standard operating procedures had been updated in light of this to minimise risks to patient safety.
- Radiology staff recalled an incident where a patient receiving a procedure for which a known side effect was rash development. This was not explained to the patient, who visited their GP as a result. The radiographer telephoned the patient to apologise. This was logged on the incident reporting system and radiographers were reminded of the need to raise awareness of potential side effects ahead of treatment for patients.

Cleanliness, infection control and hygiene

- Control of Substances Hazardous to Health (COSHH) risk assessments for cleaning products used within outpatient areas were out of date, due for review in 2015. This meant that any national updates in relation to dangerous chemicals may not have been added, or equipment that cleaning products were used on may have changed, which could put patients and staff in danger.
- Monthly monitoring of hygiene standards were documented in cleaning schedules within the outpatient department, but we noted that locations were not recorded to aid follow-up actions.
- Risk assessments were not always kept with hazardous cleaning products. At the time of inspection we found that within the locked cleaning cupboard in the outpatient department there was caustic de-greaser, which did not have the risk assessment attached as a hard copy with the other cleaning product risk assessments for staff to refer to, to ensure their safety.
- Hand sanitiser gel was available at the outpatient entrance and exit areas.
- There were robust systems in place for key information flow. Outpatient and diagnostic imaging services both had infection prevention and control link nurses for escalating concerns to relevant committees and for feeding back decisions.
- Water safety was monitored and actions taken where full compliance was not met. A legionella audit was conducted in May 2015, identifying seven remedial actions of which six were medium and one medium to low level, an action plan was implemented to reach full compliance.
- Hospital uniform policy was followed. Clinical staff wore short sleeved uniforms to lower the risk of cross infection. Reception areas and consultation rooms were visibly clean and equipment was labelled to indicate cleaning had taken place, this was in line with best practice to ensure infection control and patient safety were maintained.
- There had been no reported hospital acquired infections reported since 2008 including; clostridium-difficile (C-Diff), Methicillin Sensitive Staphylococcus Aureus (MSSA) or Methicillin-resistant Staphylococcus aureus (MRSA).

Environment and equipment

- Health and safety meeting minutes from March 2016 noted that radiology staff were leaving the mobile x-ray machine that was used in the theatres , in the corridor which was blocking a fire exit..
- The resuscitation trolley kept within the outpatient department was checked on a daily basis, and contained the latest 2015 Resuscitation Council Guidelines for staff to follow.
- Non-availability of equipment was not highlighted or added to the department risk register, an example being; the outpatient department's bladder scanning machine was out of service, and the department were having to borrow from the wards.
- There was a robust system for the monitoring of medical gases. Internal maintenance engineers monitored, and liaised with suppliers via a contract with external providers when replacement cylinders were required.

Medicines

- Medicines were stored appropriately in the minor operations room within the outpatients department. Contrast media for radiological procedures was stored securely within the department and double locked within a cupboard so that only staff with appropriate authority could access this.
- Outpatient's staff used a prescription recording book to monitor used, returned or destroyed prescriptions. There was an on-site pharmacy open Monday to Friday between 9am and 5pm, and 9am to 1pm on Saturdays, closing on Sundays and bank holidays.

- In the event of an emergency, and outside of core pharmacy hours, the nurse in charge and the resident medical officer could gain access to the pharmacy to enable access to required medication to ensure patient safety.
- Patient group directions were not used within the outpatient department, however radiology used these for seven procedures including; computerised tomography contrast, and administration of normal saline. (PGDs) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. In practice this means that delays are minimised as a PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse or radiographer to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription.

Records

- The hospital had implemented a 43 point action plan to achieve single patient records by December 2017. Three actions due for completion within April 2016 had been completed and the remaining actions were on target, one of which involved contacting consultant's secretaries to inform them that referral, clinic, GP letters, and booking forms to be sent to the admissions team.
- Consultants did not take Spire patient records off site, but some took copies of their own consultation notes.
- Each quarter a documentation audit was completed and submitted as part of the spire quarterly scorecard audit. Results for 2015 showed a 95% - 100% compliance in documentation. One area that was non-compliant was the consultant daily record documentation, which was nurse led by verbal instruction from the consultant, for patient discharge the following day.
- Outpatient data supplied by the hospital confirmed that 98% of patients were seen in clinics with hospital notes present for medical and nursing review which meant that staff could easily review patient history and investigations.
- The radiology manager was monitoring the Radiology Information System (RIS) following a number of errors in recording of the allocated radiologist and insurance type of patient. The manager was confident that this was an improving picture although it was still in the early stages.
- From February 2016 all x-rays were to be reported on by radiologists, previously some consultants had stated that reports were not required as they were happy to review and interpret images themselves. This meant that there had been a potential risk that consultants who were not trained specifically in radiology could misinterpret patients' imaging.

Safeguarding

- Training records showed that 27% of Spire Hartswood hospital staff in February 2016 had completed the annual update of adult safeguarding training and 20.6 % for child safeguarding training against a quarterly target of 25%.
- The matron was the designated safeguarding lead, and along with a nurse and the registered nurse (child branch) had all been trained in level 3 child safeguarding.
- If the service's registered children's nurses were unavailable, the hospital had a service level agreement with an agency who could provide children's nurses to support child patients attending clinic for treatment.
- Safeguarding information was available for staff at the nurses station. There were no safeguarding issues reported within Spire Hartswood within 2015.

Mandatory training

- Compliance with the eight core pieces of mandatory training was close to trajectory. The hospital measured staff's mandatory training on a three monthly 25% increment basis, to track compliance throughout the year, with an annual overall target of 95%. At the time of inspection in May 2016 outpatient's, and diagnostic imaging staff were 43% compliant against a target of 50% by the end of June 2016.
- Information governance was provided to staff through the NHS learning system and formed part of the NHS contract to ensure that staff completed information governance training annually. Between April 2015 and March 2016 95% of staff had completed the training, which met the target of 95%. Managers offered some flexibility for staff achieving their mandatory training.

Requires improvement

Outpatients and diagnostic imaging

Training was delivered in both classroom sessions and via electronic learning which could be completed in quiet periods at work or staff could log into the system at home to complete the training and claim time back.

Assessing and responding to patient risk

- Risk assessments were in place for patient protection. The radiology department had a standard operating procedure for checking patients' pregnancy status before conducting radiographic examinations, to ensure that it was safe to expose female patients to radiological procedures.
- Diagnostic imaging had standard operating procedures (SOPs) to ensure that patients were offered consistent treatment based on best practice principles. The radiology department had SOPs and policies covering emergency requests for computerised tomography (CT), and general imaging procedures, and a SOP for care of the critically ill patient.
- The April 2016 outpatient department meeting minutes discussed how there had been no written communication to staff members about the process to follow when requested to make a minor operation procedure booking for a child. It was verbally confirmed that for children's minor operation procedures and blood tests, there must be a registered nurse, children's branch, (RN) on site.
- Nursing staff used a 'handover book' within the department to ensure that key messages were passed between shifts.

Nursing staffing

- There was no agency staff usage however bank staff were regularly used to cover gaps within both diagnostic imaging and outpatient services. The majority of bank staff had been directly employed with the hospital previously so had good knowledge of systems and processes. New members of bank staff were inducted as substantive staff were.
- There were between eight to 18% vacancies across staff groups within; outpatients, and diagnostic imaging. The largest gap was in outpatients who were minus one full time registered nurse and one full time health care assistant.
- There were low levels of sickness within the outpatient department.
- Retention of staff was generally good. In terms of longevity of service, 73% of outpatients nursing staff and 79% of outpatient health care assistant staff had been in post for more than a year.

Medical staffing

- Consultants were available within the outpatient department between 8am and 8pm Mondays to Fridays and on Saturday mornings.
- Radiologist staffing was flexed across specialities so that when their own area was quiet they could offer assistance to another speciality which required additional support.
- Agency resident medical officer's (RMO) did not receive an induction to the outpatient's department. Feedback received in March 2016 indicated that an individual's experience of induction into the hospital had not been thorough enough to equip them for the role. Agencies RMO's worked seven days at a time during the day and were located on site on an on-call basis out of hours within that week.
- There were no consultant members of staff directly employed by the hospital, they provided their specialist services by working under the hospital's 'practising privileges', which were regularly reviewed with the Medical Advisory Committee.

Major incident awareness and training

- The hospital had procedures in place in the event of a major incident occurring on site. Power generators were in place in the case of a power cut, to provide emergency lighting.
- A one-off 'code red' scenario based training was provided for staff which replicated a major incident situation in February 2016. When asked about major incident training, staff spoke about the fire safety electronic mandatory training module they completed, and stated that regular fire alarm and generator tests were conducted.

Are outpatients and diagnostic imaging services effective?

We are not currently rating outpatient and diagnostic imaging services for the effective domain, however we found;

Requires improvement

Outpatients and diagnostic imaging

- Local audits were conducted for service improvements however there was lack of challenge or peer review.
- Consultant's practising privileges were reviewed regularly by the Medical Advisory Committee.
- The infection prevention and control lead attended a local network to share learning and best practice taken from national guidance.
- Clinical policies used national best practice guidance.
- Patient information was available via the hospital's website.
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Evidence-based care and treatment

- Staff had access to corporate policies for incident reporting of adverse incidents and near misses, but these had not been adapted for local use to guide staff to site specific details within their working environment.
- National Institute for Health and Care Excellence (NICE) and Medicine and Healthcare Regulatory Agency (MHRA) guidance were discussed within clinical governance meetings, and relevant guidance was circulated electronically with hard copies made available to consultants for review.
- Regional learning was encouraged and shared. The head of infection prevention and control attended the regional healthcare associated infection network group held by the local clinical commissioning group each quarter. The aim of these meetings was to create a participative learning network that ensured safe and effective services were delivered, in line with national infection prevention and control policies and standards.
- Quarterly monitoring audits took place within the outpatient's department which included recommended areas for improvement, and action plans for; sharps boxes, drug storage, sutures, and uniform policy audits.
- Clinical policies were informed by best practice national guidance. As part of the inspection we reviewed Safeguarding vulnerable adults clinical policy dated January 2016 and the Resuscitation policy clinical policy , dated December 2015 which included references from; The Care Act 2014, and the department of health's 2000 publication of No secrets (multi-agency procedures to protect vulnerable adults from abuse). The Resuscitation policy referenced 2007 joint statements from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.
- An annual quality improvement tool (QIT) audit was conducted which analysed whether wards and departments provided and maintained a clean and appropriate environment for patients. This audit was conducted between April and June 2015. Compliance standards for this audit were set at 90%, diagnostic imaging were compliant for Q2 but not Q3 and Q4 at 88% and 89% respectively. Computerised tomography (CT) and magnetic resonance imaging (MRI) consistently achieved compliance, and the main outpatient's department did not meet the compliance threshold in Q1 at 87% but then met compliance rates for the remaining quarters.
- Following a telecommunications audit the radiology department reconfigured their telephone answering system to ensure that patients received a prompt response.
- Diagnostic imaging had 43 policies and standard operating procedures to ensure consistent and safe provision of care for patients.

Pain relief

- Patients had access to a pod-cast presentation in relation to pain management by one of the hospital's consultants, which could be accessed via the hospital's website.
- There were no pain relief patient group directives used within the outpatient department for prompt administration, however these were used within diagnostic imaging to ensure prompt response to patient need.
- Pain relief was not routinely given in the outpatient department, but there was a pain clinic that patients could attend.

Patient outcomes

- There are no outpatient or diagnostic imaging Healthcare Quality Improvement Partnership (HQIP) national audits on the 2016 audit plan.
- Quarterly audits of care pathways took place within the outpatient's department and included recommended areas for improvement and action plans.
- Evidence of quarterly multi-disciplinary team (MDT) audits showed low compliance with audit criterion. Q1

Requires improvement

Outpatients and diagnostic imaging

demonstrated that 34% of patient cases provided evidence of an MDT discussion happening, this dropped to 5% for Q2 and rose to 10% for Q3, Q4 data was not available at the time of inspection.
- Local audits were undertaken by individual areas own lead staff which meant that there was the lack of challenge or peer review.

Competent staff

- Consultant's fitness to practice was regularly checked within the medical advisory committee, for which they were required to provide documentation as evidence.
- Children's outpatient appointments were supported by the matron in their safeguarding children lead role. There were two registered nurses, children's branch, one of which was nominated as lead and a physiotherapist specialising in paediatric work to provide experienced input to the care of children.
- Medical appraisal was used to support consultants with their education, training and practice to comply with practising privileges requirements reported via the medical advisory committee, in accordance to the provider 'clinical 17' policy.
- Outpatients nursing and health care assistant staff had completed 90% of their 'enabling excellence' annual appraisals during the period January 2015 to December 2015.
- Outpatient nurses stated that there was a specialist trained bariatric nurse available to support patients with their appointments.

Multidisciplinary working (related to this core service)

- Consultants practicing at this hospital were involved in a local 'quarterly complex knee meeting', where local consultants discussed appropriate care or procedures for patients with complex knee issues. The hospital hosted the Essex group discussion on site.
- The physiotherapy team provided cross-cover for in-patient and outpatient departments to aid with patient rehabilitation.

Seven-day services

- Medical cover was provided 24 hours a day seven days a week. Consultants working under practising privileges could be contacted either via their mobile telephone number or via their secretary for the duration of their patient's stay at Hartswood.
- Consultant's covered each other's annual leave, and the outpatient department had access to consultant contact information in case of a medical emergency. The hospital's resident medical officer, senior management team and support services could all be reached via mobile in an emergency.
- Outpatient and diagnostic imaging clinics were available to patients into the early evenings and on Saturdays.
- Consultant radiologists had access to the PACS system, which meant that if urgent reporting was required the imaging team would contact the most appropriate radiologist seven days per week.
- There was an on call service for radiographers.

Access to information

- Radiological x-rays, scans and reports were available via the picture archiving and communication system (PACS) or the radiology information system (RIS), or if consultants were off-site these could be accessed securely via the information exchange portal (IEP).
- NHS referrals were monitored electronically via a tracker tool, to monitor referral and treatment timescales.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Failure to adequately manage patients with mental health problems/dementia was a moderate risk on the risk register listed under clinical governance. One of the three existing controls for this risk was the provision of in-house dementia training, which had been advertised in the April staff newsletter.
- In 2016, mental capacity act 'role specific' electronic learning had been introduced into the mandatory safeguarding adults training.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging services as good because;

- Patients spoke very highly of the treatment and care they received.

Requires improvement

Outpatients and diagnostic imaging

- We observed patients being treated with dignity and respect in the outpatients department.
- March 2016 patient survey results showed that patients felt that the care and treatment they received was excellent for between 97% to 100% from consultants, radiographers and nursing staff.
- Pod-casts were available on the hospital web-site providing consultant discussions about various conditions.

Compassionate care

- The March 2016 patient survey showed that 100% of outpatients felt that the treatment they received was excellent from consultants (55 responses). The figure was 97% for outpatient nursing staff (34 responses). Outpatients felt that the treatment they received from x-ray and imaging staff was excellent in 100% of the 15 responses received.
- We observed physiotherapy staff working with a patient in a respectful and dignified manner within the outpatient department, and reception staff welcoming patients in a warm manner as they checked into the clinics.
- February 2016 patient satisfaction feedback comments were mostly very positive and included; "Everything from the OPD appts, through to the room and food, not forgetting the wonderful staff, have been excellent."
- Staff at Spire Hartswood completed a 'compassion in practice' module as part of their annual mandatory training requirements, to equip them with dealing with potentially upset and distressed patients and family members.

Understanding and involvement of patients and those close to them

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- An outpatient nurse stated that they routinely sat down and spoke to anxious patients before they went in for their consultation or treatment. They advised that they felt it was important to talk directly to the patient and not just their relatives or carers. They told us that they would enable eye level conversation with patients in wheelchairs.
- Parents or carers of children were able to attend imaging appointments, and were protected by standing behind the staff screening barrier to prevent unnecessary radiological exposure, whilst remaining within eye sight of their child. This also meant they could continue to give verbal support and encouragement throughout.

Emotional support

- Patients had access via the hospital website to videos with consultants covering what to expect when they came into hospital for a procedure, examples included; neurosurgery, and breast cancer which could be used to help them prepare for an inpatient procedure following outpatient appointments.
- There was a robust system for offering patients chaperone support. We saw chaperone notices in the outpatient area. This role was usually completed by healthcare assistants, who would attend an appointment for emotional support. We observed a patient requesting a chaperone, a nurse was called into the consultation room. Staff told us that all consultation rooms had linkage to an alert system which paged staff for chaperone assistance.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatient and diagnostic imaging services as good for responsive because;

- Data supplied by the hospital confirmed that referral to treatment (RTT) times were met for 11 of the 12 months of 2015 for outpatient and diagnostic imaging patients.
- There was a comprehensive booking system in place, which included defined exclusion criteria and enabled waiting times to be easily accessible.
- "You said, we did" posters were available in patient waiting areas, demonstrating changes in practice following complaints received.
- Staff had received guidance information for vulnerable patients. Staff had been issued with mini handbooks as reference guides for dealing with mental capacity or deprivation of liberty patient situations.
- In house dementia training was being run by a member of staff who was also a 'dementia friend'.
- Relatives were able to stay with patients at all times, if required.

- Pod-casts presentations were available for patient and public access in relation to a variety of clinical procedures offered, via the hospital website.

However;

- There were no 'late start' or 'late finish' audits completed for clinics within the outpatient department, details of late clinics were documented in a notebook kept on the nurses station, but there was no formal analysis of the content.
- Two of the three patients told us that they had on isolated occasions had to wait over an hour for their appointments.

Service planning and delivery to meet the needs of local people

- Outpatient services were provided between the hours of 08:00am to 08:00pm Monday to Friday and 08:00 – 02:00pm on Saturdays, which allowed patients to attend appointments outside of working hours.
- There were service led agreements (SLA) in place for the hospital to undertake treatment of NHS patients within set specialties agreed between the hospital and the local NHS trust. This showed collaborative working to reduce patient waiting times and improve access to treatment. There were five specialities currently included which were ear, nose and throat (ENT), orthopaedics, ophthalmics, urology and general surgery.

Access and flow

- The hospital received notification of NHS patient referrals via an electronic referral system, the bookings team reviewed this system daily and held a patient booking tracker electronically which showed the numbers of patients referred, booked and waiting. Staff told us that priority listings and arrangements were the responsibility of the consultant, not the hospital. Therefore dates for surgery were reliant on consultant availability and theatre space rather than the hospital actively managing the system proactively.
- For NHS outpatient and diagnostic imaging patients, referral to treatment times were met for 11 of the 12 months between January to December 2015, December fell below the target of 92% at 89%.
- Patient referrals were usually sent through as a booking form from the consultant's secretary, for surgical patients these would then be processed by the theatre administrative team, before being returned to the outpatient's department. The booking team had a number of exclusion criteria and if they had any concerns about a patient, they raised this with the hospital director for authorisation. This ensured that only appropriate referrals were accepted.
- Nursing staff told us that the average waiting time for patients with the outpatient department was ten minutes. If consultants were running late the process was that they contacted the nursing staff, who would inform patients.
- We spoke with three patients about their waiting times for outpatient appointments. One patient advised they only waited about ten minutes for an appointment, but the other two both spoke of waits in excess of an hour. In one of the cases the consultant was running late and this was explained to the patient and when they had requested rebooking their appointment the reception staff had suggested that it was better to wait. The second patient felt that they could have been telephoned at home to notify them of the over-run, the delay was explained and an apology given.
- Patients who did not turn up for outpatient clinic appointments were telephoned by receptionists to ensure they were safe and to reschedule their appointment.
- From February 2015, local audits on start times and finish times had been introduced to monitor any delays or over runs in clinics. At the time of inspection, the hospital had collected 10 weeks worth of data, and was not in a position to draw any conclusion around themes. In addition, times that patients were seen in clinic were reviewed to establish how consultant structure clinic slots and reduce waiting times.
- Radiology staff stated that they had not received any complaints about patient waiting times for consultations.
- Reporting times for radiological imaging was five days, or earlier if clinically indicated by the referring clinician.

Meeting people's individual needs

- Relatives were able to stay with patients at all times, if required.
- Patient leaflets were available in the outpatient reception area covering a range of conditions and treatment options.

Requires improvement

Outpatients and diagnostic imaging

- In-house dementia training was provided for 11 staff who had recently attended a dementia awareness course in the hospital run by a member of staff who was also a dementia friend. This meant that staff experienced in caring for people living with dementia were available.
- Outpatient staff had a mini handbook which they were encouraged to carry on their person to refer to hospital guidance in relation to the mental capacity act and deprivation of liberty safeguards.
- Both outpatient and radiology reception areas had larger chairs available for bariatric patients.
- The outpatient department had two children's specialist nurses (RNs) and use of children's agency nurses via an SLA if required for cover.
- Chaperone services were advertised, actively used by patients, and documented within patient notes.
- Videos were available on the hospital website demonstrating what patients could expect when coming into hospital.

Learning from complaints and concerns

- The hospital director had ultimate responsibility for the management of complaints and was supported by the matron and the senior team. Complaints were logged electronically then sent to the relevant department for local investigation. Complaints were shared in team meetings for learning, and themes and trends were reviewed within senior team meetings, relevant committees and at the medical advisory committee.
- The hospital website had links for patients to access information about how to complain.
- Review of hospital complaints demonstrated that there had been four complaints made between October to December 2015, and six complaints made between January 2016 and 22nd March 2016 for outpatient and diagnostic imaging services. Of the 10 complaints made within the five months October 2015 to March 2016, three had partially been upheld and the hospital had taken steps to reach an agreement with the patients involved.
- "You said, we did" posters were displayed in public areas of the hospital to provide evidence of learning from complaints.
- A cosmetic surgery complaint was logged by the hospital early in 2016, the complaint investigation found that incorrect advice had been given post-surgery, and as a result surgical procedures were changed to minimise the risk of reoccurrence.
- Complaints were shared with hospital teams and consultants for learning.
- As a result of complaint feedback the process used for booking of dressings for minor operations in the outpatient department had been changed to avoid double booking and over-running of clinics.
- Radiology staff have changed the way information is shared within the department, to ensure prompt responses and handover of important information following complaint feedback.
- Within the 2015 clinical governance report a priority for complaint management during 2016 was identified; to ensure that all hospital staff received customer care training. The aim was that by sharing learning from previous complaints, staff would be able to understand the triggers that can cause patients to have poor experiences within services, this had been implemented as part of role specific e-learning.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated outpatient and diagnostic imaging services as requires improvement for well-led because;

- The 2015 staff survey showed a lack of staff confidence in senior leadership, working together, and service quality.
- Of the 18 risks on the risk register for; outpatients, radiology, none had key actions, responsible persons, or due dates assigned.
- We were not assured that risk management was used effectively to support incident and complaint trends, as per the risk assessment policy.
- Outpatient department team meetings were scheduled to be monthly meetings, but at the time of inspection were happening on a six-weekly basis.

However;

Requires improvement

Outpatients and diagnostic imaging

- We saw evidence of an action plan in place for the implementation of an electronic single patient record.
- Positive management of a serious incident involving unintended x-ray exposure demonstrated that managers responded promptly and appropriately to minimise reoccurrence.
- Patient feedback was acted upon to provide service improvements.
- An average of 76% of nursing and care assistant staff employed within the outpatient department had been in post for more than a year.
- The 2015 staff survey results showed that staff had confidence in 'engagement', 'my work', and 'my manager'.

Vision and strategy for this this core service

- The national Spire vision was to be recognised as a world class healthcare business bringing together the best people to develop the best clinical environments and deliver the highest quality care.
- There were a set of core values in place for staff to follow which included; caring being a passion, succeeding together, driving excellence, doing the right thing, delivering on promises and keeping it simple.
- The 2015 Clinical Governance report stated that there were plans to expand the outpatient's department, as well as theatres, due to increases in demand that current provision could not meet.

Governance, risk management and quality measurement for this core service

- Governance systems were not robust or integrated. There were various methods in place, including the electronic incident reporting system and various hard copy handover and communication books, that were used for collating of issues and concerns which meant that combined oversight was difficult.
- Quality and risk management processes were not robust. Some consultants had been interpreting their patient's imaging directly rather than by specialist trained radiologists, until January 2016. This was raised as an issue by the radiology manager within the clinical governance committee and practice had changed as a result, requiring all images to be reported on by trained radiologists.
- New national guidance was discussed and minuted within clinical governance meetings and circulated to relevant clinicians. Formal minuting of relevance for implementation within the hospital did not occur.
- Processes to ensure staff awareness for changes in practice and updates was not robust. For example, the communications book used within the outpatient department still had details from January and February 2016 which had not been signed as being read, by members of staff.
- The risk register was not reflective of current departmental risks and oversight to reduce risk was lacking. Of the 18 risks on the risk register for outpatients, and diagnostic imaging, none had key actions, responsible persons or due dates assigned.
- Integration of governance was inconsistent, with some incident investigations and complaints being followed up with an appropriate risk assessment as per the February 2016 risk assessment policy, but some instances of faulty equipment affecting provision of service, not being risk assessed.
- The hospital had root cause analysis (RCA) local guidelines for staff dated May 2016 as the hospital had identified that previous RCAs had lacked detail and had not always identified all learning opportunities.
- The Medical Advisory Committee (MAC) met quarterly and had a defined membership to ensure the group were quorate. The MAC regularly reviewed consultant's practising privileges prior to approval and renewal to allow them to continue practicing in the hospital.
- The outpatient's team leader stated that the department's aim was to hold monthly team meetings. At the time of inspection these were happening on a six-weekly basis due to staff capacity.

Leadership / culture of service

- There was an open culture to reporting of incidents and staff within outpatients and diagnostic imaging were aware of duty of candour. Complaints were a standard agenda item at the Clinical Governance Committee (CGC), and the Medical Advisory Committee (MAC) meetings. The escalation process via these committees was designed to encourage consultants to become more aware of patient needs and expectations.

Requires improvement

Outpatients and diagnostic imaging

- Reception staff stated that they were proud to work for the Spire group, adding that the hospital was a nice place to work and that they received good support from their manager who was both approachable and understanding.
- Consultants spoke very positively about the hospital's care and safety within the outpatient department, and reported feeling supported by the Hospital Director. .

Public and staff engagement

- The 2015 annual staff survey had a response rate of 63%. The highest scoring elements of the survey were in relation to engagement (86%), my work (86%), and my manager (79%). The three lowest scoring categories were; senior leadership (54%), working together (55%), and service quality (67%).
- A five month patient led assessment of the care environment (PLACE) audit was completed in the outpatients department between February and June 2015. Results were within 8% of England averages for each of the seven domains. The most noticeable low was 'privacy, dignity and well-being' at 79% which was 8% lower than the England average.
- Outpatient staff told us about two instances of patient feedback which had resulted in improvements being made. One was the separation of patient and staff car parking, so that each had allocated spaces, and the other was provision of WiFi which had been made available in most patient areas.

Innovation, improvement and sustainability.

- Demand and capacity were an issue. A business case and planning application was in progress at the time of inspection, to build a new hospital locally to deliver a modern, spacious and well-designed hospital.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Importantly, the provider must:

- Adopt a single patient record system, ensuring that all patient records are up to date, contain relevant information, include medical and nursing notes, patient risk assessments and administration pathway records. The hospital must also make sure records are available and legible.

Action the provider SHOULD take to improve

In addition the provider should:

- Review governance process to ensure a greater level of management oversight. Including the role of the MAC
- Review the process for root cause analysis (RCA) and ensure a robust, consistent approach to analysing incidents and identifying lessons to be learnt. Improve process for sharing lessons and actions following incidents.
- Ensure completion of refurbishment to remove all carpets from areas where clinical interventions may take place such as patient rooms.
- Review the methodology currently in use for monitoring hand hygiene and consider undertaking hand hygiene audits to evidence effectiveness of hand washing.
- Ensure the quality of records is improved and monitor to ensure documentation content is clear, legible and accurate. Improve the recording of review by medical staff within the patient care record.
- Review preoperative fasting arrangements for patients and ensure regular monitoring to evidence improvement.
- Ensure fire escapes are left clear and review storage options for mobile imaging equipment to ensure these are not a hazard.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance** How the regulation was not being met: Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – ‘’Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.’’ We found gaps in some of the patient records we reviewed. Not all patient notes were retained by the hospital, risk assessments had not been completed in some instances and records were not always available in outpatient clinics.