

# St Anthony's 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?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

This was the first comprehensive inspection of Spire St Anthony's Hospital, which was part of CQC's ongoing programme of inspection of independent acute hospitals. We carried out the inspection on 13 and 14 September 2016. Following this, two unannounced visits took place on 20 and 22 September 2016.

Spire St Anthony's hospital is an acute independent hospital that provides outpatient, day care and inpatient services. The hospital is owned and managed by Spire Healthcare Limited. A range of services such as physiotherapy and medical imaging are available on site. The hospital offers surgical procedures as well as rapid access to assessment and investigation. Services are available to people with private or corporate health insurance or to those paying for one off treatment. Fixed prices, agreed in advance are available. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

The inspection reviewed how the hospital provided outpatient services (including to children), medical care, surgical services and critical care, as these were the four core services provided by the hospital.

Just before the planned inspection, the hospital's senior management team took the decision to stop treating and admitting children under the age of 18, including as outpatients and to stop providing critical care at levels 2 and 3. The hospital had a long history and had been run as a charity for 100 years. Spire took it over in late 2014 and had to make significant changes to modernise premises and practices, which included building six new theatres. While acknowledging that many improvements had been made over the previous 20 months since Spire took over the hospital, there was considerable work still to do, so overall we rated the hospital as requires improvement.

We rated outpatients and diagnostic imaging as good and surgery as requires improvement. We were unable to rate medicine as there was not sufficient data provided about medical care and the medical ward itself was closed for refurbishment at the time of the inspection. We also could not rate critical care, as the service was not operating at the time of the inspection.

### Are services safe?

**By safe we mean people are protected from abuse and avoidable harm.**

- The hospital was not reporting all serious incidents promptly to national bodies. A never event had not been reported as such and the hospital's process for investigating serious incidents lacked rigor.
- There was an appropriate system for reporting clinical and non-clinical incidents, but there was limited evidence of staff learning from incidents.
- The hospital had slightly higher rates of falls, venous thrombo-embolism and pressure ulcers than its target.
- Staff were aware of their responsibilities regarding safeguarding vulnerable adults and children and knew who to contact if they had any concerns.
- Mandatory training was up to date in most areas.
- The hospital had three resident medical officers (RMOs), who covered the wards, cardio-thoracic patients and critical care.
- 331 consultants had practising privileges. 10.6% (36) consultants had not carried out any clinical activity in the past year.
- The hospital used paper records for patient care, which were mostly adequately completed.
- Medicines were managed and stored safely.

# Summary of findings

## Are services effective?

**By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.**

- National guidance was mostly followed.
- Improvements were needed to ensure all surgical patients had a full pre-operative assessment and the WHO safety checks were routinely carried out.
- We could not benchmark the hospital nationally for patient outcomes, although we saw some information to compare the hospital with other Spire hospitals across a range of indicators.
- Staff development was taking place in theatre processes and in critical care.
- There was limited internal multidisciplinary working.
- Medical and surgical staff were required to have practising privileges to work at the hospital and these were appropriately checked and maintained by the Medical Advisory Committee as necessary. We saw evidence of consultant contracts being discontinued or being suspended, if they did not meet the practising privileges criteria.
- We found staff mostly had a general awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Patients were happy with the choice of meals and drinks.

## Are services caring

**By caring, we mean that staff involve and treat patients with compassion, dignity and respect.**

- Most patients we spoke with reported a positive experience of their care. They reported staff were kind and maintained their privacy and dignity.
- Patients and their families reported being involved in their care, including being informed about potential costs in most departments.
- Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- 92% of staff (hospital-wide), up to September 2016, had attended compassion in practice training which was mandatory at the hospital. The deadline for remaining staff was the end of December 2016. This was a high completion rate.
- The hospital was rated very positively in patient feedback provided.
- Staff offered support to patients and families who wanted or required it, and there was strong chaplaincy support.

## Are services responsive?

**By responsive we mean that services are organised so they meet people's needs.**

- Patient flow through the hospital was generally smooth, although targets for discharge were not always in place at the time of admission.
- The service was generally responsive to patient needs although there was limited support for those living with dementia.
- The hospital met and exceeded targets for responding to patient needs such as referral to treatment times.
- Complaints were mainly well-managed, but the number of complaints about payment was a concern. Self-paying patients needed to be given clearer information about costs, and the hospital's billing process was not always accurate.

# Summary of findings

## Are services well-led?

**By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.**

- The hospital director had been in post for nearly two years. Some of the senior management team (SMT) had been in post a year or less. However, staff described that the management made a positive impact on the hospital and said the hospital director and other senior managers were visible to staff and patients.
- There were plans for the development of services in most departments, although we did not see a defined vision for medical inpatient services.
- Governance and performance monitoring was in place across most services, although some of this was very new and it was too early to judge its effectiveness.
- The senior management team (SMT) were aware of what needed to improve and were working on this. They were aware of the risks, but a stronger process was needed to ensure risks were accurately rated and actions were in place to mitigate the risks.
- The culture of the services was mostly positive and staff felt engaged in how the hospital was to improve.
- The SMT decided the week before our inspection to suspend paediatric services and critical care services. These decisions had been taken quickly and evidence showed if the hospital had carried on these services, there could have been some safety risks.
- Auditing of the services provided was improving, although information was not provided at sufficiently detailed level in some areas.

We saw outstanding practice including:

- The design of the new theatres and the training programme for staff being developed.

However, there were also areas of where the provider needs to make improvements. The provider must:

- Improve all its governance processes, so that patients receive safe and effective care. For example: ensure there are effective systems to monitor and review all patient deaths and other adverse events, including involving the medical advisory committee; ensure risks are tightly managed with clear mitigation; ensure compliance with practising privileges policies.
- Implement a robust governance structure for paediatric services and ensure that hospital staff and consultants are all appropriately trained prior to re-starting all paediatric care.

The provider should:

- Review and close incidents and complaints promptly to ensure learning to improve the service is identified at the earliest opportunity,
- Assess all risks and record, monitor and review actions to control risks,
- Ensure effective multidisciplinary working take place across all specialities.
- Review the process of pre-operative assessment to ensure all patients requiring one have this sufficiently far ahead of the surgery procedure date for results to be available.
- Continue to control surgery bookings so that procedures do not overrun and that doctors do not add patients late to the list.
- Ensure staff receive feedback about incidents and complaints to help them learn and improve.
- Ensure nurse documentation of patient observations is accurate.
- Staff should review the appropriateness of a cross on the wall in patient rooms.
- Staff should consider a means of capturing informal complaints raised by patients, and improve the timeliness of complaints handling.

# Summary of findings

- The hospital should review its support elderly patients and those living with dementia to ensure staff have an understanding of how to assess and meet the needs of this group of patients.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

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Requires improvement 

# Spire St Anthony's

## Services we looked at

Medical care; Surgery; Critical care; Outpatients and diagnostic imaging.

# Summary of this inspection

## Background to St Anthony's Hospital

Spire Healthcare Limited acquired St Anthony's Hospital in May 2014 from the Roman Catholic charity, Daughters of the Cross, which had run the hospital since 1904. The acquisition was referred to the Competition and Markets Authority for approval, which was granted in September 2014, after which Spire Healthcare arrived on site.

The hospital has 92 beds in ensuite rooms. Some of these beds are used flexibly for inpatients or day cases. There is one medical ward (20 beds) and three surgical wards.

The hospital's facilities include six newly opened theatres (three with laminar flow), a cardiac catheter laboratory for cardiac procedures, and a critical care unit with eight beds with a potential for a further four beds. There are 19 consulting rooms and a minor treatment room. There is also a private GP service and a newly built physiotherapy suite that has a gym and hydrotherapy pool. Diagnostic imaging includes MRI, CT scan, X ray, ultrasound and bone density scanning. There is a sterile services department and a pathology laboratory on site.

The hospital provides a range of services to adults. Paediatric services were suspended at the time of the inspection. Services offered include general surgery, orthopaedics, cosmetic surgery, gynaecology, urology, physiotherapy and diagnostic imaging. Most patients are self-paying or use private medical insurance.

We inspected St Anthony's as part of our planned comprehensive inspection programme. We looked at the four core services provided at the hospital: surgery, critical care, medicine and outpatients and diagnostic imaging.

The registered manager, Mr Melvin Robson, registered on 4 June 2014.

The nominated individual from Spire Healthcare Limited, Mr Jean-Jaques De Gorter, registered on 1 October 2010.

## Our inspection team

Our inspection team was led by: Inspection Lead: Roger James, Inspection Manager, Care Quality Commission.

The team included three CQC inspectors and a variety of specialists: an orthopaedic surgeon, a critical care consultant and a consultant haematologist, three nurses, a radiographer, a pharmacist inspector and an expert by experience.

## 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?

Before our inspection, we reviewed a range of information we held about the hospital and each core service. We carried out an announced inspection between 13 and 14 September 2016 and unannounced inspections on 20 June and 22 June.

As part of the inspection process, we spoke with members of the executive management team and individual staff of all grades. We held a focus group for staff at the hospital. We spoke with members of staff at all levels, including consultants, who were not directly employed by the hospital, and patients and relatives who



# Summary of this inspection

use the hospital services. We visited all clinical areas, observed direct patient care and reviewed patients' records of care and treatment. We also reviewed how medicines were managed.

We received 50 comment cards from patients and relatives during the inspection. The majority were very positive about the service they received. We also reviewed the provider's complaints process.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experience of the quality of care and treatment at St Anthony's Hospital.

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

## Information about St Anthony's Hospital

At the time of the inspection visit, there were 331 doctors working at the hospital under practising privileges. There were three resident medical officers (RMOs).

There were 118 full time equivalent (WTE) registered nurses employed at the hospital at the time of our inspection. Of these, 94 were working on the wards, 13 were working in theatres and 11 in the outpatients department. There are six WTE care assistants working on the wards and 36 Operating Department Practitioners and care assistants working in theatres.

During the period April 2015 to March 2016, the hospital cared for 3079 inpatients and 3325 patients were admitted for day case procedures. Total NHS funded patients were 723. There were 5721 privately funded inpatients and 32544 outpatient attendances. 18% of all patients and 26% of inpatients were over 75 years.

The most common surgical procedures were:

- Diagnostic oesophago-gastro-duodenoscopy
- Diagnostic colonoscopy

- Adult cardiac catheterisation
- Diagnostic endoscopic examination of the bladder
- Medial branch block
- Percutaneous transluminal coronary angioplasty
- Primary total hip replacement
- Total prosthetic replacement
- Primary repair of inguinal hernia
- Multiple arthroscopic operation on knee

The most common medical procedures were:

- General medical/surgical
- Urology
- Cardiology
- Gastroenterology
- Other: gynaecology
- Neurology

There was no accountable officer for controlled drugs at the time of the inspection because the post holder had just left. The accountable officer is now Bryan Harty.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

# Medical care

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

## Information about the service

Spire St Anthony's Hospital has one medical ward, St Mary's Ward with 20 beds. Medical services include assessment, diagnosis and treatment of adults by medical intervention rather than surgery, and some patients were admitted for respite care.

The hospital provides medical inpatient services to patients who are self-paying or are insured. Patients in the year to March 2016 included 262 general medical patients; 71 cardiology patients and 67 gastroenterology patients. Others were admitted for urology and gynaecology, and a few for neurology, rheumatology, haematology and pain management.

Some of the patients are elderly and a few choose to have end of life care in a room at the hospital rather than transfer to a hospice. For palliative care, staff link with a hospice on the same site but under different management.

The medical ward was closed for refurbishment during our inspection. A few medical patients were accommodated on Marie Therese Ward during this period. As the ward was closed, minimal data was provided specifically on medical treatment at the hospital, and inpatient numbers were very low, we have not rated this service.

We spoke with six patients and relatives, six nurses, three senior nurses, one healthcare assistant. We also spoke with other staff such as hospitality and cleaning staff, as well as a member of the hospital's league of friends. We reviewed patient and medication records and observed care delivered on the ward where medical patients were staying.

## Summary of findings

We inspected medicine but did not rate it because the medical ward was closed during our inspection, there were very few medical patients and minimal data about medical wards was provided. The observations we have made of medicine are necessarily generic based on observation made relating to the few medical patients in another ward during our inspection

- Patients were treated with compassion, dignity and respect.
- Staff were focused on providing patients with a good experience during their stay in the hospital.
- The medicines storage and management arrangements were in line with national guidance.
- Equipment was easily available and was suitably maintained and checked by an appropriate person.
- The hospital was able to provide appropriate isolation facilities to reduce the prevalence of healthcare associated infections.
- Staff assessed and responded to patient's risk.

However:

- There were no mortality review meetings of medical patients.
- There was no formalised multidisciplinary team working.
- Most data was collected and reported hospital-wide rather than specifically on medicine.

# Medical care

## Are medical care services safe?

Not sufficient evidence to rate

- All staff directly employed by the hospital had access to the electronic incident reporting system and knew how to use it.
- Most staff had completed the required mandatory training.
- All wards, toilet facilities and waiting areas were clean and isolation facilities were available if required.
- There was appropriate equipment available to respond to emergencies.

However,

- There were no mortality review meetings.
- Not all resident medical officers (RMOs), nurses and healthcare assistants were aware of learning from incidents.
- Incidents were not closed promptly.
- Patient records were not always accurately completed.

## Incidents

- Nursing staff were able to explain how to report incidents using the electronic reporting system, but did not receive feedback and learn from incidents. Nurses and healthcare assistants were unable to tell us about examples of shared learning from incidents including learning across the hospital.
- The hospital had reported six serious incidents (hospital wide) in the past year. 6% of clinical incidents were reported as severe including death.
- There had been 25 clinical incidents in general medicine, eight in medical (other) and seven in geriatric medicine.
- Incidents were not closed promptly. Only 34% of incidents were closed (hospital wide) within the hospital target of 45 calendar days. The target was to close 75% of incidents within this time period which was far from being achieved. This was poor.
- It was difficult to analyse medical incidents because of the way they were reported. Of the deaths reported from January to September 2015, four were of medical patients, one with cancer, one with chronic respiratory illness, one with septic shock and another with a history of falls. We did not receive comparable analysis for 2016. There had been 12 deaths since January 2016, all but

one were reported to CQC as expected deaths, with most patients admitted to the medical ward with serious co-morbidities. This meant that the data appeared to be more similar to a nursing home than an acute Independent hospital.

- Root cause analyses (RCA) were carried out for serious incidents including unexpected deaths. We had concerns about the quality of RCA investigations. Not all deaths or all serious incidents were presented to medical advisory committee (MAC) meetings.
- Staff understood the principles of the duty of candour, though not necessarily the term. We saw evidence that the duty of candour had been applied.

## Safety thermometer or equivalent

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit for patient and their families to see the prevalence of avoidable harms. In the NHS, it covers new hospital acquired pressure ulcers, patient falls with harm, new venous thromboembolism (VTE), also known as blood clots, and urinary tract infections (UTIs) associated with the use of catheters. Spire collated equivalent data via a national clinical scorecard. This was displayed in all departments and in staff only areas of the hospital which ensured that ward staff had ownership of the data they collected.
- The hospital did not meet its clinical outcomes targets for falls, pressure ulcers or venous thrombo-embolism, between January and the end of August 2016.
  - Pressure ulcer (PU) prevalence was 0.6 per 1000, higher than the goal of fewer than 0.1 per 1000. This was one patient.
  - The number of patients having falls was 2.53 per 1000 against a target of less than 2. We were not provided with numerical data but this is estimated to be four patients.
  - VTE risk assessment 75% had been poor (75%), below the hospital target of 95%, between April and June 2016. By September 2016, the rolling scorecard showed this had risen to 100%.
- There were six incidents of hospital acquired VTE or PU in the year April 2015 to March 2016.
- Staff developed action plans to address concerns about falls or pressure ulcers where rates were above the national Spire target. These were submitted to central teams for review and scrutiny.

# Medical care

## Cleanliness, infection control and hygiene

- There were three reported incidences of *Clostridium difficile* (C. diff), hospital-wide, in the past year.
- We saw that staff adhered to the 'bare below the elbow' policy.
- Hand sanitisers were available at the entrance to and throughout the wards. Staff were seen using these at appropriate times. A hand hygiene sanitiser audit was conducted quarterly and the results in the last clinical scorecard were 27, above the Spire target of 18.
- There was a hand wash basin at the entrance to wards, with wrist operated taps.
- Personal protective equipment such as gloves and aprons were readily available to reduce the risk of cross infection.
- The ward areas were visibly clean and tidy. Domestic staff, who were employed by the hospital, confirmed the ward was cleaned daily and we saw evidence of cleaning.
- Sharps bins were available for the safe disposal of sharps. Most sharps bins we checked were labelled and dated and none were overfilled which reduced the risk of sharps injuries and infection.
- There were no incidents of urinary tract infection in patients with catheters.
- We reviewed an endoscopy cleaning audit showing cleaning in line with guidelines. Staff sampled the water weekly. The unit was working towards accreditation by the Joint Advisory Group (JAG) on gastrointestinal endoscopy.

## Environment and equipment

- Fire alarms were tested quarterly and extinguishers were checked monthly by engineers and yearly by contractors.
- Contracted engineers maintained equipment. Full electrical safety checks were undertaken yearly. All equipment seen was within date for service checks.
- There were resuscitation trolleys on the ward. These were checked daily and documented in a logbook; entries confirmed daily checks took place. This ensured the equipment was safe and ready to use when required.
- Several patients told us their rooms were too hot. Our inspection was on two unusually warm days in September 2016.

- The guidelines for Control of Substances Hazardous to Health (COSHH) were on display in the kitchens on wards. A COSHH database had been set up in the summer. There were no COSHH audits available.
- Clinical waste was securely stored in locked bins outside the hospital, for collection by a contractor.

## Medicines

- We found that medicines were stored securely and appropriately. Keys to medicines cupboards were held in safes within restricted access treatment rooms.
- Controlled Drugs (CDs) were securely stored in accordance with legal requirements. A separate key was held in a safe in the treatment room.
- Nurses checked the balances medicines daily and completed the CD registers correctly. We saw staff had double-signed entries to provide evidence of an authorised witness to checks.
- Nurses did not use medicine trolleys on the wards. Each patient's hospital-prescribed medication, and their own drugs, were kept in locked wall cabinets in their hospital rooms. Nurses had the keys to these.
- A protocol for assessing patients' suitability for self-administration of medicines was in use throughout Spire Hospitals.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were within the recommended range of 2 - 8°C.
- Pharmacy had effective arrangements for reconciling medicines they had ordered. However, we were told resident medical officers undertook some reconciliation and we found two charts where reconciliation had not been done.
- Staff told us they had no problems obtaining medicines from the pharmacy when needed. Pharmacy topped up ward stock twice a week. Other medicines were ordered on an individual basis for patients. This meant that patients had access to medicines when they needed them.
- Pharmacists had access to the British National Formulary, as well as all policies and information relating to medicines management (including the antimicrobial formulary).
- Nurses recorded the allergy status of each patient. Patients wore a red wristband to indicate allergy. Not all the drug charts we looked at were signed for by those administering the drug, which meant we could not be certain the medicine had been given to the patient.

# Medical care

- We reviewed six patient medication charts in wards across the hospital and found several errors: two charts gave no reason for prescribing antibiotics; on another, staff had used the abbreviation 'u' in relation to a prescription for Fragmin (an anticoagulant that helps prevent the formation of blood clots). The hospital policy explicitly stated this abbreviation should not be used because of the risk of error in interpretation. Another chart showed no dosage unit for a medicine and on another, the time an antibiotic was given was not recorded.
- Medicines were available in an emergency drugs cupboard outside the pharmacy (on the ground floor). They were appropriately stored, access was restricted to authorised personnel and we found that there was a system in place to monitor their use.

## Records

- Patient records were mainly on paper, kept in ring binders. The paper notes were available to doctors, nurses and other healthcare professionals. Records were confidentially stored and not left open or on display to keep patient data confidential. Information governance was part of the mandatory training programme staff were required to complete. Completion at the time of inspection was 64%. The remaining staff had until the year end to complete this annual module and completion of this training was linked to staff appraisal and eligibility for any performance related bonus
- We reviewed six patient records and found they were completed in a logical way. The clinical notes showed care plans, observations and patient progress. Routine nursing assessments were included such as vital signs observations, falls assessments, assessment for pressure areas (Waterlow score), venous thromboembolism (VTE) assessment and nutritional status (Malnutrition Universal Screening Tool - MUST). Some early warning scores were incorrectly completed, for example figures were not entered into the correct boxes which meant that scores might not be totalled correctly and a patient's deterioration might not be spotted.
- We noted that few patients had Do Not Attempt Resuscitation (DNAR) orders, and saw that the risk

register mentioned the absence of DNAR discussions with patients and families as a risk in relation to end of life care. Three patients had died without DNAR orders in place in the 2016 until the time of our inspection.

- The hospital retained patient records for 11 years after conclusion of treatment, in line with Department of Health Guidance.

## Safeguarding

- Spire Healthcare Limited had a national safeguarding policy. The hospital had a safeguarding lead for adults in vulnerable circumstances and one for children, as well as a link nurse. The safeguarding leads had established contact with the Head of Safeguarding and Designated Nurse for the local Clinical Commissioning Group.
- As a prompt for staff, the names and photographs of the hospital safeguarding leads were on the wall in ward offices, with details of how to report concerns. These details were not incorporated in the policy on the intranet, which was a generic policy for Spire hospitals as a whole.
- The policy and protocol for safeguarding referrals was available for staff to access on the intranet. The hospital Deprivation of Liberty Safeguards policy and process was also available.
- The staff we questioned were able to explain the principles of safeguarding for children and adults. They were able to identify potential signs of abuse, including verbal and emotional abuse, and the process for raising concerns and making a referral. A nurse gave us a good example of concern raised over a 'controlling' relative and action taken.

## Mandatory training

- Uptake of mandatory training had been low in the first part of the year. Between April and June 2016, 34% had received training against a target for that period of 50%. The hospital target for staff completion of mandatory and statutory training for the full year was 95%. 90% of staff (hospital-wide) had completed mandatory updates at the time of the inspection. This had been achieved by ensuring staff carried out their training during the hospital's temporary closure for a week in August 2016. Most training was delivered online through the Spire electronic system, which staff could access in the hospital or at home.



## Medical care

- The hospital target for staff completion of mandatory and statutory training for the full year was 95%. At the time of our inspection, compliance with mandatory training for staff in theatres was 97% which was good.
- The mandatory and statutory training programme covered equality and diversity, health and safety awareness, infection control, compassion in practice, adult and child safeguarding (levels 1 and 2), fire safety and manual handling. Managing violence and aggression was optional but recommended. There were additional role specific modules on topics such as the mental capacity act and deprivation of liberty safeguards, safe transfusion, incident reporting and controlled drugs.
- Nurses had a small booklet, known as a z card, 'Your clinical statutory and mandatory training', which included reminders of key aspects of mandatory training, including safeguarding and deprivation of liberty safeguards.

### Assessing and responding to patient risk

- Risk assessments were completed at the time of admission, which prompted staff to order specialist equipment, such as pressure relief mattresses. Nurses told us the external contractor delivered equipment promptly if it was not available in the hospital.
- Nurses used pressure area risk assessment charts in line with national guidance. We noted pressure ulcers were reported in the electronic incident reporting system used at the hospital.
- The hospital had its own designated tissue viability nurse to provide staff with advice related to pressure sore care. Nurses were guided by the wound classification charts to accurately assess wounds but did not know if there was an external contact from whom they could seek advice if they had concerns about pressure wound care
- Nurses assessed patients at risk of falls, however we noted from a serious incident that this assessment was not always done on admission. A "call don't fall" poster had recently been put in patient rooms to encourage patients to use the buzzers and call for assistance whenever required. A quarterly falls report was prepared for the hospital as a whole but there was not yet evidence to show this had reduced falls.
- The hospital had reported three incidents of VTE (venous thromboembolism) in the last 12 months. We

observed nurses carried out VTE assessments in line with national guidance, and compliance with this guidance was monitored, although earlier in 2016, April to June 2016, the compliance had only been 75%

- Patients mostly had easy access to call bells and we observed staff responded to their calls promptly. Senior nurses were able to request additional staff to support patients who required an increased level of support or one to one assistance as necessary. Emergency call bells were available in each patient bedroom and bathroom.
- Most staff had received training in basic life support (93%). There was standard emergency equipment available to support patients in emergency, which included defibrillators.
- Staff used the national early warning score (NEWS) system to alert relevant staff to patients who may be deteriorating. Nurses told us they received training in how to use the system and felt confident using it, however, the on-call team told us that occasionally wards contacted them later than was desirable when a patient was becoming more unwell. The hospital audited compliance with the policy on use of NEWS monthly and had reported a score for compliance with NEWS records was 90% compared with a target of 95%. However, of the eight NEWS charts we reviewed, three were not completed in line with hospital guidance nor followed the escalation plans on the back of the NEWS assessment. The hospital Patients identified as at risk of dehydration had fluid balance charts to monitor fluid intake and output. However, on three out of four patient charts (on different wards), we saw nurses had not totalled the 24 hour fluid balances which made it difficult to identify trends. This was contrary to policy which said a 24 hour fluid balance should be totalled on each shift. This was only audited annually.
- Night time concerns about patients were escalated to the bleep holder in the critical care unit who could summon the RMO. There were always two RMOs on duty. We were told that end of life medical patients were only transferred to critical care if they would benefit from Continuous Positive Airway Pressure (CPAP) therapy.

### Nursing staffing

- Regular bank staff, and sometimes agency nurses covered shift gaps. There were some student nurses.

# Medical care

Bank and agency use was 4% for inpatient nurses and 13% for inpatient healthcare assistants. The use of bank and agency nurses was low by comparison with other hospitals for which we hold data.

- There were some long, established nurses on the wards. Nurses were graded as staff nurses, sisters and senior sisters.
- Very little use was made of healthcare assistants on wards. The ratio of nurse to healthcare assistants, hospital-wide was 15.7 to 1.
- Some staff and patients told us there were fewer nurses than under the former hospital management. However, we did not observe high workloads and nurses we spoke with said they had time to care for patients and complete paperwork.
- We observed nurse handover at the end of the day shift on the ward. Each day nurse in turn handed over key details of the patients they had cared for that day to the incoming team. The nurse in charge, who was not supernumerary, then allocated patients between the night staff. Handover was well-managed and each nurse gave a holistic view of each patient so the nurses taking over care were well-informed. Nurses had a printed handover sheet of patients on the ward.
- Staff worked different shift patterns, some short days and some long days (12 hours). Managers told us that staffing levels were determined by the dependency of patients in the hospital at any given time and standard ratios of 1:5 nurse to patient ratio during the day and 1:7 at night were adopted.
- We were told that the number of staff on each shift was determined by the expected number and dependency of patients. Ward sisters completed a daily report to help senior staff assess skill mix in relation to patient acuity.
- Newly appointed staff completed a corporate induction, which was run several times a year, as well as ward induction.
- There was a preceptorship programme for newly qualified nurses, which was an 18 month rotational programme. There was a list of local mentors and 'Sign Off Mentors'. We saw a good example of a student nurse with a disability, supported with an interpreter through practice.

## Medical staffing

- Patients' treatment plans were made by their consultant.

- There were doctors available on site at all times, known as resident medical officers (RMO). One RMO covered the wards and another RMO covered cardio-thoracic patients. Both were directly employed by the hospital. The critical care RMO was contracted from an agency.
- The ward RMOs were responsible for reviewing patients daily and for communicating with the patients' consultant if there was a concern.
- For the hospital-employed RMOs, Spire arranged training. There was no consultant mentoring for RMOs, which would be good practice.
- RMOs worked 24 hours on call, and worked one weekend in four. No shifts were unfilled on the RMO rota in October 2016.
- An informal medical handover between RMOs took place each day about 9am. This was a verbal handover about the patients' conditions and followed the assessment areas of the clerking process.
- Managers did not audit the number of times the RMO was woken during the night to attend patients. We were told that if they had been awake for long periods during the night, the hospital could arrange locum cover through an agency, but there was no further information about when this had happened. The risk register in July 2016 identified a risk that when one of the two RMOs was away, the other RMO could work 24/7 for a month which would have been potentially unsafe. However, at the time of the inspection, the RMO numbers had been increased to 4 and the risk register had been updated to reflect this. The rotas provided to CQC before inspection did not show any RMO working without breaks so corroborated that on site medical cover was safe..
- Lead consultant physicians were on call for their own patients remained responsible for the care of their own patients during their inpatient stay. The admitting consultant was required, as part of their practising privileges, to visit patients daily or more frequently at the request of the nurse-in-charge of the patient or the RMO. RMOs confirmed that most consultants came to visit their patient if there was a concern.
- The Spire Consultant handbook required all consultants (including surgeons, anaesthetists and physicians) to document their cover arrangements in the patient notes. We saw that consultant absence was shown on the whiteboards in the nurses' offices. We did not see this in patient notes.
- There were formal, written arrangements to provide adequate cover to patients when the lead consultant



## Medical care

was not available. Doctors were required to name another consultant who would oversee the patient during their absence. Occasionally patients stayed on the ward when they were nearing the end of life. Nursing staff knew how to contact the palliative consultant based at a hospice on the same site if support was needed on managing chronic pain. The consultant at the hospice also had practising privileges at the hospital.

### Major incident awareness and training

- The hospital had procedures in the event of an incident on site.
- There was major incident plan and policy which covered potential incidents causing loss of services, with contingency plans for various scenarios. There were departmental action cards explaining what to do, for scenarios such as fire or electricity failure. Managers said they had carried out a table top exercise for major incident response. There were varying levels of awareness of this among ward nurses.
- Staff had practiced evacuation and the use of equipment in the previous month. 97% of staff had completed fire safety training.

### Are medical care services effective?

Not sufficient evidence to rate

- Staff used care pathways, informed by appropriate national guidance for the management of common medical conditions.
- Staff gave patients information about pain and offered pain relief when needed.
- Staff assessed patients' nutritional needs and monitored them.

However

- The hospital did not collect sufficient patient outcome data on medical patients for us to assess effectiveness of treatment.
- There were few medical patients in the hospital during our inspection and the medical ward was closed.

### Evidence-based care and treatment

- Policies and guidelines we looked at were current and based on evidence-based practice from the National Institute for Health and Care Excellence (NICE). Spire policies were produced centrally and cascaded to hospitals to share with their staff.
- Spire issued a monthly 'Safety update' to its hospitals with policy updates, patient safety alerts, medical device alerts and regulatory updates. This was issued to all Heads of Department to disseminate to their staff and put in each departments communication file.
- Spire had carried out a mock inspection soon after the group took over the hospital and used shortfalls to focus improvements. Two further mock inspections had been carried out the most recent of which led to suspension of critical care as it did not meet all current standards.
- Spire's clinical scorecard required the hospital to complete a number of audits quarterly with standards linked to national benchmarks, where available, and national guidelines. This allowed the hospital to compare its performance with other Spire hospitals.
- There was no facility for analysing long term trends at the hospital, because formal audits had been minimal under the previous hospital ownership.

### Pain relief

- Nurses told us, and patients agreed that there were effective processes to ensure patients' pain relief needs were met. 84 % of patients (hospital wide) felt the hospital did all they could to control the pain, and 14 % said staff controlled their pain a 'fair' amount.
- We witnessed nurses asking patients whether their pain was being effectively managed and if they were comfortable. Pain scores were recorded in patients' notes that we looked at, with evidence of follow-up to see if pain had been controlled. However, the hospital did not have a clinical nurse specialist for pain management or a consultant for pain management.
- If a patient's pain score was high, ward staff could escalate the problem to the critical care team. Normally, patients' pain on the wards was managed through discussion with pharmacy staff.

### Nutrition and hydration

- Staff used the malnutrition universal screening tool (MUST) as recommended by the NICE standard for nutritional support of adults. This tool was developed by the malnutrition advisory group of an organisation that raises awareness of malnutrition. Its use was

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supported by the British Dietetic Association (BDA), the Royal College of Nursing (RCN) and the Registered Nursing Home Association (RNHA). However, we found not all fluid balance charts were totalled to allow staff to assess fluid balance and hydration status. We were told that a dietitian oversaw hospital menus. There was no dietitian on site, but staff told us they consultants could refer a patient to a dietitian if relevant. We saw evidence that some patients used supplements and thickeners indicating input from a dietitian.

- Patients were not disturbed when eating their meals and staff would assist patients with their meals as necessary.

## Patient outcomes

- There was limited evidence to demonstrate the hospital management was monitoring or benchmarking outcomes for medical patients.
- St Anthony's Hospital was preparing to submit required data, through Spire's head office to The Private Healthcare Information Network (PHIN) by 1st September 2016, as required by the Competition and Markets Authority Market Investigation Order 2014. PHIN is required to publish private hospital data as 11 performance measures, including key safety and quality indicators such as mortality rates, readmission rates, unplanned patient transfers and patient feedback. The aim is to provide helpful and accessible information on the quality of care provided by private hospitals and consultants; and where possible, making this directly comparable to NHS data.
- Although the hospital director told us Spire was on track to meet PHIN obligations and that the hospital said their own data was complete for patients with adverse events, this data was not shared with CQC.
- Nurses completed the Visual Infusion Phlebitis (VIP) score, in line with good practice, and documented the time of cannula insertion.

## Competent staff

- Staff joining the hospital received both corporate and local inductions. Agency staff were given a local induction to the clinical area covering the ward layout, procedures in the event of an emergency and the location of emergency equipment, for example the resuscitation trolley.
- The director told us the hospital's matron assessed all resident medical officer qualifications and suitability before they were taken on.

- The medical advisory committee (MAC), which included representation of many specialists working at the hospital, advised the hospital director about applications for practising privileges. The hospital reviewed the practising privileges of each practitioner every two years to ensure doctors were competent. Individual data on activity and performance was reviewed to enable the hospital director to make an informed decision on whether or not to renew practising privileges. The review included information on medical practice, relationships with patients and colleagues and any training completed recently, as well as any outliers in the doctor's practice as regards mortality, readmission rates or sepsis.
- Physicians in the hospital participated in the GMC revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice. The hospital provided data that showed 100% revalidation rates for all clinical staff working under practising privileges in inpatient areas.
- We saw evidence of suspension of consultants practising privileges where consultants failed to produce evidence on competence. Ten consultants had their practising privileges removed between April 2015 and March 2016. Three retired and others moved out of the area. All cardiologists who worked at the hospital were members of the British Cardiac Interventional Society. However, although practising privileges implied compliance with hospital policies and guidelines we were aware from talking with staff and from records that this was not always the case.
- Staff appraisals were known at Spire hospitals as 'enabling excellence'. Their focus was on enabling staff to contribute to improving hospital performance, involvements in projects and innovation and development of services. The appraisal system at St Anthony's had only been introduced in 2016, so no staff had yet completed the full process. We could not therefore evaluate the success of the process. Over 80% of ward staff had had an initial appraisal meeting to set objectives.
- The hospital supported continued professional development of its staff, including supporting staff to obtain formal qualifications as well as through practical training.

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## Multidisciplinary working

- Multi-disciplinary working in medical care was limited. There was no evidence of routine multidisciplinary working involving therapists on the medical ward. Some nurses thought it would be beneficial for medical patients to have physiotherapy in bed but had not followed this up with consultants.
- The hospital did not employ dietitians or occupational therapists, but had links with these professionals whose advice would be sought if consultants considered it necessary.
- For patients near the end of life we were told that staff could seek advice from hospice staff, although this arrangement was not formalised in a service level agreement.
- Staff told us they liaised with community health services about the discharge of some patients who needed input from district nurses or the local palliative care team.
- Letters to GPs were an accepted part of the discharge process.

## Seven-day services

- Pharmacy opening times for the on-site dispensary were between 9am and 8pm Monday to Friday, 9am to 1pm on Saturdays and 10 am to 12pm on Sundays. Outside these hours a pharmacist was on call to provide pharmaceutical advice and support to staff.
- There were usually two RMOs available 24 hours a day. There was always a critical care RMO, and the cardiothoracic RMO alternated with the medical RMO at weekends and at night. The RMOs had access to consultants who were on call for their patients, or to a nominated consultant in their absence. The RMOs said they contacted the consultants out of hours as required.
- There was an engineer available Monday to Saturday during working hours. An out of hours on call system operated outside of these hours for emergencies.
- Access to diagnostics was normally available between 7am and 5pm but there was access on call if CT, X-ray or MRI was required urgently out of hours.
- A consultant microbiologist was available 24 hours a day.

## Access to information

- The Spire national policies were available electronically, but there were also paper copies on all wards. Some local policies were available in paper form on wards. Earlier in the year there had been no systematic process for ensuring that local policies were up to date, or

ensuring that changes in national policies were followed and the risk had been recognised on the risk register. By the time of inspection, a process had been implemented and policies were being managed in line with Spire policy HOP 01 - Procedures for the management of policies.

- All nursing and medical documentation, including risk assessments, care plans and theatre documentation, were in paper form.
- Digital images and test results were stored electronically and relevant surgical staff, consultants and RMOs had individual logins to view these. Computer stations with intranet and internet access were available on the wards for staff to use.
- Wards had a communications book which contained clinical updates. Staff had to sign to indicate they had read the new information.
- Spire produced 'hospital briefs' for staff on topics such as dementia, safeguarding and the 'Malnutrition Universal Screening Tool' ('MUST').
- Agency nurses and locums had access to the same ward training documentation, updates and information as permanent members of staff.
- All staff had technology within their email accounts to allow secure transfer of information by email within and outside the hospital.
- A consultants' newsletter, reported on activity and incidents, and hospital-based staff were also updated with a newsletter.

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

- Staff gained patients consent before undertaking interventions. Staff had received training on the Mental Capacity Act (MCA), and at the time of our inspection staff told us there was no patient in the hospital who lacked capacity to consent. However, not all ward staff had good understanding of capacity.
- Senior staff were aware of the role of the independent mental capacity advocate (IMCA) who are a legal safeguard for people who lack the capacity to make specific decisions: including making decisions about serious medical treatment, and power of attorney. Staff were familiar with best interests' decisions, and knew that a patient might make an unwise decision but that did not mean they lacked capacity.
- Staff told us they had limited exposure in practice to caring for patients that required their liberty to be

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deprived in their best interest. From discussion with staff, we considered they did not all understand the principles of deprivation of liberty safeguards (DOLs). Staff said they would talk to their manager if they thought a patient needed bed rails, for example.

- The hospital had low beds for people at risk of falling out of bed.

## Are medical care services caring?

Not sufficient evidence to rate

- Patients reported that nurses and doctors were friendly and they treated them with respect and compassion.
- Patients felt involved in decisions about their care and treatment. We observed that staff were caring and they spoke to patients in a dignified way.
- Staff were seen to be compassionate (hospital-wide) and patients were satisfied with the support and care provided to them and their relatives.
- Patient survey feedback was positive, although response rates were low. Patients were fully involved in all aspects of their care as were their relatives, if the patient agreed.

## Compassionate care

- All patients were complimentary about the care they received. One patient could not think of anything negative to say and said that staff got to know their likes and dislikes and arranged things as they liked them in their room. One patient said 'no one in this hospital treats me as an old person- 'just as me', and described the hospital's 'lovely ethos'.
- We observed cleaning and housekeeping staff engaging patients in conversation and checking whether they would like their door open or closed.
- Patients we spoke with made positive comments about the treatment provided at the hospital. We observed staff being friendly and compassionate in their approach. One patient told us "the nurses are good because they have time." A patient's relatives also told us "everything has been very good."
- We noted the hospital's satisfaction survey given to all patients on discharge reported 99% of patients asked in June 2016 were likely to recommend the hospital, although in June the response rate was only 12% which was low by comparison with other hospitals.

- 83% of nurses (hospital-wide), up to September 2016, had attended compassion in action training which was mandatory at the hospital. This was a high completion rate.

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

- Patients said consultants took time to explain care to patients and families as appropriate. Patients had named consultants looking after them.
- Patients told us, if they were insured, the hospital made clear what was and was not covered by their insurance. Arrangements were made to refer patients back to their GP if they wanted care they were not insured for such as outpatient follow up appointments within the NHS.
- Patients felt involved in their treatment and told us staff explained each stage and optional treatments available to them. One patient told us "the consultant comes in most days and keeps me well informed."

## Emotional support

- Staff spent time with patients and their families if they were upset. We saw staff display empathy and support towards patients and their relatives.
- Patients at their end of life could be supported by a palliative care team in the hospice on site (but not part of the hospital), although there was not a formal service level agreement for provision of this specialist service.
- Nurses understood the principles of end of life care and respected patient's decision related to preferred place of care at their end of life.
- Nuns in the convent on site could offer mass to patients who would like this. The hospital was able to facilitate links with religious leaders in the local community, such as Imams as required.
- Clinical and non-clinical staff spent time with patients to discuss concerns and provide support and reassurance.

## Are medical care services responsive?

Not sufficient evidence to rate

- There was cooperation with other consultants as necessary to ensure patients received appropriate care and treatment.
- Patients' family could visit at any time during the day.
- Patients had a choice of food.
- The hospital actively sought patient's views.

# Medical care

- Interpretation services were available as needed and arranged, via an external service level agreement, either face to face or via telephone based on patient preference.

## Service planning and delivery to meet the needs of local people

- Patients had access to the consultant of their choice.
- Patients told us the appointments system was easy to use and patients made appointments at times to suit them including evening and weekends.
- Chaperones were available.
- Visiting hours were open, allowing friends and relatives to visit patients when they wanted. Nurses said they generally asked people to leave by 11pm, so they knew exactly who was on the ward at night for safety reasons.
- There was free parking in a large car park.
- Privacy and dignity was maintained on wards by having single rooms with individual bathrooms and a 'presence green button' that alerted staff to people being in their room.
- We found there were no activities for people to be occupied and stimulated on the wards.
- Some patients who knew the hospital under its previous charity ownership said it was positive to be part of a larger structure and that the investment in the hospital was welcomed.

## Access and flow

- Although the medical ward was closed at the time of the inspection, staff told us there were no waiting times for admission as a medical patient. A patient could usually be admitted on the day.
- The admission policy specified that all patients would be admitted by a consultant who had practising privileges granted by the Medical Advisory Committee (MAC).
- Doctors and nurses told us they had access to diagnostics and test results promptly to inform patient's treatment plans.
- We were told that medical patients were not moved between wards during their stay unless there was a medical reason, such as their condition deteriorating and they required intensive care. However, because the medical ward was closed for refurbishment at the time of the inspection, some patients had been moved out of necessity.
- The service did not collect data on the unplanned readmission rate to medical wards.

- Staff informed GPs when patients were discharged and could arrange for support from community health and social services if required.
- Patients were greeted on arrival in the ward and reception staff and nurses explained the call bell (including asking the patient to test it) and other features of the patient's room.
- Three patients mentioned to us that it was hard to control the ambient temperature in rooms and that bathrooms could be too hot. External temperatures were high during our inspection. Not all rooms were air-conditioned. Windows could be opened to let in some air but not wide enough for someone to fall out of them.
- All patient rooms had free Wi-Fi and television.
- All patient rooms had a cross on the wall, from the Roman Catholic origins of the hospital. However, staff showed us they could take these off the wall if patients did not want them. Not all patients might know that they could ask for this.
- The call buttons had different buttons for nurses, lights and catering services, as well as a torch on the back. Patients found these convenient to use.
- Patients had a daily menu to choose meals from and onsite catering staff prepared fresh meals. Patients had access to food such as sandwiches and soup between meal times as required. Water was available to all patients throughout the day. A Patient-led assessment of the care environment (PLACE) survey had been completed for the first time in June 2016 and the only issues noted were that unsaturated spreads were not offered and fresh fruit was not available at all times. Patients responding to the hospital's June 2016 satisfaction survey rated the quality of the food at 82%, below the Spire average of 88%.
- Food and hot drinks were also available to patients at night time on request.
- Patients were able to order meals not on the menu, including for special diets such as halal or gluten free.
- Patients who had been inpatients under the hospital's previous ownership, said the quality of the food was not as good now. Three patients mentioned orders were not always fulfilled accurately. However, most patients we spoke with commented positively about the food. The latest PLACE audit also indicated that the quality of food was much better than the national average (94.1% compared to 88.3%) and patient satisfaction results



## Medical care

show improvement over time with satisfaction with food and its service. The previous owners did not seek formal patient feedback and therefore Spire has nothing to compare results against.

- A modern, well-lit chapel on site, offered a quiet space for any patient regardless of faith, although it was predominantly Christian in appearance.
- Staff had access to interpreting services for patients who did not speak English and some staff spoke other languages.
- Consultants performed routine dementia screening for elderly patients. A senior nurse told us an additional assessment would be completed if a patient “showed signs of dementia” and most staff had completed training in recognising the early signs of dementia.
- Although Spire produced guidelines for staff about dementia, the hospital made less provision to help elderly or people living with dementia than might have been expected for a hospital taking a high proportion of older inpatients. For example, signs were not at eye level signs, there was little use of contrasting colours in patient rooms, distinctive toilet doors or large faced clocks. Patient rooms only had a digital clock. A number of the patients were very elderly and some were living with dementia. Within the 2016 PLACE audit, the hospital scored 66.4% for dementia-friendly environment measures. The average national PLACE score for dementia friendly provision is 75% which is more than the hospital was achieving.
- Although Spire produced guidance on 'This is me' passports, these were not used. Staff told us they would ask relatives about the name a patient liked to be called, normal routines and whether they needed reminders or support with daily life. Staff arranged for some patients, such as those with confusion, to be cared for on a one to one basis if this was necessary.
- We saw a chaperone policy and that chaperones were available for ward patients.
- We found there were no activities for people to be occupied and stimulated on the wards.
- There were no mortuary facilities at the hospital. The provider had a local agreement with an undertaker to use their facilities.

### Learning from complaints and concerns

- The hospital had a complaints policy for staff to follow. The hospital had received 67 complaints, of which 18 (27%) were still open. 26 (39%) of complaints were about billing and charging.
- We noted that complaints about patient experience were on the risk register.
- Patients said they knew how to raise concerns and give feedback and had information about this before admission as well as other information about what to expect. We saw a leaflet inviting comments called ‘Please talk to us’.
- Nurses told us ward managers were proactive in preventing complaints and addressed most concerns informally and directly. Staff told us this helped to prevent formal complaints.
- Complaints in writing and by telephone were captured, but not informal complaints in wards or other areas. A recently established Quality Improvement Group (QIG) considered complaints and patient satisfaction survey results to identify potential areas for improvement. Departments were asked to contribute to solutions.
- Patient feedback from the monthly patient satisfaction survey was shared with staff, but staff seemed unaware of formal complaints. Staff were not able to think of changes of practice made in response to complaints.

### Are medical care services well-led?

Not sufficient evidence to rate

- There was no vision or strategy to drive the development of medical services which seemed to operate in part as a nursing home rather than an acute hospital for medical patients.
- Governance in medicine was poor. There was no risk register specific to medicine.
- The medical ward was closed for refurbishment during our inspection and medical patients were being cared for in the hospital on another ward in single rooms.

However

- Staff considered they offered a good quality of care.
- Nurses and consultants said they were kept informed of developments in the hospital.
- We observed that nursing staff worked as a team.

# Medical care

## Vision and strategy for this this core service

- The hospital had an overall vision to be recognised as “a world class healthcare business” but there was no specific vision and strategy for medical services.

## Governance, risk management and quality measurement for this core service

- Governance in medicine was poor and lacked a clear policy on admissions. Some medical admissions appeared to be social admissions rather than acute hospital admissions, and the medical wards could be more like a nursing home.
- There was no specific medical department risk register, although there were eight ward related risks on the main risk register. The two risks most relevant to medical admissions were ‘failure to provide the quality of care expected for elderly patients (especially those admitted with multiple co-morbidities),’ and ‘patients admitted for end of life care may have poor symptom control’ but these were not specifically linked to medicine.
- There was no risk on the risk register about care for patients living with dementia, an area where we considered there were improvements to be made.
- There was no formal agreement with the hospice on end of life care even though some patients chose to end their lives in the hospital.
- For discussion of governance and risk management more widely in the hospital, please see the Surgery report under Well led.






## Leadership and culture of service

- St Anthony’s hospital’s medical ward had a lead consultant and there was a senior designated nursing lead for the ward.
- All staff were familiar with the management structure within the wards. Each ward had a sister in charge who reported to the matron.
- The senior staff team regularly undertook walkabouts and were visible and approachable.
- Staff reported there were good working relationships between clinical and non-clinical staff.

## Public and staff engagement

- We spoke with several patients who had been to the hospital several times which was a testament to their perception of the care given.
- Some staff had applied to work at the hospital because other staff had given a favourable report of working conditions.
- The service encouraged patients to give feedback on their experience; there were feedback cards in reception areas.
- The hospital sought patient’s views; there was a patient’s comments box with a questionnaire available to patients encouraging them to comment on quality of the service provided.
- Patients’ feedback was reported, reviewed and discussed quarterly at the Quality Improvement Group and senior nurses meetings.
- Staff reported there were regular opportunities to meet with senior managers in the hospital and they were visible around the hospital.

# Surgery

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

## Information about the service

Spire St Anthony's Hospital undertakes a range of elective day and inpatient surgery. 13% of patients are from the NHS. The remainder have private health insurance or are self-paying. Between April 2015 and March 2016, 4361 surgical procedures were carried out covering orthopaedic, cardiac, general and cosmetic surgery. The majority of surgical patients attended as day case patients. All surgery is elective.

The hospital had been providing cardiac surgery since 1970. Cardio-thoracic surgery accounted for 22% of surgical procedures in 2015-2016.

Six new operating theatres, three with laminar flow (a ventilation system that removes bacteria, viruses and dust particles from the air flowing in and out of a theatre, creating an isolated, clean environment) opened in August 2016. One theatre is a hybrid theatre (a theatre combining a full surgical operating theatre with X-ray and ultrasound imaging equipment for cardiac surgery). There is a four bed recovery area, and an adjacent critical care unit.

There are three surgical wards: St George's Ward is primarily for cardio-thoracic surgery patients, and has 12 beds; Marie Therese Ward is for orthopaedic and respiratory medicine patients and has 14 beds. St Theresa's Ward is for breast, gynaecology and urology patients and has 20 beds. St Mary's Ward, usually a medical ward, was closed for refurbishment during the inspection as part of a planned refurbishment programme. Staff used rooms on this ward as short term accommodation for day surgery patients. There was a contract with an NHS hospital for weight loss surgery and for orthopaedic and cardiac procedures.

We inspected the peri-operative care pathway from pre-admission, admission, through operating theatres and recovery onto surgical wards. We looked at provision for both inpatient and day case patients. We inspected the new operating theatres, recovery and the three surgical wards.

We spoke with 10 patients and their family members. We observed care and treatment and looked at 10 care records. We also spoke with more than 20 staff members, including allied healthcare professionals, nurses, doctors and senior management staff, porters, catering and domestic staff. In addition, we reviewed data and performance information about the service and compliance with national guidance and legislation in all areas of the hospital.



# Surgery

## Summary of findings

We rated surgery as requires improvement because:

- The hospital was not reporting serious incidents promptly and systematically to national bodies. A never event had not been reported as such. The hospital's process for investigating serious incidents lacked rigor, and did not translate quickly into learning and improving practice.
- The hospital had higher rates of falls, venous thrombo- embolism incidents and pressure ulcers than its target.
- The control of risks needed strengthening.
- There was a shortfall in the management of consultant surgeons who booked patients late, did not use pre-operative assessment and did not observe the WHO checklist. This impacted on patient care and safety.
- There was limited information on patient outcomes

However,

- Consultants were on call 24 hours and two resident medical officers (RMOs) were available 24 hours a day, seven days a week.
- There were enough nursing staff on duty during the inspection and we observed them to be kind and caring, which was borne out by patient feedback.
- Patients had timely appointments and treatment.
- Visitors could visit patients at any time.

## Are surgery services safe?

Requires improvement 

We rated safety as requires improvement because:

- The hospital was not reporting all serious incidents requiring to be reported externally, promptly and systematically. One never event had not been reported.
- Ward staff did not always react promptly to patients who were becoming more unwell because nursing records were not always correctly completed.
- There were no mortality or morbidity meetings.
- Procedures in theatre were sometimes carried out without patients being fully pre-assessed for risk factors before surgery.
- Theatre lists sometimes overran and continued into the evening.

However;

- Equipment was well maintained and cleaning and infection control was good.
- Medicines were generally well managed.
- There were enough staff on duty during our inspection.

## Incidents

- The hospital told us they had not declared any Never events. However, we found there had been a Never event at the hospital in June 2015. This was a retained needle after surgery, which had been investigated as a serious adverse event. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The learning from this Never event did not appear to have been disseminated to consultants. Theatre staff were not were able to describe any changes that had been made as a result. However, they were able to tell

# Surgery

us that in response to another more recent serious incident, swab count white boards and 'safeguard' swab containers had been introduced which indicated evidence of learning amongst the theatre team.

- The hospital had reported nine serious incidents (SIs) (hospital-wide) from April 2015 to the time of our inspection. 6% of their clinical incidents were categorised as severe. Not all these incidents had been reported to the CQC, which is a regulatory requirement.
- We had concerns about the rigor and timeliness of serious incident investigations. These were missed opportunities to identify issues and improve the service.
- On inspection, we observed a pre and post procedure swab and needle and instrument count in theatre, checked by two registered nurses. The scrub nurse signed that the swab, needle and instrument checks were correct at the end of the procedure.
- There had been 33 deaths in the reporting period April 2015 to September 2016. Twenty two of these were expected deaths, classified as medical or oncology. The deaths included 9 deaths within 31 days of surgery. Four had had cardiac surgery. Three had died from multiple organ failure, two from cardiac failure, and the others each from sepsis, myocardial infarction, pneumonia and pulmonary embolism. The hospital did not run Mortality and Morbidity review meetings. The number of deaths was higher than expected when compared to a group of independent acute hospitals which submitted performance data to CQC. Mortality is rare in independent acute hospitals. After the CQC raised the issue of mortality, the hospital director told us Spire intended to review mortality centrally. This hospital was unusual among independent hospitals in having a medical ward.
- The hospital used an online incident reporting system. There were 672 clinical incidents overall. 78% of incidents in the hospital between April 2015 and March 2016 had occurred in surgery (522). There were 89 non clinical incidents. This was the biggest service in the hospital. The proportion of incidents was similar to other independent hospitals for which CQC hold data.
- All staff had access to the incident reporting system. Nurses told us they now reported incidents online themselves rather than asking a line manager to do it. We did not see any incident reports made by doctors. Hospital-wide, most incidents were categorised as 'no harm', but there were 97 incidents of low harm, 166 of

moderate harm, and 30 as severe harm including death. Incident reports did not routinely state the time of the incident to help staff analyse whether there were specific times of day or night that incidents occurred. Nor did they specify exact locations; instead they simply stated wards or theatres, which further limited scope for analysis. At ward level, nurses showed limited awareness of learning from incidents.

- Spire's target was to close 75% of incidents within 45 calendar days of the incident being reported. The hospital was only closing 34% of incidents in this timeframe which was poor. Delays in investigating reduced the opportunity to learn from incidents and prevent their recurrence.
- Hospital staff did not report all relevant incidents to the CQC, and those reported were not always reported immediately.
- The most common medicine incident in wards was a missed dose of medicine. In response, the pharmacy outlined lessons learned from each incident for all staff to read. It was not clear whether all staff, including RMOs read this useful information. It was too soon to say whether these 'lessons learnt' were reducing medication incidents.
- The themes in the reporting log for surgery were late running of theatre, falls without harm, pressure ulcers and medication errors.
- Safety goals had been set using a clinical scorecard, with key performance indicators benchmarked across the Spire Group. Spire results were reported quarterly, but the hospital had monthly rolling results too. These showed the hospital was making steady improvements.
- From November 2014, all providers had to comply with the Duty of Candour regulation. The Duty of Candour means that healthcare services must be open and honest with patients when things go wrong, giving them reasonable support, truthful information and a written apology.
- The term was not familiar to all staff we spoke with, even though we were told all staff had a briefing last year. However, senior staff we spoke with understood the principles and were able to explain how they would respond, should a mistake happen. We saw examples of where staff had used the Duty of Candour. Nurses we spoke with did not think the hospital shared the results of incident investigations with families, although the

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senior management team confirmed this was the case. Nurses had been briefed on the Duty of Candour and how the process of sharing information with patients' families formed part of this process.

## Safety thermometer or equivalent (how does the service monitor safety and use results)

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit for patient and their families to see the prevalence of avoidable harms. In the NHS, it covers new hospital acquired pressure ulcers, patient falls with harm, new venous thromboembolism (VTE), also known as blood clots, and urinary tract infections (UTIs) associated with the use of catheters. This was displayed in all departments and in staff only areas of the hospital which ensured that ward staff had ownership of the data they collected..
- The hospital did not meet its clinical outcomes targets for falls, pressure ulcers or venous thrombo-embolism, between April and June 2016.
- The hospital did not meet its clinical outcomes targets for falls, pressure ulcers or venous thrombo-embolism, between January and the end of August 2016.
  - Pressure ulcer (PU) prevalence was 0.6 per 1000, higher than the goal of fewer than 0.1 per 1000. This was one patient.
  - The number of patients having falls was 2.53 per 1000 against a target of less than 2. We were not provided with numerical data but this is estimated to be four patients.
  - VTE risk assessment 75% had been poor (75%), below the hospital target of 95%, between April and June 2016. By September 2016, the rolling scorecard showed this had risen to 100%.
- There were six incidents of hospital acquired VTE or PU in the year April 2015 to March 2016.
- Staff developed action plans to address concerns about falls or pressure ulcers where rates were above the national Spire target. These were submitted to central teams for review and scrutiny.

## Cleanliness, infection control and hygiene

- All the clinical areas we visited were visibly clean, well-organised and clutter-free. All floors in corridors were clean. There was little evidence of dust, except on high rails in critical care ward.

- Housekeeping staff undertook domestic cleaning. We saw completed cleaning schedules showing cleaning had been carried out.
- Infection prevention and control was generally well managed. The hospital had a named lead for infection prevention and control (IPC) and reliable systems to protect people from healthcare associated infection. A microbiologist was available to give advice.
- There were hand sanitiser points at the entrance to wards and throughout public areas. Our observation of staff practice, review of audits, comments from patients confirmed that staff complied with good hand hygiene practice.
- Staff audited hand hygiene monthly. Other IPC audits were carried out quarterly (catheter care) or six monthly (e.g. patient equipment). Wards had hand wash basins for staff with wrist operated taps.
- We saw protective personal equipment (PPE) on wards such as gloves and aprons for staff to use to maintain IPC standards. We observed staff wearing and disposing of PPE appropriately.
- Patient's reported that the hospital was clean with one commenting 'The hospital has always been kept very clean with particular attention to hygiene.'
- The theatre manager was a member of the infection control committee. Managers conducted regular audits of infection prevention and control compliance in theatres. We saw an audit of the former theatres and cardiac catheter lab from June 2016. The results had led staff to revise the cleaning schedule to ensure some cleaning to include clogs and some machines not previously included.
- We saw from a theatre uniform audit in May 2016, that not all staff were compliant with clean uniforms, caps covering all their hair, and shoes. We did not see an action plan to improve compliance or a re-audit to review it. There was a Standard Operating Procedure for the wearing of theatre clothing.
- Protective equipment was available in wards and theatres. In theatres, this included FFP3 masks for use on high risk patients during aerosol generating procedures associated with pathogen transmission (such as surgery involving the use of high-speed devices).
- Theatre staff used appropriate hand decontamination processes before starting surgical procedures.

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- The new theatres had been designed so all contaminated instrumentation was taken for disposal or decontamination through a corridor at the back of theatres. This was to keep a clear separation between clean and dirty instruments.
- The central sterile services department cleaned, packed and sterilised surgical instruments on site.
- There were three reported incidences of *Clostridium difficile* (C. diff), hospital-wide in the past year. Staff were not aware of a strategy to reduce recurrence. There were no incidents of other reportable infections such as methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin sensitive *Staphylococcus aureus* or E-coli.
- Patients were generally screened for infections such as MRSA before admission for surgery, but sometimes patients were admitted before test results were available contrary to best practice.
- There were no incidents of urinary tract infection in patients with catheters.
- Out of 4361 surgical procedures between April 15 and March 16, there had been 17 surgical site infections (SSIs), which was low. However, the rate of infection during breast procedures was above the average for NHS hospitals in that period although this higher rate was attributed to only 3 patients given low patient numbers. We asked if there was an improvement plan and were told there was not. There were no reported SSIs from primary hip and knee replacements, spinal, gynaecology, cranial or vascular procedures so the hospital was performing better than target in these areas.
- Routine swabs (nose and groin) and of wounds were carried out on inpatients on wards.
- Senior nurses told us rooms were deep cleaned once patients with infections had vacated them. We saw records of deep cleaning of some rooms.
- The new theatres were well-designed, spacious and clean. One feature was a bed bay outside each theatre where beds could be placed without blocking corridors. Store rooms in theatres and on wards were neat and well organised which made it easy to find supplies.
- The anaesthetic room and theatres had automatic doors. The doors were set to open in sequence with patient access and flow in mind.
- In theatres, in addition to resuscitation trolleys, there was equipment for managing difficult airways, major haemorrhage and malignant hyperthermia (MH). This was to manage a rare, life-threatening condition that can be triggered by exposure to certain drugs used for general anaesthesia. We saw that the equipment was checked daily and checks were recorded.
- Staff recorded instruments used in operating theatre to ensure they were traceable in the event of patient infection. All theatre equipment was recorded on an asset list.
- All the equipment in wards and theatres that we checked had the date of the most recent service, and electrical safety check clearly displayed. We did not find any equipment that was overdue for service. Staff told us medical equipment engineering services repaired equipment.
- In the hybrid theatre, there were dosimeters for all staff. Lead aprons were used to reduce radiation dosage to staff and lead coat cleaning records were seen. There were local rules for radiation procedure.
- A four bed recovery area had curtains round the beds and was equipped with portable monitoring equipment.
- The surgical wards were well organised and quiet.
- The hospital's first Patient-Led Assessment of the Care Environment was carried out in June 2016. The hospital passed all items for the condition, appearance and maintenance part of the assessment. Wards were accessible to patients and visitors with limited mobility.
- There were fire extinguishers at appropriate points throughout wards and theatres. Some fire extinguishers in public areas were not on stands, which is best practice where they cannot be bracketed to a wall.
- Resuscitation trolleys in wards each had security tabs present and intact. We saw nurses completed checklists daily. All necessary equipment and consumables were present, sealed as appropriate, and in working order. Seals were broken monthly to check drug expiry dates.
- Theatre trolleys had resuscitation guidelines dated 2015, but on the cardiac ward, the card above the

## Environment and equipment

- Staff in theatres said there were no problems with the timely supply of complete, sterile surgical sets, as long as bookings were made with due notice. Problems arose when consultants added patients late to operating lists. Theatre staff were seeking to stop this practice and ensure consultants completed booking forms with details of instruments needed with at least 72 hours' notice.

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resuscitation trolley displayed the 2010 algorithm. When brought to the attention of staff during the inspection, this was replaced immediately. Staff had received training in the updated 2015 algorithm as part of their mandatory training.

- The guidelines for Control of Substances Hazardous to Health (COSHH) were on display in the kitchens on wards. A COSHH database had been set up in the summer. There were no COSHH audits available.
- Waste management was compliant with the Department of Health Safe Management of Waste 2011 guidance. An external contractor removed waste.
- There was a new well-equipped gym and a hydrotherapy pool for rehabilitation physiotherapy.
- We saw from an incident report that when a defibrillator had been used on a ward in June 2016 in a cardiac arrest, it did not print out. We noticed there was daily checking that defibrillators were charged, but not a check that they could print, so learning had not been taken from this incident to change practice.
- We were shown one of the new operating theatres that was planned to be used for paediatric patients once the service had restarted. Although, not yet completed, it had a large anaesthetic room with space for two parents to be in the room while a child was in there. A traffic light system was planned to ensure that children did not see any adult patients on their route to the theatre. Construction was due to start on a new recovery area with a separate space for children to recover.

## Medicines

- We found that medicines were stored securely and appropriately. Keys to medicines cupboards and patient medicine boxes in their rooms were held in safes within restricted access treatment rooms.
- Controlled Drugs (CDs) were securely stored in accordance with legal requirements. A separate key was held in a safe in the treatment room, with restricted access. Nurses checked the balances of these medicines daily and completed the CD registers correctly. We saw staff had double-signed entries, to provide evidence of an authorised witness. Pharmacy staff carried out twice yearly audits.
- All controlled drugs in the anaesthetic rooms in theatre were stored in locked cupboards.
- Intravenous fluids were stored appropriately within treatment rooms and theatres.

- Nurses did not use medicine trolleys on the wards. Each patient's hospital-prescribed medication, and their own drugs, were kept in locked wall cabinets in their hospital rooms. Nurses had the keys to these.
- A protocol for assessing patients' suitability for self-administration of medicines was in use throughout Spire hospitals.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were within the recommended range of 2-8°C. In theatres, we saw some days when fridge checks had not been recorded. We subsequently found this was because the theatres were closed on those days. However, this had not been documented.
- The pharmacy manager told us that there was pharmacy input into the Medical Advisory Committee (MAC) and Hospital Effectiveness Committee. There were no specific medicine committees. Although not obliged to implement NICE Technology Appraisals, The pharmacy manager said Spire strongly recommended the implementation NICE Technology Appraisal recommendations on the use of new and existing medicines and treatments to enable them to prescribe medicines that were evidence-based and they had implemented this which was good.
- Pharmacy staff were considering using the Medication Safety Thermometer, an improvement tool focusing on medicine reconciliation, allergy status, medication omission and identifying harm from high risk medicines. They were considering benchmarking their performance against other hospitals. Meanwhile, we saw evidence of the hospital self-assessing itself against a quarterly quality dashboard, and had produced actions plans to improve their outcomes with regard to Medicines Optimisation: ensuring that patients get the right choice of medicine, at the right time to help them improve their outcomes by managing their medication correctly.
- Patient outcomes from medicines were monitored and assessed through audits of controlled drugs, missed or omitted doses, pharmacy interventions and safe storage of medicines.
- Pharmacy had effective arrangements for reconciling medicines they had ordered. However, we were told RMOs undertook some reconciliation on wards and we found two orders where reconciliation had not been done.
- Staff we spoke with said they had no problems obtaining medicines from the pharmacy when needed.



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Pharmacy staff topped up ward stock twice a week and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.

- Pharmacists had access to the British National Formulary as well as all policies and information relating to medicines management (including the antimicrobial formulary).
- In theatre, we saw good practice in the accessibility of adrenaline and emergency anaesthetics, which staff did not draw up unless needed.
- Nurses recorded the allergy status of each patient. Drug charts we looked at showed staff had not signed these in all cases. Patients wore a red wristband to indicate a patient who had diabetes or an allergy.
- We reviewed six patient medication charts in wards across the hospital, and found several errors: two charts gave no reason for antibiotic prescription; on another, staff had used the abbreviation 'u' in relation to a prescription for Fragmin (an anticoagulant that helps prevent the formation of blood clots), when the hospital's policy explicitly stated this abbreviation should not be used because of the risk of error in interpretation; another showed no dosage unit for a medicine and on another, the time an antibiotic was given was not recorded.
- Medicines were available in an emergency drugs cupboard outside the pharmacy (on the ground floor). They were appropriately stored, access was restricted to authorised personnel and there was a system in place to monitor their use.

## Records

- Patient records were mainly on paper, kept in ring binders. The paper notes were available to doctors, nurses and other healthcare professionals. Records were appropriately stored and not left open or on display so as to keep patient data confidential. Completion at the time of inspection was 64%. The remaining staff had until the year end to complete this annual module and completion of this training was linked to staff appraisal and eligibility for any performance related bonus.
- We reviewed six patient records and found patient notes were completed in a logical way. The clinical notes showed care plans, observations and patient progress. Routine nursing assessments were included such as

vital signs observations, falls assessments, assessment for pressure areas (Waterlow score), venous thromboembolism (VTE) assessment and nutritional status (Malnutrition Universal Screening Tool - MUST).

- The hospital used a handwritten, standardised form for nurse led pre-operative assessment. The notes we looked at were legible, signed and dated in line with the corporate patient record policy.
- Senior staff told us that they were encouraging surgeons to ensure all patients had a full pre-operative assessment in line with safe practice. However, this was not audited and we saw evidence from past incidents of some complex procedures being carried out with neither pre-operative assessment nor a detailed patient medical history. This was a serious risk in our view, but was not on the risk register.
- The hospital maintained an implant register to ensure that details of implants and equipment would be available to the healthcare products regulator. Staff also recorded cosmetic implants and prostheses, with their serial numbers in patient medical notes.
- The hospital retained patient records for 11 years after conclusion of treatment, in line with Department of Health Guidance.

## Safeguarding

- Spire Healthcare had provided a national safeguarding policy for its hospitals. The hospital had a safeguarding lead for adults in vulnerable circumstances and one for children, as well as a link nurse. The safeguarding leads had established links with the Head of Safeguarding and Designated Nurse for the local Clinical Commissioning Group.
- The lead for safeguarding children was due to attend a level 4 course, the training for named professionals dealing with safeguarding children and young people.
- As a prompt for staff, the names and photographs of the hospital safeguarding leads were on the wall in ward offices, with details of how to report concerns. These details were not incorporated in the policy on the intranet, which was a generic policy for Spire hospitals as a whole.
- The policy and protocol for safeguarding referrals was available for staff to access on the intranet. The hospital Deprivation of Liberty Safeguards policy and process was also available.
- The staff we questioned were able to explain their understanding of safeguarding and the principles of

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safeguarding for children and adults. They were able to identify potential signs of abuse, including verbal and emotional abuse, and the process for raising concerns and making a referral. A nurse gave us a good example of concern raised over a 'controlling' relative and action that had been taken.

## Mandatory training

- Uptake of mandatory training had been low in the first part of the year. Between April and June 2016, 34% had received training against a target for that period of 50%. The hospital target for staff completion of mandatory and statutory training for the full year was 95%. 90% of staff (hospital-wide) had completed mandatory updates at the time of the inspection. This had been achieved by ensuring staff carried out their training during the hospital's temporary closure for a week in August 2016. Most training was delivered online through the Spire electronic system, which staff could access in the hospital or at home.
- At the time of our inspection, compliance with mandatory training for staff working in theatres was 97% which was high.
- The mandatory and statutory training programme covered equality and diversity, health and safety awareness, infection control, compassion in practice, adult and child safeguarding (levels 1 and 2), fire safety and manual handling. Training on managing violence and aggression was optional but recommended. There were additional role-specific modules on topics such as the mental capacity act and deprivation of liberty safeguards, safe transfusion, incident reporting and controlled drugs. Nurses had a small aide memoire (known as a z-card) that contained useful reminders for staff to show where they could access key information.
- Newly appointed staff completed a corporate induction, which was run several times a year, as well as ward or theatre-based induction.

## Assessing and responding to patient risk

- Identification of patients' anaesthetic risk took place in outpatient pre-operative assessment clinics. The purpose of the assessment was to ensure patients were fit to undergo an anaesthetic. We were told that an anaesthetist would review patients where risks were identified. Not all patients had a pre-operative assessment; some simply submitted a questionnaire. The nurse triaged their returns to see if they should

attend a clinic before surgery. Spire's Admission and Discharge Policy guided processes for types of pre-operative assessment by age and co-morbidity in line with NICE guideline CG3.

- For most NHS patients referred for surgery, their NHS hospital carried out the pre-assessment.
- We did not see an example of an anaesthetist's assessment of an elective patient or a template of what tool they used.
- We were told that the hospital were aware of the need to ensure that patients seeking cosmetic surgery had appropriate assessments. This was to assess the emotionally vulnerable, including taking relevant psychiatric history and discussions about body image as required in the General Medical Council's (GMC) Guidance for doctors who offer cosmetic interventions. We were told that Spire Healthcare was revising the Consultant Handbook to reflect the Royal College of Surgeon's (RCS) guidelines for cosmetic surgery, which had been introduced in April 2016, five months prior to the inspection; however there were no audits to ensure cosmetic surgeons were following the recommended procedures.
- Patients at risk of carrying MRSA were swabbed before admission so, if necessary, they could be treated with antibiotics in advance of their procedure. Staff monitored changing risks to patients, including whether they were becoming more unwell using the national early warning score (NEWS) system. There was a clear escalation protocol. Nurses would report deteriorating patients to the RMO, and would contact the on-call critical care team if they had urgent concerns about a patient. The hospital audited compliance with the policy on use of NEWS monthly. Of the eight NEWS charts we reviewed, three were not completed in line with hospital guidance and did not follow the escalation plans on the back of the NEWS assessment. The hospital score for compliance with NEWS records was 90% compared with a target of 95%.
- Patients identified as at risk of dehydration had fluid balance charts to monitor fluid intake and output. However, on three out of four patient charts (on different wards) we saw nurses had not totalled the 24 hour fluid balances which made it difficult to assess the hydration status of patients. This was contrary to policy which said fluid balance should be totalled on each shift. There was no audit of this, although Spire policy was to audit this annually.

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- All female patients of childbearing age were required to have pregnancy tests before surgery. This was audited as part of the clinical score card and compliance was 85%.
- Most, but not all, consultant surgeons visited their patients daily to review them and identify any concerns or additional care needs. Daily visits were part of doctors' practicing privileges agreement.
- Nursing staff in the theatre recovery felt they were able to provide safe care for patients post-operatively. All theatre recovery staff were required to complete immediate life support training and two staff had completed advanced life support training.
- There had been some patient falls. "Call, don't fall" posters had been placed in patient rooms to remind patients to ask for help when mobilising. Staff we spoke with all understood the procedure when a patient had fallen and explained it to us.
- Surgical safety checklist audits in July 2016 showed the completion of the operating theatre register. Documentation before the patient left the theatre was poor at 37%, and staff had not signed and dated all checks. We saw an action plan, but no re-audit to measure improvement.
- We saw a sepsis screening tool and Sepsis 6 pathway on wards. Where patients had skin damage, staff completed a body map.
- Emergency call bells were available in each patient bedroom and bathroom, and consulting rooms. However, in toilets used by visitors there was no alerting system for help, should a visitor fall or become ill.
- Two surgical patients during our inspection were post-operative level one patients, which meant that they were receiving intensive nursing care. If a patient required intubation (a tube placed into their airway to assist with breathing), they would need to be transferred by ambulance to an NHS hospital. A service level agreement had been set up with a nearby hospital trust.

## Use of the 'five steps to safer surgery' procedure

- We observed theatre staff complete the compulsory elements of the safety checks before, during and after surgery as required by the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) five steps to safer surgery surgical safety checklist. We saw all documentation completed at each

stage. However, we noted from the risk register, that some consultants did not use the checklist. An audit had been carried out in July 2016 of the compulsory elements: sign in, time out and sign out.

- Theatre staff held a daily pre-briefing each morning before operating lists started.
- We followed the patient pathway for one surgical patient through from the start of the anaesthetic to the time out of recovery. We witnessed staff complete the checklist comprehensively. All staff were attentive to the process. Audits of compliance submitted by the hospital demonstrated good compliance of 97-100% compliance between June 2015 and May 2016 for all five stages. The annual audit report identified team debriefing as an area for improvement as this had the lowest level of compliance of all stages, across theatres at 97%.

## Nursing staffing

- In the hospital as a whole there were 94 WTE registered nurses and 6 healthcare assistants for inpatients.
- Regular bank staff, and sometimes agency nurses covered shift gaps. There were also some student nurses on placement on the wards. Bank and agency use was 4% for inpatient nurses and 13% for inpatient health care assistants, which was lower usage than most independent hospitals.
- Theatres had 48.8 WTE staff. Sickness levels were low.
- There were some long established nurses on the wards. Nurses were graded as staff nurses, sisters and senior sisters.
- There were few healthcare assistants (HCA). The ratio of nurse to health care assistant hospital-wide was 15.7 to 1.
- Some staff and patients told us there were fewer nurses than under the former hospital's management. However, we did not observe high workloads and nurses we spoke with said they had time to complete paperwork.
- Theatres were staffed in accordance with The Association for Perioperative Practice (AfPP) recommendations. A recruitment programme for theatre staff was under way as there were now two more theatres than before.
- We observed the nursing handover at the end of the day shift on the ward. Each day nurse in turn handed over key details of the patients they had cared for that day to the incoming team. The nurse in charge, who was not supernumerary, then allocated patients between the



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night staff. Handover was well-managed and each nurse gave a holistic view of each patient so the nurses taking over care were well-informed. Nurses had a printed handover sheet of patients on the ward.

- Staff worked different shift patterns, some short days and some long days (12 hours). Managers told us the standard ratio calculated was 1:5 nurse to patient ratio during the day and 1:6 at night. However some nurses told us the ratio was sometimes 1:7.
- We were told that the number of staff on each shift was dependent on the expected number and dependency of patients. Ward sisters completed a daily report to help senior staff assess skill mix in relation to patient's acuity.

## Medical staffing

- Patients' treatment plans were made by their consultant.
- Although 331 doctors had practising privileges at the hospital, 45% of these had no episodes of care in the past year. 30 consultants had more than 110 episodes of care.
- There was one RMO covering the wards and one RMO cared specifically for cardio-thoracic patients. Both were directly employed by the hospital. Spire arranged induction and training. However, there was no consultant mentoring for RMOs, which would be good practice.
- The employed RMOs worked 24 hours on call, and one weekend in four. No shifts were unfilled from the RMO rota we saw for October 2016. They normally had two days off a week. The risk register in July 2016 identified a risk that when one of the two RMOs was away, the other RMO could work 24/7 for a month which would have been potentially unsafe. However, at the time of the inspection, the RMO numbers had been increased to 4 and the risk register had been updated to reflect this. The rotas provided to CQC before inspection did not show any RMO working without breaks so corroborated that on site medical cover was safe.
- An informal medical handover took place each day about 9am. This was a verbal handover about the patients' condition and followed the areas of the clerking in process.
- Managers did not audit the number of times the RMO was woken during the night. We were told that if the RMO had been awake for long periods during the night,

the hospital could arrange locum cover through an agency, but there was no further information about when this had happened. There were no other audits of RMO workload.

- Individual surgeons remained responsible for the care of patients during their inpatient stay. The consultants were contactable 24 hours a day. The RMO was aware of how to contact consultants for advice and guidance and did so as necessary. The Spire Consultant handbook required all consultants (including surgeons, anaesthetists and physicians) to document their cover arrangements in the patient notes. We saw that consultant absence was shown on the whiteboards in the nurses' offices.
- We were told surgeons usually arranged their own anaesthetists for their operating lists. There was no formal rota of anaesthetic cover should a consultant's buddy anaesthetist not be available, although the hospital held a list of anaesthetist contact details.
- Radiologists were available to support cardiac surgery requiring interventional radiology.

## Major incident awareness and training

- The hospital had procedures in the event of an incident on site.
- There was a major incident plan and policy, which covered potential incidents that could cause loss of services, with contingency plans for various scenarios. There were departmental action cards for scenarios such as fire or electricity failure, which explained what to do. Managers said they had carried out a table top exercise for major incident response.
- Staff had practiced evacuation and the use of equipment in the previous month. 97% of staff had completed fire safety training.
- The service had 36 hours supply of electricity from back-up generators and back up batteries for some equipment in the event of a power cut.

## Are surgery services effective?

Good 

We rated effectiveness as good because;

- Policies followed NICE and other guidelines for clinical practice.
- Pain was assessed and managed appropriately.

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- Consultants were on call 24 hours and two RMOs were available 24 hours a day, seven days a week.
- On call pharmacy advice was available 24 hours a day.

However,

- There was limited data on patient outcomes. The hospital was submitting current data to the Private Healthcare Information Network (PHIN), an organisation that publishes independent hospital data to help patients make informed healthcare decisions, so data would be available in the following year.
- Multidisciplinary working and recording of MDT discussions was still at an early stage of development.

## Evidence-based care and treatment

- Policies and guidelines we looked at were produced centrally by Spire for all their hospitals. These were current and based on evidence-based practice from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.
- Spire issued a monthly 'Safety Update' to its hospitals with policy updates, patient safety alerts, medical device alerts and regulatory updates. It was up to hospitals to cascade these to staff. We did not see these cascaded to ward nurses.
- Spire had carried out a mock inspection soon after the group took over the hospital and used shortfalls to focus improvements. Two further mock inspections had been carried out the most recent of which led to suspension of critical care as it did not meet all current standards.
- The hospital audited aspects of care to check that it was in line with Spire policies and to improve services. Spire's clinical scorecard required the hospital to complete a number of audits quarterly with standards linked to national benchmarks, where available, and national guidelines. This allowed the hospital to compare its performance with other Spire hospitals. The hospital had a clinical audit programme for 2015/16. Audits in relation to surgery were the percentage of patients fasted within guidelines, VTE risk assessments and prophylaxis, surgical site infections, unplanned surgical cases during same admission, unplanned admissions within 30 days of discharge and compliance in recording patients' temperatures. Against these measures, except for recording patients' temperature in theatre and recovery, the hospital was performing better

than the Spire average. For temperature recording the hospital had scored 35% in the previous quarter. However, we saw the score for recording temperature had risen to 93% in the month of our inspection.

- Hospital staff carried out regular audits of their practice specifically against NICE guidelines to benchmark their own performance against the rest of the Spire Group. These were reported quarterly via Spire's clinical scorecard.
- There was no facility for analysing longer term trends at the hospital, because formal audit had been minimal under the previous hospital ownership.
- The hospital treated cardiac patients. Staff told us, and we saw from records, that where cardiac patients had extreme fluid retention, their weight was checked daily when they were having fluid offloading treatment. Electrocardiograms (ECGs) were done as clinically indicated. This was in line with good practice.
- The theatre team had an objective for 2017 to complete regular audits of the theatre environment to ensure compliance with National Safety Standards for Invasive Procedures (NatSSIPs). All organisations that provide NHS funded care in England must follow these. NatSSIPs provide a high-level framework of national standards of operating department practice created for local providers to use to develop and maintain their own more detailed standardised local operating procedures.

## Pain relief

- Nurses told us, and patients we spoke with agreed, that patients' pain relief needs were met and pain was well managed. Nurses told us feedback and audits had shown improvements in pain management over the past year. 95% of patients now had pain scores recorded with every set of observations. Staff told us that where patient's procedures were likely to cause pain, such as abdominal or pelvic surgery, they spoke to patients on the morning of surgery to reassure them about pain and nausea. If a patient's pain scores were high, they would escalate the problem to the critical care team for advice.
- Overall, 84% of patients reported their pain was controlled a great deal (June 2016). This was lower than the Spire average of 92%.
- We witnessed nurses asking patients whether their pain was being effectively managed and if they were comfortable. Pain scores were recorded in the patients'

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notes we looked at, with evidence of follow-up to see if pain had been controlled. However, the hospital did not have a clinical nurse specialist or a specialist consultant for pain management.

- 'As required' pain relief was prescribed within theatre. Ward staff told us the RMOs reviewed pain relief if a nurse or patient requested this.

## Nutrition and hydration

- Before they had surgery, patients were told about fasting guidelines during the pre-operative assessment or consultation. For patients having a general anaesthetic, fasting was six hours prior to surgery for solid food and two hours for clear fluids was the guideline. One NHS patient said they had not had clear information about fasting, although clear instructions were provided to every patient in their pre-admission letter or by telephone should there be a late booking.
- An audit showed 75% of patients were fasted within guidelines between April and June 2016, against a target of 50% and this had risen to 100% in September 2016.
- The hospital used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. Where patients were identified as medium or high risk of malnutrition, food intake was to be recorded, and the patient was to be encouraged and given assistance with meals.
- Patients with special dietary requirements were identified at pre-operative assessment, such as those requiring high calorie or low fat diets and their needs were met. One patient who had a soft, pureed diet thought the food was adequate but mentioned staff had not added thickeners to their drinks. The hospital did not employ a dietitian, but two dietitians had practising privileges so consultants could refer patients to these, if advice was needed.
- During meal times, patients would be positioned safely and comfortably if required for their meal and staff would assist patients with their meals as necessary.
- Dietary plans were included in patient care plans.

## Patient outcomes

- Staff reported unplanned returns to theatre through the hospital incident reporting system. There were 8 returns to theatre from January to end August 2016 (0.4%). These were mainly cardiac and general surgery patients. This was better than the Spire target.
- National benchmarking of patient outcomes was limited as in most private hospitals. The hospital was

submitting required data, through Spire's head office to The Private Healthcare Information Network (PHIN), as required by the Competition and Markets Authority Market Investigation Order 2014. PHIN is required to publish private hospital data as 11 performance measures, including key safety and quality indicators such as mortality rates, readmission rates, unplanned patient transfers and patient feedback. The aim is provide helpful and accessible information on the quality of care provided by private hospitals and consultants, where possible, making this directly comparable to NHS data.

- The director told us Spire was on track to meet PHIN obligations. The hospital said their own data was complete for patients with adverse events but did not supply this data to CQC. Patient Reported Outcome Measures (PROMs) collection for private patients was being used in some Spire hospitals as part of a pilot. PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery, but St Anthony's hospital was not in this pilot. Spire's corporate objective was to have all hospitals collecting PROMs for surgical procedures for hips, knees, cataract and groin hernia by 30 September 2016.
- Four consultants at this hospital supplied data to PROMs. No complications had been reported for the patients treated at St Anthony's Hospital.
- We were told that individual consultants submitted data to NICOR (National Institute for Cardiovascular Outcomes Research) regardless of where they performed the procedure, NHS or private. The hospital did not collate or publish this data which remained with the individual consultant. The main cardiac procedure at St Anthony's Hospital was coronary artery bypass grafting (CABG); a type of surgery that improves blood flow to the heart.
- In addition, the hospital participated in National Blood Transfusion Comparative Audits and had taken part in the most recent PLACE survey with results published nationally providing additional opportunity for benchmarking outcomes with other providers.
- Nurses completed the Visual Infusion Phlebitis (VIP), in line with good practice, and documented the time of cannula insertion.
- Medical staff said physiotherapy staff worked hard to get the best outcomes for their patients.

# Surgery

- There had been 17 unplanned returns to theatre from January 2015 to 21 August 2016, mainly for post-operative bleeding. Seven of these were following cardiac surgery. One person with major haemorrhage had returned to theatre twice. The hospital met its own target for unplanned returns to theatre in 2015, averaging 0.15 against a target of 0.2. However, the hospital scored worse than the Spire national average of 0.1 for returns to theatre.
- Of the 41 unplanned readmissions within 28 days of discharge from January 2015 to end August 2016, the main categories of patient were those who had cardiac or thoracic surgery (12 patients), urology patients (10) and orthopaedic patients (4). The main reasons for readmission were pain control, urinary retention or urinary tract infections, other infections or shortness of breath. This was a low rate of readmission. Staff were exploring whether pre-operative assessment was yielding adequate information to assess patients suitability for admission for surgery at a private hospital.
- 93 cosmetic procedures had been carried out since January 2016.
- Physicians in the hospital participated in the GMC revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice. The hospital provided data that showed 100% revalidation rates for all clinical staff working under practising privileges in inpatient areas.
- We saw evidence of suspension of consultants practising privileges where consultants failed to produce evidence on competence. Ten consultants had their practising privileges removed between April 2015 and March 2016. Three retired and others moved out of the area. All cardiologists who worked at the hospital were members of the British Cardiac Interventional Society.
- Staff appraisals were known at Spire hospitals as 'enabling excellence'. Their focus was on enabling staff to contribute to improving hospital performance, involvements in projects and innovation and development of services. The appraisal system at St Anthony's had only been introduced in 2016, so no staff had yet completed the full process. We could not therefore evaluate the success of the process. In theatres, over 88% of staff had had an initial appraisal meeting to set objectives. The rate for ward nurses was similar.
- The hospital supported continued professional development of its staff, including supporting staff to obtain formal qualifications as well as through practical training.
- Staff in theatres had a good plan for training since appointing a practice educator. Theatre staff had been trained in medical devices used in theatre to ensure they could use it competently and safely.
- There were already competencies for most theatre staff. The training team leader in theatre had recently developed competencies for HCAs in theatres. Staff were allocated time to do training and there was access to training funding.
- Theatre managers were seeking to build a leadership structure within the department, identifying key team leaders and giving them the tools and training needed to develop their teams.
- Only two theatre staff were trained in Advanced Life Support at the time of the inspection. All had intermediate life support training. Some staff were also being trained in paediatric life support in anticipation of the recommencement of surgery for children.

## Competent staff

- Staff joining the hospital received both corporate and local inductions. Agency staff were given a local induction to the clinical area covering the ward layout, procedures in the event of an emergency and the location of emergency equipment, for example the resuscitation trolley.
- The director told us the hospital's matron assessed all resident medical officer qualifications and suitability before they were taken on.
- The medical advisory committee (MAC), which included representation of many specialists working at the hospital, advised the hospital director about applications for practising privileges. The hospital reviewed the practising privileges of each practitioner every two years to ensure doctors were competent. Individual data on activity and performance was reviewed to enable the hospital director to make an informed decision on whether or not to renew practising privileges. The review included information on medical practice, relationships with patients and colleagues and any training completed recently, as well as any outliers in the doctor's practice as regards mortality, readmission rates or sepsis.

# Surgery

- We saw an induction plan for agency theatre staff and evidence that it was being used.
- Theatres had closed for a week in August to allow all relevant staff to train on the new equipment and ways of working in the new theatres. The old theatres had been decommissioned. Most staff working had completed a course on managing patients in recovery, and the remaining staff were booked on training next year.
- The critical care and cardiothoracic RMOs told us they were never asked to work outside their scope.
- There was a cardiovascular perfusionist (a specialised healthcare professional who uses the heart-lung machine during cardiac surgery). There was a critical care cardiac meeting with the perfusionist and senior sisters to discuss learning each month. However, this was not attended by a surgeon, anaesthetist or a cardiologist.

## Equipment

- The inspection team observed the new theatres and found them to be thoughtfully designed and well-equipped. This view was echoed by the surgeons and anaesthetists we spoke with, who reported the new theatres had high quality equipment.

## Multidisciplinary working in surgery

- Multidisciplinary team (MDT) working within the surgery service was under consideration, but had not really started. We saw that a formal cardiology MDT was being set up. The intention for these meetings was to review activity in the cardiac catheter laboratory, complication rates, infection statistics and mortality. The first meeting had been in August 2016 and would be monthly. They would review complex cases where discussion would be beneficial. MDT discussion outcomes were not currently recorded in patient notes.
- Similar multi-disciplinary meeting frameworks were being established for cosmetic surgery and orthopaedics.
- We observed multidisciplinary input in caring for and interacting with surgical patients on the wards. Staff of all disciplines, consultants, nursing and physiotherapists, worked alongside each other throughout the hospital.
- Referral arrangements for physiotherapy from surgery were informal which was not good practice. Physiotherapists looked at theatre lists daily to identify patients who might need their input. There was a risk that these informal arrangements might mean patients

fell between services and did not receive the support they needed. Since inspection CQC were informed that a formal handover meeting between physiotherapists and a senior ward member of staff had been introduced. This meeting was used to confirm that all patients requiring intervention are seen and do not “fall between services”.

- The hospital did not employ dietitians or occupational therapists, but we were told their advice could be sought at the request of a consultant.
- We observed well-structured discussions between a physiotherapist and a patient practicing walking up stairs.
- Nurses referred patients to community health and social services where additional support would be needed by a patient at home.
- A bariatric nurse and an appropriately qualified anaesthetist were involved when patients were admitted for weight loss surgery at the hospital.

## Seven-day services

- Pharmacy opening times for the on-site dispensary were between 9am and 8pm Monday to Friday, 9am to 1pm on Saturdays and 10 am to 12pm on Sundays. Outside these hours a pharmacist was on call to provide pharmaceutical advice and support to staff.
- There were two RMOs on site 24 hours a day during the week. There was always a critical care RMO. The cardiothoracic RMO alternated with the medical RMO at weekends. The RMOs had access to consultants who were on call for their patients, or to a nominated consultant in their absence. The RMOs said they contacted the consultants out of hours when required.
- There was an engineer available Monday to Saturday during working hours. An out of hours on call system operated outside of these hours for emergencies.
- Theatres were staffed and used, Monday to Friday 8am to 8pm, and on Saturdays from 8am to 5pm. There was an on call team for theatres outside of these hours, which meant that emergency procedures could be carried out, should a patient need to return to theatre..
- A pathology laboratory was open Monday to Friday.
- A consultant microbiologist was available 24 hours a day.

## Access to information

- The Spire national policies were available electronically, but there were also paper copies on all wards. Some local policies were available in paper form on wards.



# Surgery

Earlier in the year there had been no systematic process for ensuring that local policies were up to date, or ensuring that changes in national policies were followed and the high risk had been recognised on the risk register. By the time of inspection, a process had been implemented and policies were being managed in line with Spire policy HOP 01 - Procedures for the management of policies.

- All nursing and medical documentation, including risk assessments, care plans and theatre documentation, was in paper form.
- Digital images and test results were stored electronically and relevant surgical staff, consultants and RMOs had individual logins to view these. NHS patients' records were photocopied on discharge, and passed on to the referring NHS hospital. The original surgical record was retained by St Anthony's hospital.
- Computer stations with intranet and internet access were available on the surgical wards for staff to use. There were relatively few.
- Wards had a communications book which contained clinical updates. Staff had to sign to indicate they had read the new information.
- Spire produced 'hospital briefs' for staff on topics such as Dementia, Safeguarding and the Malnutrition Universal Screening Tool (MUST)
- Agency nurses and locums had access to the same ward training documentation, updates and information as permanent members of staff.
- A white board in the theatre block displayed daily theatre lists. Staff offices on wards had white boards in the office which displayed key patient data.
- All staff had email accounts that allowed secure transfer of information by email within and outside the hospital.
- The hospital was setting up an electronic discharge system to send information to patients' GPs where the patient wanted to share information with their GP.
- A consultants' newsletter reported on activity and incidents, and hospital based staff were also updated with a newsletter.

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

- Patients told us nurses explained treatment and care and sought verbal consent before proceeding. We observed this taking place.
- All patients we spoke with said their consultant had given them information about the benefits and risks of

their surgery at a consultation appointment, before they signed the formal consent form. They therefore had time to think about the risks and benefits in advance of the surgery. We were told that at this hospital all patients will always have had an appointment with the consultant on a separate occasion before having surgery. There were no one stop shop procedures. One patient told us they appreciated being asked on the day if they still wanted to proceed.

- Consent forms, which complied with Department of Health guidance, were kept with patient notes. They identified the procedure to be undertaken, associated risk and had the signature of the professional involved and the patient. Patients we spoke with told us they had separately consented for anaesthesia, in line with the hospital's policy.
- Patients were asked if they would prefer spinal anaesthesia, local anaesthesia or a general anaesthetic where there was an option.
- The sample of patient records we reviewed demonstrated consent for surgery was completed in full.
- Staff we spoke with had a general awareness of the Mental Capacity Act, 2005 and told us they would refer patients to the hospital safeguarding team if patients required an MCA referral.
- Staff were aware of the role of the independent mental capacity advocate (IMCA) who are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about serious medical treatment, and power of attorney. They were familiar with best interests' decisions, and understood that a patient might make an unwise decision, but that did not mean they lacked capacity.
- All staff had a small booklet, known as a z card: 'Your clinical statutory and mandatory training' which included reminders on key aspects of mandatory training including safeguarding and DOLs.

## Are surgery services caring?

Good 

We rated caring as good because:

- All staff introducing themselves and interacted in a friendly way with patients.

# Surgery

- There were systems to collect patient feedback and patients' views were largely positive.
- Nurses had sufficient time to spend with patients to reassure them.
- Most consultants visited patients daily, although sometimes quite late in the evening.

However;

- Some self-paying patients were anxious about unanticipated costs.

## Compassionate care

- We saw staff providing compassionate and considerate care to patients. Staff from all professions interacted with patients and relatives in a professional and thoughtful manner. We saw reception staff welcome new patients and escort them to their rooms on arrival.
- The patients we spoke with were complimentary about the quality of care they received. Some patients told us nurses were 'kind and gentle'. One patient described staff as "very attentive" and another patient described feeling like 'an honoured guest'. A third patient mentioned 'the little touches' that made them feel better about being in hospital. Several patients had been inpatients before and others said they would be happy to return to the hospital if necessary.
- Comments received from patients on comment cards to us included 'The operating staff were caring, making sure I was comfortable and pain free'; 'I have always received the best care and attention in all these years that I have been coming here' and 'I have nothing but praise for the staff who looked after me on this and previous occasions. I was treated like an honoured guest.'
- Patients and any family members told us that staff had greeted them with a smile and were friendly. Patients told us staff had explained call bells and using the hospital's Wi-Fi. A poster in patients' rooms reminded them to buzz for help.
- Some patients mentioned that call bells were not answered instantaneously when staff were busy; however, we observed prompt responses during our inspection. Two patients mentioned that staff did not always ensure call bells were in reach and said they sometimes felt isolated in a room where they were not in sight of staff. Many patients kept their doors open so

they could see staff going by. Patients told us the housekeeping staff were courteous, knocked on doors and introduced themselves and were happy to chat if the patient wanted to.

- Theatre staff, throughout the patient's journey, considered their dignity and privacy. Patients were covered throughout transfer from the ward areas to theatres. Patients were only uncovered once in the operating theatre. Patients in recovery were kept covered.
- The hospital collected feedback from patients using a monthly patient satisfaction survey. It included questions on the quality of food, the extent to which their pain was well -managed, and the quality of nurses and other key staff groups. It also incorporated questions from the Friends and Family Test. The Friends and Family Test (FFT) results were consistently very good across surgery areas, with an annual average recommendation score of 96% for the period April 2015 – March 2016. . Each question was analysed by whether patients were NHS, insured or self-paying. Data was provided monthly and analysed along with free text comments.
- All patients responding in June 2016, considered care and attention from nurses was excellent (91%) or very good (9%). 93% rated the care from their consultant as excellent or very good and 83% gave this rating to RMOs. Nurse to patient ratios were high enough to allow nurses time to care for patients. All staff had attended a customer service training programme. Letters of compliment and feedback from the Patient Satisfaction surveys regularly highlighted 'good' care from the patient and family/carers perspective. Volunteers had been an established part of hospital over many years and provided a League of Friends shop and visited patients, although some volunteers felt the hospital management did not support their role. Nuns from the convent also visited patients as volunteers
- We observed good interaction by all grades of staff with patients and their relatives. We heard staff speaking to patients politely and in a warm and pleasant manner. There was evidence that staff on the wards had established good relationships with patients and their relatives. Some patients told us they had developed a trusting bond with the nurses. They mentioned some individual nurses by name as being exceptionally caring and compassionate.

# Surgery

- The deputy matron and the IPC lead undertook ward rounds to speak to patients to check they were happy with the standard of care.
- 83% of nurses (hospital-wide), up to September 2016, had attended compassion in action training which was mandatory at the hospital. This was a high completion rate.

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

- Most of the patients we spoke with were involved as much as they wanted to be in their care and treatment. They told us staff explained things to them in a way they could understand, and were clear about their recovery goals and extra support, such as physiotherapy.
- Patients on surgical wards told us their consultant surgeons had fully explained the risks and benefits of the procedure and provided information about after care and home support. The patients we spoke with felt involved in their care and were given opportunities to ask questions.
- Staff involved patients throughout their pathway of care. Staff explained procedures to patients in a calm, unhurried way, allowing time for conversations about any concerns the patient might have. The patient satisfaction survey showed that earlier in the year, not all patients had been clear about side effects of medication (scores were around 75%). The hospital score had improved to around the Spire average of 88% in May and June 2016
- Patients told us they had regular contact with their consultant, who answered all their questions, including about side effects and pain. A patient who had been admitted for 'unexpected' surgery said that the consultant had given careful explanations and they had all their questions answered.
- Comments received from patients included 'Everyone has acted very professionally and taken time to ensure I was kept informed of what was happening next.'
- Most patients knew and understood the costs of treatment. Insured patients were generally not expecting extra costs. However we heard from some patients and from staff that some self-paying patients had worries about the cost of extra medicines prescribed, and were anxious when they were found to need additional treatment that was beyond what had been agreed before they were admitted.

- We did note however, that some patients wearing red allergy bands were not aware of the reason. However, allergies were discussed with all patients as part of the pre-assessment process and a patient was given the red band to wear on admission where this is the case, as an alert to staff.

## Emotional support

- Nurses with experience in cardiac nursing were able to draw on their experience to reassure cardiac patients
- One patient we spoke with said 'nurses pay attention to my feelings' not just my medical needs. Several patients mentioned the support they had from specific nurses when they were feeling low. We saw from the patient satisfaction survey in June 2016 that 93% of patients found someone in the hospital to talk to about their worries and fears.
- Comments from patients included 'The nurses were attentive of my anxiety and tried to reassure me.' and 'I was reassured before the operation as I was very nervous but I felt in safe hands.'
- One patient had a birthday party arranged for 14 people which indicated thoughtful attention to a patient's needs.
- Nuns in the convent on site could offer mass to patients who would like this. The hospital was able to facilitate links with religious leaders in the local community, such as imams as required.
- Clinical and non-clinical staff checked on patients' well-being regularly and spent time with patients to discuss concerns and provide support and reassurance before and after their procedures.

## Are surgery services responsive?

Good 

We rated responsive as good because:

- Patients had timely appointments and treatment, that were convenient to them
- Appointment times were flexible including evenings and weekends.
- Cancelled appointments were re-scheduled within 28 days.
- Visitors could come to see patients at any time.

However,



# Surgery

- The hospital should review its support elderly patients and those living with dementia.
- There was little evidence of change of practice in relation to complaints.
- A few patients were not satisfied with their admission experience, although 81% thought it was excellent.

## Service planning and delivery to meet the needs of local people

- Patients had access to the consultant of their choice.
- Patients told us the appointments system was easy to use and they could make appointments at times to suit them including evening and weekends.
- Chaperones were always available if required.
- Some NHS patients were treated at the hospital if an NHS hospital could not perform the surgery on time. NHS hospitals mainly referred patients whose pre-operative assessment showed they were low risk and did not need an anaesthetic review. For orthopaedic patients, the same surgeon who would have carried out the procedure in the NHS, carried out the surgery at St Anthony's hospital. They used the same implants, if relevant. One referring hospital told us they sent patients needing knee arthroscopies, anterior cruciate ligaments (ACL), shoulder decompressions, shoulder arthroscopies/stabilisations, or non-complex hip/knee replacements. Consultants were satisfied that St Anthony's hospital achieved the same clinical outcomes.
- However, one NHS hospital reported weaknesses in the quality of communication from St Anthony's Hospital with NHS patients. It was unclear where the fault lay, but we saw that on one occasion a female patient had been documented as male, and another patient was only given one days' notice of their procedure at St Anthony's hospital. Also, some patients had not understood that follow up, such as physiotherapy, would be within the NHS and not at St Anthony's Hospital. The same NHS hospital reported there had been some clinical coding discrepancies for procedures. We saw evidence that they were working with St Anthony's staff to improve coding.
- Visiting hours were open, allowing friends and relatives to visit patients when they wanted. Nurses said they generally asked people to leave by 11pm, so they knew exactly who was on the ward at night for safety reasons.
- There was free parking in a large car park.
- All patients had single rooms with ensuite facilities.

- Privacy and dignity was maintained on wards by having single rooms with individual bathrooms and a 'presence green button' that alerted staff to people being in the room.
- There were no activities for people to be occupied and stimulated.
- We met one elderly patient who was not having surgery as the consultant thought the procedure would be too risky without access to intensive care which was suspended at the time of the inspection. The patient understood the high risk of anaesthetic to an elderly person.
- Some patients who knew the hospital under its previous charity ownership said it was positive to be part of a larger structure and that the investment in the hospital was welcomed.
- There was an on-site pathology service.

## Access and flow

- Patients had timely access to assessments, diagnosis and treatment. There were minimal delays in accessing treatment following diagnosis. A date convenient to the patient was agreed, usually within a week or two of the consultation.
- In the six weeks prior to our inspection, the surgery service had six new theatres. At the time of our inspection, the new theatre block was not yet being used at capacity. Senior leaders told us they planned to expand this service over time
- There were 10-15 cardiac cases a week, for angiograms, angioplasty, stent insertion and pacemakers.
- There had been four cancellations of surgery for non-clinical reasons in the year to March 2016 and all had been rescheduled within 28 days. Staff said new bookings were scheduled quickly. There were 17 cancellations in total from April 2016 to end August 2016. Data was only collected from April.
- Senior staff reported and investigated all cancelled operations.
- From January 2015 to December 2015, the hospital had admitted 1711 inpatients, 6587 day case patients and 7525 patients had been through theatre.
- From January 2015 to December 2015, there had been eight unplanned transfers of a patient to another hospital. In the last 12 months, there had been three unplanned transfers which was not high by comparison with other independent hospitals.

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- Staff told us that although the flow within surgery from admission, through theatres, wards and discharge was mostly managed effectively, theatre sessions sometimes overran. Theatre managers were trying to tackle this through seeking better estimates from surgeons of the time needed for procedures to avoid delays to other patients. This would help avoid late running beyond 8pm when the theatres were due to close for the night. However, this plan was not yet working. On our unannounced inspection, at least one patient was in theatre for routine surgery at 8.30pm. One patient told us that, on their previous admission, they had returned to the ward from recovery in the early hours of the morning.
- Analysis had shown that 25% of theatre bookings were short notice bookings which potentially caused problems in ensuring sufficient staff were rostered, risked a lack of specialist equipment needed by the surgeons and meant there was not time for the patient to have a full pre-operative assessment. Theatre staff were attempting to require at least 72 hours' notice of all bookings as well as fully completed booking forms from surgeons, to enable safe planning, although we noted that Spire's policy said surgeons should give seven days' notice of bookings.
- The theatre team was recruiting an administrator to manage the bookings for all theatres by consultants or their secretaries. They expected this would help ensure the correct amount of time was allocated for each patient, reduce the risk of overruns and stop late surgery or cancellations which could be a risk to patients when staff were tired. Also, this would avoid last minute bookings where there was a risk that pre-operative assessment was not done and that equipment was not available.
- Across the hospital, 83% of inpatients were discharged before 11am. Some patients who attended for day procedures chose to leave quite late, up to 11pm. Staff considered this acceptable as long as the patient had support at home. Only 39% of day patients were discharged within 6 hours of their procedure.
- Staff told us they had contacts in local authorities to plan appropriate care packages for relevant patients when they were discharged home. Even if there were short delays to discharge, this did not block beds for other patients as the hospital always had some spare beds.
- On discharge, nurses sent a copy of the patient's discharge letter to the General Practitioners (GP) with the agreement of the patient. This detailed treatments received and any follow up required to promote a joined up approach to post-operative care.
- Data from the clinical scorecard showed the target for the percentage of patient's responding with 'excellent' to the question of being prepared for discharge was achieved, with an average score of 75% in 2015, against a target of 71%.
- We were told that patients were occasionally moved between wards during their stay to maintain patient safety and safe staffing as well as where there was a medical reason such as their condition deteriorating and they required intensive care. Patients were cared for in single rooms and the hospital managers considered that patient movement had minimal impact on patients and their families.
- Patients were treated within NHS target times. Such patients had post-operative follow up appointments at their NHS hospital. All clinical case notes were sent across to the hospital before surgery and collected when the patient was discharged. The hospital retained copies of all clinical notes and discharge information, but provided copies to the NHS hospital.

## Meeting people's individual needs

- Staff were able to accommodate patients' individual dietary requirements. Patients chose their menu choices in the morning for lunchtime service and again in the afternoon for evening meal service. A staff member asked patients for menu choices. Some patients said they did not always receive what they ordered. Visitors were offered refreshments and could pay for a meal if they wanted to eat with a patient.
- There was information for cardiac patients and visitors on display in the cardiac ward to support information that patients had from consultants and nurses.
- Patient rooms were modest in size, but well laid out with adequate space to move around. Partners were not normally allowed to stay because of space constraints, but this was occasionally arranged if there was a clear benefit to the patient.
- Three patients mentioned to us that it was hard to control the ambient temperature in rooms. Bathrooms could be too hot. External temperatures were high

# Surgery

during our inspection. Not all rooms were air-conditioned. Windows could be opened to let in some air but were not wide enough for someone to fall out of. All patient rooms had free Wi-Fi and television.

- The call buttons had different buttons for nurses, lights and catering services as well as a torch on the back. Patients found these convenient to use.
- Staff had experience of dealing with patients with learning difficulties; for example they would allow a relative to accompany patients to the anaesthetic room and recovery area.
- A modern, well-lit chapel on site offered a quiet space for any patient regardless of faith, although it was predominantly Christian in appearance.
- All patient rooms had a cross on the wall, from the Roman Catholic origins of the hospital. However, staff showed us they could take these off the wall if patients did not want them.
- Interpretation services were available as needed and arranged, via an external service level agreement, either face to face or via telephone based on patient preference.
- Patients had a daily menu to choose meals from and onsite catering staff prepared fresh meals. Patients had access to food such as sandwiches and soup between meal times as required. Water was available to all patients throughout the day. The hospital had undergone a Patient-led assessment of the care environment (PLACE) for the first time in June 2016 and scored above the national average of 88%. The only points noted in relation to food were that unsaturated spreads were not offered nor was fresh fruit available at all times.
- Patients responding to the hospital's own patient satisfaction survey in June 2016 rated the quality of the food at 82%, below the Spire average of 88%.
- Patients who had been inpatients under previous ownership said the quality of the food was not as good now. Three patients mentioned orders were not always fulfilled accurately. However, most patients we spoke with commented positively about the food.
- Although Spire produce guidelines for staff about dementia, the hospital made less provision for the elderly or people living with dementia than might have been expected for a hospital taking elderly patients. For

example, signs were not at eye level signs, there was little use of contrasting colours in patient rooms, distinctive toilet doors, red plates or large faced clocks. Patient rooms only had a digital clock.

- In the 2016 PLACE assessment, the hospital scored 66.4% for dementia-friendly environment measures. This is below the national average for 2016 of where 75% of requirements were met.
- Although Spire produced central guidance on 'This is me' passports, these were not used for patients with dementia at St Anthony's hospital. Staff told us they would ask relatives about the name a patient liked to be called, their normal routines and whether they needed reminders or support with daily life. However, the wards were calm and a reasonably domestic in scale which would help alleviate confusion. Staff would book one to one care to look after patients who were suffering confusion, as appropriate.

## Learning from complaints and concerns

- The hospital had a complaints policy for staff to follow and received 79 complaints in 2016 of which 24 (30%) were still open. The majority of complaints were about billing and charging. There were few complaints about theatres.
- We noted that complaints about patient experience were on the risk register.
- Patients said they knew how to raise concerns and give feedback and had information about this before admission as well as other information about what to expect. We saw a leaflet inviting comments called 'Please talk to us'.
- Nurses told us ward managers were proactive in preventing complaints and addressed most concerns informally and directly. Staff told us this helped to prevent formal complaints.
- Complaints in writing and by telephone were recorded, but not informal complaints in wards or other areas. A recently established Quality Improvement Group (QIG) considered complaints and patient satisfaction survey results to identify potential areas for improvement. Departments were asked to contribute to solutions.
- We learned from one NHS hospital that commissions care for its orthopaedic patients at St Anthony's hospital, that there was not always clear communication with patients about where they would receive follow-up physiotherapy.

# Surgery

- Patient feedback from the monthly patient satisfaction survey was shared with staff, but staff were not able to tell us of changes to practice made in response to formal complaints.

## Are surgery services well-led?

Requires improvement 

We rated well led as requires improvement because:

- The control of risks needed strengthening to reflect all the risks and to include explicit mitigation actions.
- There were shortfalls in the management of some consultants who booked patients late, did not use pre-operative assessment and did not observe the WHO checklist.
- The analysis of the causes of serious incidents did not go into sufficient depth, and did not translate quickly enough into learning and improving practice.
- The hospital governance structure was very new and processes were not embedded. It was too early to assess its impact.

However;

- The hospital had a clear vision and values.
- There was effective and inclusive leadership in theatres.
- The views of patients were gathered.

## Vision and strategy

- The hospital's vision and values reflected Spire Healthcare's national vision and values: to build complex services and increase market share with the support of the stakeholders, consultants, patients, staff and regulators. Based on the foundations of the unique ethos of care at St Anthony's, the managers aimed to make the hospital a beacon hospital within the Spire network. They aimed for the hospital to be in the top 25% of Spire hospitals for each of the key measures audited, including patient, staff and consultant satisfaction surveys.
- 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 were aware of and broadly understood Spire's vision and values. Nursing staff were proud of the care they offered to patients.

- The vision of theatre managers was to give safe and effective surgery to patients, improving patient flow and theatre utilisation. There was no clear vision for medicine.

## Governance, risk management and quality measurement

- A hospital director and a matron led the hospital. They were supported within the senior management team (SMT) by the chair of the medical advisory committee (MAC), finance and commercial manager, business development manager and heads of clinical and non-clinical services. There was a weekly SMT meeting for which action points were minuted. The governance arrangements were well-defined, although some aspects had only been put in place during 2016 and it was too early to judge their effectiveness.
- A "Task Force for Transformation" met monthly, focused on the continuing changes to drive changes in the hospital since its acquisition nearly two years ago.
- A Hospital Effectiveness meeting (HEM), comprised the heads of department and was overseen by a member of the SMT, usually the head of clinical services. This group met weekly and reported to the clinical governance committee. The hospital director received papers and occasionally attended. This meeting reviewed the quarterly clinical scorecard.
- The hospital's clinical governance group, chaired by a consultant and MAC member, met quarterly. We reviewed minutes from the meetings, which contained the facts of reported incidents but no record of discussion or conclusions. Actions identified were not time-bound. The clinical governance committee did not make a formal report to the MAC about incidents. We were not fully assured that there was sufficient oversight of, and learning from incidents.
- After the former chair of the Medical Advisory Committee stepped down in October 2014, the hospital director took the opportunity to refresh the membership and role. The process had taken a year. The current chair was a consultant surgeon. There were 11 consultant members. The committee met quarterly.
- We reviewed the minutes of the last three MAC meetings, which were written in an informal style. The agenda followed a format set by Spire. There was more focus on financial issues than on hospital practice and healthcare. Good practice would suggest the MAC should twice a year review and discuss all deaths;

# Surgery

unplanned re-admissions to hospital; unplanned returns to theatre, unplanned transfers to other hospitals; adverse clinical incidents; incidence of post-operative deep vein thrombosis and post-operative infection rates for the hospital. There was no evidence in this minutes that these issues were discussed.

- We would also expect the MAC to review a high level risk register. The absence of this was a gap in assurance.
- The hospital's risk management was weak. The risk register contained all the risks for each department which meant it was very long. This made it difficult for the senior management team (SMT) and the clinical governance team to have full oversight of the key risks at the hospital. The top risks were financial.
- However, the risk register did not document some of the risks we identified. Mitigating actions were often not sufficient to address risks, for example the fact that some consultants apparently did not comply with the consultant handbook said that an existing control was 'adherence to the consultant handbook', but not how this would be monitored and achieved. There were no timescales for mitigating action to resolve risks recorded on the risk register. We saw no risks directly derived from serious incidents at the hospital, such as the risk of undertaking surgery on elderly patients without full pre-operative assessment. We did not see systems to audit whether the existing controls on the risk register were achieving the desired result.
- The risk register specific to surgery, listed 11 theatre risks, the highest of which was failure to follow the WHO checklist, because of the surgeon deciding not to use'. This was a serious and significant risk and unacceptable practice.
- The highest risk on the surgical wards was failure to prevent post-operative complications. Staff told us that one action to mitigate this was for every shift to have a nurse trained in acute illness management. This had not yet been achieved on every shift, although training had started. This action was not on the risk register as a mitigating action. An action indirectly referred to was having a full medical history but there was no target date for ensuring adequate pre-assessment was carried out.
- Senior managers recognised the governance processes were new and still evolving. They had only established most committees in the past year.
- We had significant concerns about the rigor and timeliness of Serious Adverse Event investigations. The Serious Incident Framework 2015/16 recommends reporting within two working days, establishing the need for full investigation within three working days and completing reports within 60 working days. We reviewed four root cause analyses (RCA) reports. The process at the hospital was slow. The investigation of an incident in January 2016 had begun in March 2016 and was not completed until 6 September 2016. RCAs were on the risk register, but in our view, their quality was a more serious risk than the grading given.
- Investigators had not been trained in root cause analysis. Some of the analyses we reviewed contained elementary errors; for example obviously incorrect dates and lack of detail on timing. There was not always full information about the medicines patients were taking, or their NEWS scores. Staff were not able to demonstrate evidence of urgent changes made in response to serious incidents in the past year. Action plans did not always result in SMART (specific, measurable, attainable, relevant and time-bound) actions, and learning to prevent recurrence. Several issues identified as poor practice in these RCAs were observed on our inspection, so effective learning had not yet taken place.
- Senior managers told us they provided feedback from governance meetings to their respective teams in team meetings and emails. Staff at ward level did not think they received feedback.
- At local level in surgery, we considered governance was good and theatres were well run, with effective information sharing systems. There were daily theatre meetings before the operating list started. On Friday meetings took place to plan for the following week. Senior theatre staff met monthly to discuss wider issues, and 'all theatre staff' sessions were also run monthly, alternating the days each month, so part-time staff were included as far as possible.

## Leadership and culture of service

- Some key posts were vacant, notably the head of clinical services/matron. Although recruitment was in hand the head of clinical services from another Spire hospital was covering that role at the hospital. A deputy matron had an additional role: to develop paediatric services which would initially be open to outpatients and later incorporate surgery.



# Surgery

- Most staff we spoke with spoke well of the executive team hospital and felt there was a reasonably 'open door' culture.
- The hospital had briefed most staff on the Duty of Candour, however we did not see arrangements for monitoring the application of this.
- Traditionally, the consultants had not been much involved with the hospital. However, some were now running education sessions for nurses and other staff.
- Theatre staff told us the culture had become more positive in the past few months. Some told us the executive team, had not always listened to their concerns. However, most theatre staff appeared to like working at the hospital. The theatre staff and consultants greatly appreciated the quality and design of the new theatres. For other staff they were a visible symbol of the benefits of investment.
- Within theatres, the senior theatre managers worked together as an effective team. We observed an inclusive and constructive working culture within this service.
- Staff completed equality and diversity training as part of their mandatory training and Spire had a policy for equality of opportunity which staff were aware of. There were very few staff from black and ethnic minority groups, only 2%. This was a much lower percentage than the Spire average.
- The staff survey results for 2014 and 2015 were benchmarked against other Spire hospitals. Many of the results at St Anthony's hospital were lower than the Spire averages. This was not surprising, given the extent of recent change. The scores for feeling senior managers appreciated challenges of staff on the ground or gave rationale for their decisions was low, below 45%. Spire average 61%. A particular concern was staff perception that there were not enough staff to care for the number of patients. However, on our inspection, we found most staff we spoke with were positive about working at the hospital.
- Several staff members told us they now had more opportunities for professional development than in the past.
- The hospital director held staff drop-ins every 2-4 months which gave staff another opportunity to suggest changes. Examples of changes made as a result were changes to the theatre lists and an increase in the number of parking spaces for staff.
- Managers held a quarterly 'birthday celebration' with tea and cake for all staff with a birthday in the last quarter. An 'inspiring people' award was given to staff who had gone over and above' their duty. Other events were celebrated with staff, such as National Nurses Day, Easter, Christmas, the Queen's birthday.
- There was a counselling service for staff through occupational health service.

## Public and staff engagement

- We spoke with several patients who had been to the hospital many times. Their readiness to return was a testament to the care given.
- The hospital gathered patient opinion using the Friends and Family Test, and the Patient-Led Assessment of the Care Environment, which had been carried out at the hospital for the first time. In addition, senior staff 'walked round' clinical areas several times a day to ensure oversight and highlight any concerns and be visible and accessible to all staff.
- Most staff we spoke with acknowledged that the change from being a charity run hospital, to one that was part of a wider hospital network had been unsettling at first. Some staff had left. Most staff we spoke with thought the changes had been necessary to modernise hospital practice.

## Innovation, improvement and sustainability

- The management had worked hard to modernise the hospital, focusing on areas which had been highlighted in their internal reviews as not yet meeting national standards. Patients and staff recognised that there had been improvements.
- An active cardiac support group had been running for 23 years for former patients and their partners which had speakers and staff on hand to answer queries. There were 10 meetings a year. This had been nominated for Spire's national inspiring people award.
- New theatres opened wider opportunities including expansion of services to provide paediatric surgery in due course. The design of the theatres was to be commended for patient flow and access and a vision for the future.



# Critical care

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

## Information about the service

The critical care unit (CCU) at St Anthony's Hospital provided care and treatment primarily to adult patient's having elective surgery. The unit did not, at the time of inspection, take emergency admissions from other hospitals or critical care units, although it had done so in the past. Most patients who were admitted were those who had been expected to transfer after surgery, but patients could be escalated to the critical care unit from wards in the hospital if their condition deteriorated.

Surgical lists were provided in advance, to help the critical care unit with planning. In the event of an unplanned surgical admission, staff told us they would have some advance notice from theatre and were usually able to make suitable arrangements such as additional staffing.

At the time of inspection the critical care team were only treating Level 1 patients, that is patients who could have ward-based care and did not need organ support. 'Level 3' and 'Level 2' refers to the acuity of a patient. A Level 3 patient will very likely be ventilated and need intensive, 24-hour one-to-one care. A Level 2 patient is considered to be high dependency and requires significant nurse input and is usually cared for on a nurse to patient ratio of one to two. A service level agreement with an NHS hospital was being arranged, in the event that a patient needed transfer to a higher level of care, although this agreement was not actually in place on our inspection. We were subsequently told that the agreement was implemented after our inspection.

We have not rated this service because critical care at level 2 and 3 was not being provided during our inspection. However, as the service expected to resume later in the year we reviewed the hospitals level 2 and 3 capabilities,

based on previous data and talking to staff. When fully operational, there would be eight critical care beds available; six at level 3 and two at Level 2. Consideration was being given to adding four more Level 1 or 2 beds in a ward adjacent to the Intensive Care Unit (ICU). Between April 2015 and March 2016, the critical care unit treated 728 level 3 patients and 750 level 2 patients. There had been 22 resuscitation call-outs to wards.

We spoke to 18 staff, three patients and one relative. We checked five patient records.

# Critical care

## Summary of findings

We inspected critical care but did not rate it as the service was suspended at the time of the inspection and only providing level 1 patient care.

The service had recognised the changes needed to bring it into line with current requirements for providing level 2 and level 3 critical care, such as staff competencies and developing robust clinical effectiveness processes, and was working towards this with a view to providing level 2 care at the end of 2016.

## Are critical care services safe?

Not sufficient evidence to rate 

- The environment, equipment and medicines management were adequate.
- We saw complete entries in patient records, including monitoring data.
- There were appropriate mechanisms for assessing risk and good access to medical advice.
- There were back up arrangements for power outage and other incidents.

However

- We found staff knew about incident reporting, but root cause analyses, hospital- wide, were not effectively carried out. Infection control appeared adequate, but there were not enough audits carried out to give full assurance.
- There were not yet enough nurses, and other staff such as pharmacist and physiotherapists with the right critical care competences to enable the unit to offer higher levels of care safely.
- Additional equipment was also needed. Staff were developing clinical guidelines in line with those published by the Intensive Care Society such as for sedation, disease prevention and management and specialised care.

## Incidents

- Staff said incident reporting had improved since Spire had taken over the hospital. RMOs reviewed all critical care incidents themselves. Staff at all levels had incident training.
- Nursing staff were able to explain how to report incidents using the electronic reporting system, but did not receive feedback and learn from incidents. Nurses and healthcare assistants were unable to tell us about examples of shared learning from incidents including learning across the hospital.
- The hospital had reported six serious incidents (hospital wide) in the past year. 6% of clinical incidents were reported as severe including death.
- There were 95 incidents in critical care between 1 January and end July 2016. There had been five deaths, five pressure ulcers, five incidents of non-neutropenic sepsis. There had been 36 unplanned admissions,

## Critical care

including four from other hospitals. Seven incidents had severe harm and 26 moderate harm. Although the incident log said incidents were recorded so lessons could be learned staff were not able to show us trend analysis of incidents or action being taken to reduce incidents and monitoring of the success of those actions.

- Incidents (hospital-wide) were not closed promptly. Only 34% of incidents were closed within the hospital target of 45 calendar days. The target was to close 75% of incidents within this time period which was far from being achieved which was poor.
- Mortality and morbidity meetings were being introduced in critical care and one meeting had been held before our inspection.

### Duty of candour

- Staff explained to us the duty of candour and the importance of being open with patients and families about mistakes. They also told us about the importance of completing an incident report and reporting mistakes to their line managers.

### Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit for patient and their families to see, of the prevalence of avoidable harms. It covers new hospital acquired pressure ulcers, patient falls with harm, new venous thromboembolism (VTE) and urinary tract infections (UTIs) associated with catheters.
- The hospital did not meet its clinical outcomes targets for falls, pressure ulcers or venous thrombo-embolism, between January and the end of August 2016.
  - Pressure ulcer (PU) prevalence was 0.6 per 1000, higher than the goal of fewer than 0.1 per 1000. This was one patient.
  - The number of patients having falls was 2.53 per 1000 against a target of less than 2. We were not provided with the number of patients this represented but estimated this to be four patients.
  - VTE risk assessment 75% had been poor (75%), below the hospital target of 95%, between April and June 2016. By September 2016, the rolling scorecard showed this had risen to 100%.
- There were six incidents of hospital acquired VTE or PU in the year April 2015 to March 2016.

- Staff developed action plans to address concerns about falls or pressure ulcers where rates were above the national Spire target. These were submitted to central teams for review and scrutiny.

### Cleanliness, infection control and hygiene

- Staff were aware of infection control. We observed staff washing their hands, complying with the 'bare below the elbows' policy and using hand sanitisers when entering and exiting CCU.
- The departmental Infection Prevention and Control (IPC) link nurse ran a quarterly audit. We saw evidence that the manager and IPC link nurse reviewed the outcomes of the audit and implemented actions where the tool had identified an area of concern.
- We saw an audit from May 2016 in the CCU, which observed correct handwashing techniques, and staff being bare below the elbow and not wearing rings or watches in compliance with hospital policy.
- We saw cleaning schedules, but no evidence of regular cleaning audits, other than a site review in July 2016 that had made recommendations. There was some dust on the pendant tracks.
- A housekeeper was available all day to assist with cleaning needs. We saw evidence of cleaning in all areas throughout the day.
- Staff said there was access to deep cleaning if required, for example following the discharge of a patient who had an infection. A full deep clean had been carried out in the summer of 2016.
- Although equipment in the storage area appeared clean, there were no stickers to indicate when some less frequently used items had been cleaned, such as the Bair Hugger (a temperature management unit).
- There was an onsite microbiology laboratory which sent results electronically to clinicians.
- If a patient was subject to isolation precautions, they would be accommodated in a side room. There were six single rooms.

### Environment and equipment

- The unit was in the process of reviewing the extent to which it fully met Health Building Note 04-02 – Critical care units. It was equipped according to the guidelines provided by the Intensive Care Society and with reference to the basic standard provided in Department of Health guidance on Admission and Discharge for Intensive and High Dependency Care.

## Critical care

- There was limited storage for equipment in the critical care area, and some equipment was stored in a side room. The limited storage was on the risk register. Not all equipment in this room was in date. We saw tubing for ventilating patients in an open bag and with no filter and a power pack had not been checked for electrical safety since 2014.
- In the main store room, equipment was mostly labelled, but some items were mixed up in the named drawers.
- Emergency trolleys for resuscitation, and equipment for difficult airway management and tracheostomy, intravenous and arterial access, chest drain insertion and management, open chest and major haemorrhage, were all checked and recorded. However, we saw from records that checking had not been consistent in the past.
- Staff told us they had access to the equipment required. We noted that some equipment to enable the unit to meet current critical care standards was not yet available.
- We observed a doctor visiting a patient in ITU place a bag on a vacant bed, which was an infection risk. Subsequently the hospital told there was space for visiting medical staff to leave coats and bags in the staff rest room or the main office, to minimise infection risks and this should have been used.
- There was a dedicated waiting for families of patients in critical care to wait when they were visiting. This was signed ITU Visitors Lounge.
- A Control of Substances Hazardous to Health (COSHH) database had been set up in the summer. There were no COSHH audits available.

### Medicines

- We found that medicines were stored securely and appropriately. We saw the results of a ward storage of drugs audit, with actions.
- Keys to medicines cupboards were held in safes within restricted access treatment rooms. A pharmacist visited the critical care unit daily.
- Controlled Drugs (CDs) were securely stored in accordance with legal requirements. Nurses checked the balances of medicines daily and completed the CD registers correctly. We saw staff had double-signed entries to provide evidence of an authorised witness to checks.
- The blood fridge was kept in the critical care unit.
- The medicine fridge in the unit was not locked, but there was no public access to this area.
- The risk register reported a lack of drug storage space, but there was no action plan to improve the storage.

### Records

- Patient records were mainly on paper in ring binders. The paper notes were available to doctors, nurses and other healthcare professionals. Records were confidentially stored and not left open or on display.
- Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) this was called DNAR earlier in the report and on next line orders were not in place for most patients. We were told that staff had held discussions about greater use of DNAR forms for relevant patients in discussion with their families when a patient was likely to be in critical care. Best practice would suggest these discussions should be held further in advance.
- We reviewed in detail, five sets of current patient notes and one archived set of notes. All were fully and correctly completed, legible, dated and signed where appropriate. They showed risk assessments for blood clots (VTE), pressure sore risk, moving and handling risks, falls and nutritional status and activity of daily living (ADL) assessment. Sepsis screening was carried out if indicated.
- Surgical input and review was evident in patients, notes.

### Safeguarding

- Spire Healthcare had provided a national safeguarding policy for its hospitals. The hospital had a safeguarding lead for adults in vulnerable circumstances and one for children, as well as a link nurse. The safeguarding leads had established links with the Head of Safeguarding and Designated Nurse for the local Clinical Commissioning Group.
- The lead for safeguarding children was due to attend a level 4 course, the training for named professionals dealing with safeguarding children and young people.
- As a prompt for staff, the names and photographs of the hospital safeguarding leads were on the wall in ward offices, with details of how to report concerns. These details were not incorporated in the policy on the intranet, which was a generic policy for Spire hospitals as a whole.
- The policy and protocol for safeguarding referrals was available for staff to access on the intranet. The hospital Deprivation of Liberty Safeguards policy and process was also available.

# Critical care

- The staff we questioned were able to explain their understanding of safeguarding and the principles of safeguarding for children and adults. They were able to identify potential signs of abuse, including verbal and emotional abuse, and the process for raising concerns and making a referral. A nurse gave us a good example of concern raised over a 'controlling' relative and action that had been taken.

## Mandatory training

- Uptake of mandatory training had been low in the first part of the year. Between April and June 2016, 34% had received training against a target for that period of 50%. The full year target was 100%. 90% of staff (hospital-wide) had completed mandatory updates at the time of the inspection. This had been achieved by ensuring staff carried out their training during the hospital's temporary closure for a week in August 2016. Most training was delivered online through the Spire electronic system, which staff could access in the hospital or at home.
- At the time of inspection, 80% of all staff, including bank staff had completed all mandatory training. Remaining staff had until the end of 2016 to complete this training which was based on a calendar year programme.
- The mandatory and statutory training programme covered equality and diversity, health and safety awareness, infection control, compassion in practice, adult and child safeguarding (levels 1 and 2), fire safety and manual handling. Managing violence and aggression was optional. There were additional, role-specific modules on topics such as the mental capacity act and deprivation of liberty safeguards, safe transfusion, incident reporting and controlled drugs.

## Assessing and responding to patient risk

- Outpatient pre-operative assessment clinics were used in many cases to identify high risk patients who might need a high dependency unit or critical care bed post-operatively. There were admission criteria to check that patients were not likely to need more complex care. While the level 3 ICU service was suspended, we were told that in the event of a patient deteriorating in the unit, the patient would be stabilised and transferred by ambulance to an NHS hospital. The RMO was able to undertake sternotomy, which is making a surgical incision to gain access to the heart, if required.
- The transfer out process was explained to us. The consultant phoned the relevant hospital for a bed.

Between the consultant and the RMO, one would go in the ambulance with the patient and the other would cover the critical care unit and other hospital needs. Nine patients had been transferred out to local NHS trusts since January 2016. Most were NHS patients transferred back under the contract for further care. Two patients had been transferred out since the hospital suspended its level 2 and 3 care.

- Staff told us that weaning patients from assisted ventilation to spontaneous breathing was criteria-led, although the hospital had no written protocols.
- There was always a cardiac RMO when heart surgery was being undertaken, as some of these patients would be in the critical care unit after their procedure.
- Nurses reported a prompt response to emergency calls by the RMO and the hospital critical care team, which was on call for the hospital. Critical care team staff said occasionally wards contacted them later than was desirable when a patient was deteriorating. This was evident from the report of their response to an incident in June 2016. However, staff were not sure about the correct documentation, as the incident concerned a visitor and not a patient, so no record was made at the time. No debrief was done to learn lessons.
- Nurses used a risk assessment score to predict the likelihood of nausea and vomiting in patients. This was useful to determine preventive treatment.
- The hospital had an outreach team and an established resuscitation team, contactable by phone and based in critical care, who visited and assessed deteriorating patients.

## Nursing staffing

- Nurse staffing levels were more than adequate for the level 1 care being provided during the inspection. It was recognised that higher staffing numbers were necessary to return to level 2 and level 3 critical care. Ten new staff were needed and recruitment had started, including overseas recruitment: two band 7, six band 5 and 6 staff and two healthcare assistants. This would allow normal critical care unit staffing of three nurses, one of whom would be supernumerary and outreach in line with national standards.
- The hospital used a planning tool used to establish the number of nursing hours required per patient bed. In



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critical care, nurse staffing levels were based on the national requirement for providing level 3 critical care with a 1:1 nurse to patient ratio. For level 2 patients, staffing would be 1:2.

- There were staff working permanent night shifts. Some rotation was being introduced, where staff had flexibility to change their hours. There was a supernumerary nurse in charge at night, based in critical care, who was the bleep holder for the hospital.
- There were gaps in the night staffing, following four resignations. There were not enough permanent staff to rotate through night shifts, so bank staff were being used. Bank staff were mainly from a nearby NHS hospital. All 36 critical care bank staff were ITU specialist trained. Staff were aware of the hospital policy that bank staff should not make up more than 20% of a shift.
- Staff assessed the decision-making skills of bank staff when they first worked at the hospital. They had access to advanced life support training and mandatory training. Some bank staff only worked at the hospital and worked flexible shifts as required to meet the fluctuating occupancy of the unit.
- The average bed occupancy rate in the critical care unit had been below the national average of 85%. From April 2015 to March 2016 the occupancy rate for level 2 was 24% and for level 3 23%.
- We were told that there had been occasions in the past year when the unit had to refuse patients because there were not enough trained staff. Managers said that rostering staff was complex because of unplanned admissions but that such decisions were always taken in the patients best interests to ensure that the highest level of care was always delivered.

### Medical staffing

- Critical care RMOs were supplied by a private agency. They were senior registrars in anaesthetics. Critical care RMOs worked 24 hour shifts. We were told they did the last ward round at 10pm and were then on-call, on site. Their role included assessing patients on the wards when called by staff. Responsibility for routine decisions fell to the patient's consultant or the on-call consultant intensivist. The RMOs said there was no difficulty contacting an on-call intensivist when required but that they were empowered to make decisions in the absence of the lead consultant.

- Training of critical care RMOs was provided by the agency. Locum staff had time for orientation and access to hospital policies when working at St Anthony's Hospital. A folder of policies was provided specifically for locums.
- The on-call intensivist was from the same agency that supplied the RMO. Consultants were expected get to the hospital within 20 minutes if they were called in an emergency.
- RMOs told us the workload was generally light and sometimes there was little ward activity.
- We were told consultants saw patients within an hour of admission to CCU and carried out morning and afternoon reviews. Staff had not audited this.
- The two cardiac RMOs were employed by the hospital. They supported peri-operative care of cardio-thoracic patients. A cardiac fellow was always present for cardiac surgery and carried out procedures such as vein harvesting (the removal of some healthy blood vessels to create the bypass graft used in coronary bypass surgery to reroute blood around blocked arteries to restore and improve blood flow and oxygen to the heart).
- Some consultants had been resistant to the cessation of critical care provision in the hospital, but we were told most had accepted it by the time of our inspection. Two patients we spoke with had not been aware that critical care was not available when they were admitted for surgery and considered that if they had known this they might have delayed their procedure.

### Major incident awareness and training

- The hospital had procedures in place in the event of a major incident occurring on site.
- A site level major incident plan and policy covered potential incidents such as fire or flood or prolonged loss of services and there were contingency plans for various scenarios. There were departmental action cards for fire or electricity failure, explaining what to do. Table top exercises were carried out for major incident training.
- Training in fire safety had been completed by the majority of staff. Staff had practised evacuation and the use of equipment.
- There was 36 hours supply of electricity from a back-up generator and back up batteries for some equipment.



# Critical care

## Are critical care services effective?

Not sufficient evidence to rate

- Staff were competent and had training opportunities.
- Pain was regularly assessed, and staff were reviewing their compliance with the standards of the Faculty of Pain Medicines Core Standards for Pain Management.
- Patients had access to diagnostic imaging, pharmacy and consultants at weekends.
- Staff throughout the unit had reasonable knowledge of consent processes.
- Policies and procedures we were shown were evidence-based and in line with national standards, but staff told us they needed to develop more pathways

However;

- Not all patients earlier in the year had a clear treatment plan on admission to critical care, which was reviewed within 12 hours by a consultant in intensive medicine.
- There was limited information on patient outcomes, and no measurements against a comparator hospital within the Spire group. The hospital was not part of any regional benchmarking.
- Very little multidisciplinary working took place. There were no ward rounds or formal handovers. Physiotherapists involved themselves in care by looking at theatre lists to identify relevant patients. MDT meetings and ward rounds were on the project plan for moving towards offering higher levels of care.

## Evidence-based care and treatment

- Care bundles were not in place for all standard processes. Pathways were in development.
- We checked 15 commonly used protocols and found they were based on NICE guidelines and where relevant other sources were referenced such as European Heart Journal, Department of Health, and British Society of Echocardiography (BSE). They were up to date, having been reviewed in 2016. Level 2 and 3 protocols were currently being reviewed and revised.
- Not all patients were had a clear treatment plan on admission which was reviewed within 12 hours of admission by a consultant in intensive medicine. This was on the risk register, but there was no action plan to improve this.

- There was limited local audit activity. A critical care local audit plan was in development, including a DNAR audit and sepsis audit.
- There was no analysis of mortality in critical care.
- The team were aware that they needed to introduce a tool for screening for delirium in line with good practice. Delirium is common, especially in intubated patients.
- The team had taken note of the new guidance of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) which mandates capnography (the amount of carbon dioxide (CO<sub>2</sub>) in exhaled air) in anaesthesia, recovery and sedation, with the aim of improving patient safety, but no changes had yet been made.
- We saw an action list had been drawn up to meet national standards for the care of level 2 and 3 patients, and a project plan with timelines for meeting national standards was in place.

## Pain relief

- Staff told us that where patient's procedures were likely to cause pain, such as abdominal or pelvic surgery, they spoke to patients on the morning of surgery to reassure them about pain and nausea.
- The pain scores used in critical care were the same as those used on the wards. Nurses reviewed pain regularly.
- Overall, 84% of patients reported their pain was controlled a great deal (June 2016). This was lower than the Spire average of 92%.
- The team were reviewing what more was needed for the hospital to meet the standards of the Faculty of Pain Medicines Core Standards for Pain Management.

## Nutrition and hydration

- There was no dietitian on site, but a consultant or RMO could arrange for patients to be seen by a dietitian with practising privileges as needed.

## Patient outcomes

- The unit was not eligible, due their patient case mix, to submit data to the majority of national audits relevant to critical care.
- The unit collected some outcome data on mortality and length of stay, but it was not benchmarked. They were considering submitting data to ICNARC, the Intensive Care National Audit & Research Centre which held a database for England, Wales and Northern Ireland

# Critical care

enabling care delivered and patient outcomes to be benchmarked against similar units nationally. They were also considering linking with the South London Critical Care network for benchmarking.

- There had been 32 unplanned admissions to critical care (reported as incidents) since January 2016. Staff hoped that better pre-operative assessment could potentially reduce some unplanned admissions.

## Competent staff

- New staff reported that they had an orientation to the unit and to wider hospital processes and procedures. They also were orientated to the different consultant protocols. They shadowed a member of staff, and were supernumerary initially. They had a probationary review after six months based on the National Competency Framework for Adult Critical Care Nurses.
- The hospital's matron was responsible for assessing all resident medical officers' (RMO) qualifications and suitability.
- Staff appraisals were known at Spire hospitals as 'enabling excellence'. Their focus was on enabling staff to contribute to improving hospital performance, involvements in projects and innovation and development of services. The appraisal system at St Anthony's had only been introduced in 2016, so no staff had yet completed the full process. We could not therefore evaluate the success of the process.
- The critical care RMO ran a practice mock cardiac arrest monthly by. The lead clinicians rotated in the scenarios. One of the medical RMOs told us he had been the lead in a recent simulation. We were told that after a cardiac arrest, staff held a debrief to identify learning. However, when we reviewed an incident in June 2016, no formal debrief was held.
- Some other scenario training had recently been held, for example for major haemorrhage and transferring a critically ill patient.
- Of the fifteen nurses in critical care, 10 had an appropriate level of post registration qualification in critical care nursing. This exceeded the current standard that a minimum of 50% of nursing staff must have a post-registration award in critical care nursing (moving to 70% over time).
- The hospital supported nurses, including bank nurses, who only worked for the hospital, with their Nursing and Midwifery Council (NMC) revalidation.

- All senior nurses had Advanced Life Support training; other nurses had intermediate life support skills.
- Not all staff had current IV or blood transfusion competencies. Training was being arranged.
- There was no formal clinical supervision.
- A consultant anaesthetist told us they considered the experienced intensivist RMOs at the hospital provided good care to patients.

## Multidisciplinary working

- There was no microbiology input or physiotherapy into critical care ward rounds, although advice was available by telephone.
- MDT working was reported to be 'as needed' rather than formalised because the critical care unit had mainly very short term patients.

## Seven-day services

- Consultants were readily available at weekends as this was part of the hospital's practicing privileges agreement.
- There were on call diagnostic imaging and pharmacy services out of hours and at weekends.
- Pharmacy opening times for the on-site dispensary were between 9am and 8pm Monday to Friday, 9am to 1pm on Saturdays and 10 am to 12pm on Sundays. Outside these hours a pharmacist was on call to provide pharmaceutical advice and support to staff.
- There were two RMOs on site 24 hours a day during the week. There was always a critical care RMO. The cardiothoracic RMO alternated with the medical RMO at weekends. The RMOs had access to consultants who were on call for their patients, or to a nominated consultant in their absence. The RMOs said they contacted the consultants out of hours when required.
- There was an engineer available Monday to Saturday during working hours. An out of hours on call system operated outside of these hours for emergencies.
- A pathology laboratory was open Monday to Friday.
- A consultant microbiologist was available 24 hours a day

## Access to information

- Spire policies were available electronically on the intranet. Local policies were issued in hard copy with master files held electronically. There were paper copies of all policies on each ward.

## Critical care

- Computer stations with intranet were available for staff to use, although staff told us they preferred paper documentation.
- Agency nurses told us they had access to the same ward training, documentation, updates and information as permanent members of staff.
- On transfer from critical care to another ward, a medical discharge summary was written on a standard nursing transfer form, and verbal handover to the receiving ward was provided.

### Consent and Mental Capacity Act

- Staff told us patients were asked for their consent whenever possible before receiving any care or treatment, and staff acted in accordance with their wishes. We saw completed consent forms in patients' notes.
- Nurses understood that if patients did not seem able to make their own decisions, they might need a best interest assessment.
- Staff were aware of the role of the independent mental capacity advocate (IMCA) who are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about serious medical treatment, and power of attorney. They were familiar with best interests' decisions, and also aware that a patient might make an unwise decision, but that did not mean they lacked capacity.
- The hospital Deprivation of Liberties Safeguards policy and process was also available for staff to access on the intranet.

### Are critical care services caring?

Not sufficient evidence to rate

- We spoke with three patients who had received level one care in the critical care unit, and all praised the staff.
- Staff ensured patients privacy and dignity were respected at all times.
- Medical staff were approachable and prepared to sit and talk with patients.

### Compassionate care

- Staff were aware of the aim to make the hospital a high performer in delivering highest quality patient care within the Spire network.

- Patients reported staff were friendly and professional, one described the staff as 'really lovely.'
- Staff ensured patients privacy and dignity were respected at all times.
- 92% of nurses (hospital-wide), up to September 2016, had attended compassion in practice training which was mandatory at the hospital. This was a high completion rate

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

- One patient who spent 24 hours in critical care said the staff had been excellent and explained what they were doing and why.
- Patients told us medical staff were approachable and prepared to sit and talk to them; not just about their medical needs. If there was a problem outside the doctor's knowledge, they referred patients to a specialist.

### Emotional support

- One patient said staff had been reassuring in their time in critical care and helped allay their anxieties.
- Spiritual support was available through the Roman Catholic nuns based at the convent adjacent to the hospital. It was also possible to arrange for support from other faith groups.
- Staff told us there were no specific services for emotional support for patients such as counsellors and bereavement support on the unit, however they were able to access specialist support if needed.

### Are critical care services responsive?

Not sufficient evidence to rate

- We noted the service was drawing up plans to upgrade the service to offer level 2 and level 3 critical care as soon as more staff and training were in place. This was to meet the expectations of consultants and patients.
- There were no physical capacity problems, however the unit could not accept unplanned admissions without higher levels of staffing.
- There were no formal complaints about critical care in the complaints log from January to May 2016.
- There was a dedicated waiting area for visitors within the ward.

# Critical care

## Service planning and delivery to meet the needs of local people

- At risk patients coming for surgery were identified by the nurse or anaesthetist at their pre-assessment check and if necessary a decision was taken to request a critical care bed. This allowed the unit to plan ahead in order to meet the needs of specific patients. Staff in theatres recovery told us they worked well with the Critical Care Unit.
- The unit had not recorded mixed sex breaches whilst it was open earlier in 2016. A mixed sex breach occurs when Level one patients are placed on an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care units, as patients are normally stepped down to a ward once they reach level one dependency.

## Meeting people's individual needs

- The unit operated flexible visiting hours, with two visitors allowed at any one time.
- There were no facilities for relatives to stay overnight and they were encouraged to return home, but they were able to ring the unit for updates at any time the day. Staff told us they would direct relatives to local hotels if needed.
- Staff told us that a number of staff spoke languages other than English and could help with interpreting. Interpreters could be arranged as required.

## Access and flow

- At present the unit had enough capacity. We saw plans in place for expanding the service to provide higher levels of critical care over the next few months.
- There was no data on unplanned admissions to critical care other than what could be assessed from the incident report where there had been 32 such admissions. However, this would not have captured admissions where there was adequate staffing.
- The CCU had an Admission to Critical Care policy dated August 2016. This included roles and responsibilities of individual staff, referral processes for planned and unplanned admissions and referral processes for admissions from other hospitals.
- The majority of patients were admitted to the unit as part of their surgical pathway of care and transferred into the unit from the theatre recovery area.
- Staff said occasionally a patient stayed a few hours longer in critical care until a bed on the ward was ready.

- We were told that in 2015-2016 no surgery had been cancelled because of a lack of critical care beds.

## Learning from complaints and concerns

- Nurses we spoke with did not think patients often had complaints and critical care had very few, but were aware there was a procedure to follow.
- There were no specific complaints about critical care in the complaints log from January to May 2016. However, the log did not identify critical care as a specific department.

## Are critical care services well-led?

Not sufficient evidence to rate 

- There was a positive team atmosphere in critical care
- Staff considered senior staff and managers to be approachable.
- Staff had varying levels of awareness about the future development of the critical care service.

However

- Governance needed strengthening to ensure a safe service was provided.
- The unit maintained a risk register, but it did not reflect all the risks we identified and mitigation was not sufficiently explicit.

## Vision and strategy for this core service

- The unit's clinical strategy was in development.
- Managers planned to reopen the unit to level 2 patients later in 2016 and hoped to open to level 3 patients in 2017 when sufficient staffing was available and protocols had been developed.

## Governance, risk management and quality measurement for this core service

- A gap analysis against the most recent standards for critical care shortly before our inspection had concluded the unit was not meeting all standards to keep people safe from avoidable harm. This had led Spire to suspend the service. Concerns included not having enough nurses of the right experience, especially at night, and not having formal MDT involvement. A number of actions were recommended. Spire had developed assessment tools to assess the unit's readiness to take level 2 critical care patients.

# Critical care

- There were four risks on the risk register for critical care. A risk register and associated audit calendar that is regularly updated and acted upon is a requirement for providing critical care. There were risk owners and a list of some controls in place on the risk register, but no designated owners of action to reduce the level of risk.
- The risk register had not been updated to add the risk of temporarily suspending the critical care service. For further information on CQC's concerns about governance and risk management more widely in the hospital, please see the Surgery report under Well led,
- Staff told us governance was being reviewed as part of the hospital's improvement programme, so it reflected best practice critical care guidance. There was no unit-wide meeting held, including RMOs, to review patient outcome data including mortality, in order to improve practice.
- One requirement for critical care units was to have an Adverse Incident Reporting System and evidence of associated action planning. From our review of incident reporting elsewhere in the hospital, we were concerned that the current process lacked depth and rigor.
- The hospital did not participate in the National Database for Adult Critical Care, nor did it publish the nationally agreed dashboard that included the Standardised Mortality Ratio. We understood that staff had initiated discussions about this. Staff had not yet done any detailed analysis of patient mortality and morbidity in critical care.

- For discussion of governance and risk management more widely in the hospital, please see the Surgery report under Well led.






## Leadership / culture of service

- Staff spoke well of the critical care manager and the head of critical care education, and considered them supportive. The team's engagement score of 93% from the staff survey were better than for the hospital as a whole, and the Spire average (86%).
- Staff spoke highly of the support the unit manager provided to the whole team, patients and relatives.
- Some staff said that although the executive team were visible and had an open door policy, they had not always listened fully to staff concerns in the past.
- Senior critical care staff felt able to question and challenge anaesthetists and consultants.

## Public and staff engagement

- There was limited public engagement on the unit, as patients were not routinely asked specifically for their feedback during their critical care stay; but all were offered opportunities to comment on hospital stay as a whole
- A consultants' newsletter reported on activity and incidents, and hospital based staff were also updated with a newsletter.

# Outpatients and diagnostic imaging

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

## Information about the service

St Anthony's Hospital provides private outpatients and diagnostic services from departments within the hospital site in Cheam. The hospital provides outpatient appointments and diagnostic imaging for multiple specialties.

In the year April 2015 to March 2016 they had almost 9500 first attendances in outpatients and just over 33500 follow up appointments. Patients either paid for appointments themselves or drew on medical insurance. Less than 5% of outpatient appointments were funded by the NHS.

Appointments are offered between 8am to 9pm, Monday to Friday and 8am to 2pm on a Saturday, although this is dependent on the clinic required.

The main outpatients department is accessible on the ground floor and consists of 14 consulting rooms, one treatment room and one cardiac stress testing room. The diagnostic imaging suite is accessible by lift or stairs on the first floor and provides X-ray, Ultrasound, CT Scanning, mammogram and bone density scanning. MRI is available on the ground floor of the hospital. A newly opened extension on the ground floor provides physiotherapy services and has a rehabilitation gym, six treatment rooms and a hydrotherapy pool. Patients can self-refer, be referred by their General Practitioner (GP) or through consultant's private practice.

St Anthony's Hospital provided a children and young people's service for elective surgery until June 2016. Outpatient appointments, diagnostic imaging and physiotherapy for children and young people were provided until September 2016 when a decision was made to temporarily suspend the service at the hospital. Children

and young people made up 3% of the patients attending the hospital during April 2015 to March 2016, and a significant majority of these attendances of children and young people were within the outpatient service.

Staffing at St Anthony's Hospital consists of nurses, healthcare assistants, physiotherapists, physio assistants, radiographers, laboratory and administrative staff. Over 300 consultants have practicing privileges to carry out consultations.

As part of our inspection we spoke with eight patients and 35 members of staff including consultants, nurses, senior managers and administration staff.



# Outpatients and diagnostic imaging

## Summary of findings

We rated outpatients and diagnostic imaging as 'Good' because:

- There were systems to protect patient from avoidable harm and abuse. Staff knew how to report incidents and lessons learned from these incidents were shared within teams.
- All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly.
- The compliance rates for mandatory training were excellent.
- The provider had made the decision to suspend services for children and young people until it could be assured that the environment, staffing provision and training was appropriate to support their needs safely. They had a plan for safely re-starting this service provision by re-introducing paediatric outpatient clinics in November 2016, although the strategy was not yet finalised.
- Patients were very positive about the care that they received and the support that they were given.
- Staff were proud to work for the service and reported good support from all levels of management.
- New equipment had been introduced within the physiotherapy and radiography departments in order to provide better care for patients.

## Are outpatients and diagnostic imaging services safe?

Good 

We rated safe as good because:

- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- Medicines were managed and stored safely.
- Clinical and waiting areas were visibly clean and we observed good infection prevention and control measures.
- All staff had received mandatory training that was relevant to their role.

However:

- Some patients could have two hospital numbers which meant that records may not be complete.
- There had been no MRI resuscitation simulation training sessions. This meant that if there was an emergency within the scanner, staff may find it more difficult to remove a patient quickly.

## Incidents

- All staff we spoke with knew how to report incidents through the hospital's computer based reporting system. They were aware of the types of incidents that they needed to escalate and told us they were encouraged to report incidents.
- Evidence of reporting 'no harm' incidents was shown in an investigation report into an incident graded minor, where a needle used for sutures was not located after a procedure. The incident had been reported on the date it had occurred. However, the final report was not completed until seven weeks after the event had occurred. 139 incidents were reported for the outpatient, physiotherapy and diagnostic imaging department between January 2016 to August 2016. Of these, 72 were clinical incidents.
- The majority of incidents (111) were classed as no harm, with 21 minor harm incidents and seven moderate harm incidents.
- All incidents reported in outpatients were reviewed and investigated by the outpatient's manager. The manager would share findings from incidents with individual staff and also at team meetings. However these meetings

# Outpatients and diagnostic imaging

were not held on a regular basis. We were told that urgent updates could be added to a handover sheet. We saw one set of minutes for a team meeting that referred to one incident that had occurred within outpatients. However; other minutes did not show that regular incident discussion occurred within this forum.

- A monthly safety brief was prepared by the Spire Group and circulated across the hospital. It contained information about policy updates, medical device alerts, drug and other alerts, as well as serious incidents that happened at other hospitals.
- We were told that under previous management, reporting incidents had not been encouraged as staff were blamed for an incident occurring. However it was now seen as a learning process.
- Incidents in the diagnostics department were discussed at the team's monthly meetings, for learning. In addition, key information was placed in a folder accessible to all staff. This included minutes and action plans of the meetings if staff were not able to attend. The imaging manager would cascade information about incidents from the Heads of Department meeting within the team meetings.
- Physiotherapists had a weekly team meeting where incidents could be shared and discussed. Minutes of these were produced and staff who had not attended had to sign a record to show that they had read these.
- Managers attended a quarterly hospital clinical governance meeting where incidents were discussed and learning could be shared across departments.
- The hospital had a contract with an external company for the post of Radiation Protection Advisor (RPA) (a specialist in radiation safety and compliance matters which relevant organisations must have by law). A total of nine incidents had been reported to the RPA between April 2015 and September 2016. The incidents reported all had lessons learned documented where relevant, however some only contained the line 'be more careful' - which did not indicate how to prevent future incidents.
- Staff were familiar with the term 'duty of candour'. Staff told us they would apologise and inform the patient or their carer if an incident of avoidable harm occurred. There had not been any instances in the last year when duty of candour had been required to be applied. However, staff told us how they would apologise to patients if a clinic was running late and we saw this documented within the incident logs.

## Cleanliness, infection control and hygiene

- All areas of outpatients and diagnostic imaging that we visited were visibly clean, tidy and free from clutter. Housekeepers cleaned the department every evening except Saturday and nursing staff cleaned all surfaces within the consulting rooms between clinics.
- Staff told us that they could request housekeeping during the day to deal with any spillages.
- There was a hospital lead infection prevention and control nurse as well as a link nurses in each department. These link nurses attended a quarterly meeting and also went to an annual conference in order to keep updated with best practice.
- An environmental audit was currently completed on an annual basis; however there were intentions for this to be repeated more frequently throughout the year. The most recent audit had been completed in August 2016 and it documented that there was good management of sharps, linens and waste. There had been no needle stick injuries or body fluid exposures during the previous 12 months and good hand hygiene was observed. There was a clear action plan of recommendations for areas of improvement from the audit and most of these had been actioned within two weeks of the audit occurring.
- All clinic rooms had working facilities for handwashing, with enough paper towels and protective clothing available to use when necessary.
- The hospital had undertaken regular audits of use of hand sanitising gel from March 2015 to June 2016 and we saw the results of these audits. These showed a high compliance in use of the gel. The hospital was currently changing to hand hygiene observational audits and the first of these for the outpatients department was due at the beginning of October 2016.
- The imaging department had separate records of hand hygiene audits completed with a high level of compliance.
- We saw hospital staff washing hands and using hand sanitising gels appropriately between patients.
- Personal protective equipment, such as gloves was available for staff in all clinical areas to ensure their safety and reduce risks of cross infection when performing procedures.
- Domestic and clinical waste was disposed of correctly. We saw appropriate facilities for disposal of clinical waste and sharps such as needles located in the consultation and treatment rooms.

# Outpatients and diagnostic imaging

- Staff adhered to 'bare below the elbow' guidance whilst delivering care.
- Equipment was well-maintained and was visibly clean and we saw 'I am clean' stickers in use.
- The hydrotherapy pool had a clear risk assessment and procedures in the event of pool contamination. There was a rota of twice daily water testing and we saw where this record was completed.

## Environment and equipment

- The outpatients and diagnostic imaging department were well-maintained. Consulting rooms were of a good size, well lit, free from clutter and provided a suitable environment for treating patients.
- Nursing staff checked each room at the start of the day and laid out any specialist equipment that may be required within the clinic.
- Access to store rooms was via a coded key pad system and meant that they were secure.
- The newly built hospital extension housed the physiotherapy department and the hydrotherapy pool. There were six treatment rooms, changing facilities and also an office space for the physiotherapy team.
- The gym area within the physiotherapy department contained an appropriate selection of equipment, which was clean and well-maintained.
- There was a main outpatient's waiting room and a smaller waiting room in the imaging department. Neither of these areas had a separate area for children or any suitable toys. However, we were shown an area where a separate children's outpatients department was planned, with its own waiting area, reception and consulting rooms. It was intended that this area would be reconfigured before children's services re-started.
- Equipment was well-maintained in all departments, with stickers showing that appropriate safety checks had been completed within the last 12 months.
- Single use, sterile instruments were used where possible. The single use instruments we saw were all within their expiry dates.
- The store room where consumables were stored was clean and laid out with easy access to all equipment. On the day of our inspection, all items of equipment that we checked were within their use by dates.
- The imaging department had appropriate signage and lights outside the main doors to each scanning room to

alert staff and patients when exposures were being undertaken. However; the mammography room had a small waiting area through an additional side door in the room which had a warning sign but no light. .

- Staff told us they generally had access to equipment and instruments they needed to meet patients' needs. However, staff told us there was only one X-ray machine and this meant there was limited back up if it was broken. There were no incidents raised between January and August 2016 for failure of X-ray equipment.
- Emergency resuscitation equipment, for adults and children was available in the outpatients department and was easily accessed via the physiotherapy department along the corridor. It was inspected and the seal checked on a daily basis by nursing staff and we observed this being undertaken. Once a month, the seal was broken and all equipment thoroughly inspected. We saw documentation to show this had been completed.
- We were shown one of the new operating theatres that was planned to be used for paediatric patients once the service had restarted. Although, not yet completed, it had a large anaesthetic room with space for two parents to be in the room while a child was in there. A traffic light system was being planned to ensure that children did not see any adult patients on their route to the theatre. Construction was due to start on a new recovery area with a separate space for children to recover.

## Medicines

- The treatment room was kept clean and tidy, with keys to the drug cupboards held by registered nurses. There were separate cupboards for flammable medicines, internal and external medicines and regular medicines.
- We found that bags for intravenous fluid therapy, such as sodium chloride were not stored in the treatment rooms, however if needed these could be requested from the main pharmacy.
- Fridge temperatures were recorded on a daily basis and were found to be within the recommended range. When asked what would happen if the normal fridge temperature of 2-8 degrees went out of range, the nurse stated that a member of clinical staff would be responsible for taking the appropriate action to rectify the anomaly, which included contacting the pharmacist and estates management.
- Emergency medicines were available, accessible for immediate use, in date and tamperproof.

# Outpatients and diagnostic imaging

- Nursing staff stated they were happy with the pharmacy service received. They commended the support and advice received by the on-call pharmacist and pharmacy.
- Staff had access to British National Formulary publications (BNFs) as well as all policies and information relating to medicines management (including the antimicrobial formulary), available on the intranet.
- Staff competencies for dispensing and administering medicines were assessed by dedicated induction processes provided by the provider. This included training in oral and intravenous medicines.
- Staff understood and demonstrated how to report medicines safety incidents. This was then escalated and fed back for learning through regular meetings from the pharmacy team through the hospital effectiveness committee.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- Patient Group Directions (PGDs) are a legal document that allows some practitioners to administer a specific medicine to a group of people. The imaging department had PGDs for all appropriate medications and these were all signed and in date.

## Records

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images. Some medical notes were not held electronically. Consultants holding electronic private patient records were required to register as Data Controllers with the Information Commissioner's Office.
- Three lockable trolleys had recently been introduced to transport notes.
- The hospital policy was that a complete set of medical records must not be taken off site. If this happened, then an incident would be raised. We found six incidents of this reported between January and August 2016 with appropriate actions listed. The practicing privileges policy required consultants to ensure staff had access to medical records of all of the patients treated at the hospital at all times.
- Referrals were usually initiated by a phone call from a patients' GP or by the patient self-referring. A letter of confirmation of initial appointment as well as information on costs, a map and general hospital

information was sent out. Patients were told to bring the letter with them to the appointment or to ask that the GP faxed a referral letter, to ensure that it was held on the record.

- All paper clinic lists were kept inside black folders at the nurse's station so the details on them were not visible to patients.
- Records were kept within the hospital records department. The notes required for each day's clinic were brought to the department. We were told occasionally patients presented without an appointment on a day they knew their consultant had a clinic. If this happened, we were told that records could easily be requested from the records department on the day.
- Staff reported that records were usually available in a timely manner for clinic appointments; however, this was not routinely monitored.
- Consultants told us that they could obtain copies of medical notes from the patient's GP if needed. .
- Patients were provided with a hospital number on starting treatment at the hospital. We were told of an issue of some patients having duplicate numbers as they had been treated at different Spire hospitals and the records could not always be merged. From January 2016 to August 2016, there were 12 incidents recorded where duplicate records had been identified. This meant that the most up to date records for some patients were not always being used.
- Clinic letters had a target to be typed up within three days of the clinic occurring. A log was kept by the medical secretaries of each letters timeframes so it was possible to audit if this target was kept to.
- Each time a patient attended the outpatients department, they had their personal details checked by the reception staff. This ensured that all contact details for patients held were up to date. However there were five incidents recorded between January to August 2016, where patient letters had been sent to the incorrect address.
- If a patient did not attend an appointment, this was followed up with two further attempts to contact them and arrange another time. However, no further action was taken after this, except a record on the clinic list. We were told that it was unusual for patients to miss appointments.

# Outpatients and diagnostic imaging

- All patients referred for imaging would have a request form completed by the consultant. We saw an article that had been written in the hospitals consultant newsletter, providing information and guidance for referral form completion.
- All patient records for the radiology department were scanned and kept on an electronic information system.
- Records for physiotherapy patients were stored securely in the physiotherapy department and access was restricted to staff only. A separate physiotherapy record was held which included the referral note and these were sent to medical records once the patient's treatment had finished.
- A separate register of all patients aged between 12 and 18 years was held by the physiotherapy department to monitor all children who had received physiotherapy treatment. This had had been started in January 2016 and was completed up to the recent service suspension.
- We saw records of a peer review of patient notes audit, against the chartered society of physiotherapy guidelines, which was completed regularly in physiotherapy. Feedback was given to individuals and themes shared in team meetings when appropriate. The results of the audit were shared with other Spire hospitals in order to benchmark and share good practice.
- Diagnostic images were stored electronically and were available to clinicians through PACS (Picture Archiving and Communications System).
- The safeguarding level three training was a new three hour e-learning package. In addition, we were told that the deputy matron provided a one hour face to face introduction session to staff before they started the online package.
- The outpatient manager had completed safeguarding children level three and there was a plan for all staff within the department to complete this as an online package. Some of the physiotherapists had also completed this training and there was a plan for the remainder to undertake this.
- We were told that all staff in the radiology department had completed safeguarding level two, but none had completed level three, although there was a plan for this to be done. Although the hospital had suspended paediatric services, a few children had still been booked for ultrasound scans and these had been carried out by a paediatric radiologist, with the authorisation of the deputy matron.
- Consultants who saw children and young people in their clinic were required to complete safeguarding level three training. Training was monitored and was a requirement of maintaining practising privileges at the hospital. This was provided by the hospital where this was not provided by a consultant's NHS Trust.

## Safeguarding

- A safeguarding flow chart was available to staff within their pocket 'z-cards'. These were a small aide memoire that contained useful prompts to show where they could access key information.
- All staff we spoke with could identify the nurse safeguarding lead.
- Staff completed an on-line electronic learning training module as part of their mandatory training for safeguarding adults and children. At the time of our inspection, all outpatient and physiotherapy staff had completed Safeguarding Adults and Safeguarding children levels one and two.
- The safeguarding e-learning package contained specific relevant issues such as child sexual exploitation, domestic violence, female genital mutilation and preventing radicalisation.

## Mandatory training

- The majority of mandatory training was completed using an on-line electronic learning package. The training included infection control, fire safety, equality and diversity and health and safety.
- We were told by all staff we spoke with, that time was given during work to undertake mandatory training or they had the option to complete it at home and claim the time back.
- A spreadsheet showing mandatory training completion was kept by the outpatient's manager and shared with us. It showed that outpatient's staff were at 100% compliance for mandatory training completion. An in-house spreadsheet was used to monitor staff compliance for mandatory training in the diagnostic imaging department and showed the staff to be at 100% compliance for completion.

## Assessing and responding to patient risk

- A call bell system was available in all consulting rooms and was connected to the front reception desk. There was no alarm bell within the treatment recovery room; however we were told that a nurse always remained



# Outpatients and diagnostic imaging

with the patient following a procedure. We saw documentation from July 2016 to show that this system had been tested as serviceable. A separate call bell system was available within the physiotherapy department.

- The hydrotherapy pool always had a minimum of two people within the pool area while individual or pair sessions were being run. The second person was either in the pool or poolside, dependent on patient need. An emergency call bell was available within the pool area and there was equipment available for water rescue. The pool had been built recently. We saw records that showed that staff had completed pool rescue and evacuation training. Further refresher training was planned at three monthly intervals to consolidate the new knowledge. Signs showing the depth of the pool had been ordered, but were not yet available.
- Emergency resuscitation equipment was available and all nursing staff had undertaken life support training for adults with six having completed paediatric immediate life support training.
- In the event of a patient becoming acutely unwell, the resuscitation team from the High Dependency Unit would be called, including one of the Resident Medical Officers (RMO). If the patient was found to be acutely unwell, then a 999 ambulance would be called.
- The staff within the cardiac physiology testing room were all trained in immediate life support and said that an RMO was always available if requested.
- One RMO was provided by an agency and it was part of the contract that the doctors were up to date with advanced adult and paediatric life support training. Two other RMOs were employed by the hospital and it was mandatory that they were trained in advanced adult and child life support training.
- There had been no resuscitation simulation exercises conducted within the Magnetic Resonance Imaging (MRI) scanner. We were told that all new staff members received a briefing of the actions to be followed if there was an adverse reaction to medication. There had been three incidents of patients with adverse reactions being removed from the MRI scanner within the 12 months from September 2015 to August 2016 and no requirement for additional training had been highlighted as part of the investigations of these incidents. However; the incidents did not appear to

involve a patient who was unconscious and might be a more difficult removal which meant that staff who had only had a briefing once, may find this difficult if it were required.

- Children's services were suspended at this hospital. However we were informed that prior to this suspension, a paediatric nurse from another Spire hospital would conduct the paediatric pre-assessments, which would usually be face to face.
- Local rules are key documents for imaging staff to follow and should be accessible for staff carrying out X-rays and scans. We saw copies of these rules that contained all the relevant information, although in some rooms they were not accessible to staff. After we highlighted this to managers, this was rectified.
- If patients phoned the booking office asking for clinical advice, staff there told us they would ask the outpatient nurses for advice. If the patient phoned and said that they were unwell, the general advice would be to attend a hospital emergency department.
- We saw 'pause and check' posters on the walls of imaging rooms. This was a reminder for staff to confirm the person and area of scan or X-ray, in order to reduce the risk of overexposure to radiation.

## Nursing staffing

- There were seven nurses in outpatients covering 5.88 whole time equivalent (WTE) nursing posts and 3.5 WTE healthcare assistant (HCA) posts. In addition there was one bank nurse and one bank HCA who had just been recruited and were awaiting induction.
- We were told that staffing was calculated to meet clinic workload and if it increased, then staffing levels would be increased accordingly.
- There were no nursing vacancies within the outpatients department at the time of our inspection.
- The imaging department employed three nurses, four HCAs and also used three bank nurses and one agency nurse.
- Cover for staff leave or sickness was mainly provided by staff that were part of the existing nursing team or bank staff. There was a low level of staff sickness. Levels across outpatients between September 2015 to March 2016 were less than 2.2% most months.
- The hospital had one registered sick children nurse (RSCN) who was also the deputy matron. An additional paediatric charge nurse was due to start by November 2016. We were told that prior to the service being



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suspended, when minor procedures for children were conducted within the outpatient department, these clinics would be arranged at specific times and an RSCN from another Spire hospital would attend. The visiting RSCN would also provide care for children in the hospital ward following a surgical procedure.

## Allied Healthcare Professional staffing

- There were five physiotherapists and two physiotherapy assistants within the outpatient's team. There was one vacancy within this team. In addition, a hand specialist was employed under a bank contract. Three administrators supported the physiotherapy team.
- Physiotherapists held clinics between Monday and Friday.
- Cover for staff leave or sickness was only provided by staff that were part of the existing team. There was no agency staff use.
- Within the diagnostic imaging department, there were 19 radiographers.
- A team of administrators and medical secretaries supported outpatients by organising bookings, clinic management, typing up notes, and covering reception.

## Medical staffing

- There were over 300 consultants with practicing privileges that conducted clinics within the department.
- Two paediatric radiologists carried out ultrasounds of children within the imaging department. The children's service had been suspended, although there had been a few scans undertaken since the suspension with the authorisation of the deputy matron and lead for paediatric services. We were told that the last one had now been completed and there would be no further scans until the paediatric service was re-started.

## Major incident awareness and training

- Staff we spoke with were aware of the actions required if there was a fire on site. Staff told us that the fire alarm was tested each week and showed us an evaluation of a fire evacuation practice that had been carried out in February 2016.
- Staff completed fire safety online training as part of their mandatory training and the allocated fire marshal for the hospital was identified and communicated in daily handover meetings.
- The service had 36 hours supply of electricity from back-up generators and back up batteries for some equipment in the event of a power cut.

## Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

We found:

- There was a good multidisciplinary team approach to care and treatment.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- Work had started on measures to reduce the radiation dose level that patients received.
- There were many opportunities for continuous learning provided within the department.

However we also found:

- Not all staff had received appraisals in line with the provider's policy.
- Local clinical pathways and policies kept within the outpatients department did not appear to have been reviewed recently and it was not clear if they were up to date in line with best practice guidelines.

## Evidence-based care and treatment

- The service had access, on the intranet, to Spire's corporate clinical local policies written in line with national guidance. These policies that we saw were all within dates and had clear dates of when they were due for renewal.
- Local clinical policies and procedures were kept within a folder in the outpatients department. We were told some of these were procedures were no longer carried out within the department, but it was not clear which of these were still current and when they were due for review, as there were not dates on all of the documents.
- Guidance was provided by the Ionising Radiation (medical exposure) Regulations (IR(ME)R) for the safe use of radiological equipment. This included guidance for operating procedures, incident reporting, training and equipment maintenance and medical physics' role. These IR(ME)R procedures were accessible to staff on the hospital's intranet.

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- The imaging department were able to show us evidence of a change in protocol following an audit which had reduced the dose radiation level (DRL) in a pelvis CT scan by 75%, with no significant difference to image quality.
- Since the change in provider, the laboratory was part of Spire Pathology Services (SPS), although staff were employed by the hospital. This meant they shared resources, including a quality system and generic online handbooks, with another 23 laboratories in the group. This also meant there was contingency for service provision with other nearby laboratories. Regular scheduled audits were scheduled by SPS, who monitored and shared the results of the audits in order to assist with learning and improvement.
- The laboratory had received Clinical Pathology Accreditation (CPA) in May 2014.
- The laboratory had recently had an inspection by the Medicines and Healthcare Products Regulatory Agency (MHRA) and a report was provided to the hospital of the findings in June 2016. The laboratory had been given a certificate of compliance on the basis of a corrective action plan they submitted in response to the minor failures that were found.

## Pain relief

- Patients who had undergone a minor procedure within the department were given time to recover in a separate waiting area and nursing staff would assess their pain before they left. If they were in pain, the consultant would be asked to provide a prescription for pain relief medication.

## Patient outcomes

- The imaging department had recently started an audit process and we saw completed audits of pregnancy status checks and the CT quality standards. These had clear recommendations for improvements within the department.
- A quality improvement group had been started six months ago to improve standards for pre-MRI orbital X-ray scans.
- The Radiation Protection Advisor (RPA) (a specialist in radiation safety and compliance matters which relevant organisations must have by law) had conducted an audit of equipment and procedures in August 2016 and found that the department was nearly fully compliant,

with a few minor improvements necessary. The report had only just been received by the hospital at the time of our inspection, so there had not been any actions planned as a result of this audit.

- The physiotherapy department used the patient specific functional scale (PSFS) for all patients in order to assess the treatment that was being provided. This scale focussed on the patient's opinion of the limitations of their function with up to five activities and can be used to assess how a person's abilities change from their initial assessment to their discharge. The hospital reported this for one group of patients; however it was planned that a report would be produced for all patients in order to identify more themes. Outcomes of the scale results were fed back directly to staff and any themes were raised at the staff meetings.

## Competent staff

- All new nursing staff to the hospital underwent formal induction, for which we saw a check list, and completed competency paperwork. Induction periods were tailored to the needs of the individual and area of work. We saw examples of competency paperwork for the CT scanning process and equipment.
- We saw completed competency frameworks for Lifescan clinics, the hybrid theatre and Magnetic Resonance Imaging (MRI) equipment.
- Supervision of nurses within outpatients was arranged and monitored on a self-directed basis. We were told that the consultants were helpful in supporting the nurses to undertake this.
- Clinical supervision of the physiotherapists was carried out by the physiotherapist manager.
- The physiotherapy team had one hour a week of protected time where they were able to conduct the notes audit, have in-service training, a journal club and review discharges.
- Members of the physiotherapy team had recently completed a foundation course in aqua therapy in order to treat patients within the new hydrotherapy pool. We also saw competency records for the physiotherapy assistants for aqua therapy.
- Staff directly employed by the hospital all received annual appraisals which were known as 'Enabling Excellence'. All clinical, reception and booking staff we

# Outpatients and diagnostic imaging

spoke with told us they had received an annual appraisal which supported their development. However, we were told that none of the outpatient secretaries had ever received an appraisal.

- We saw a copy of an initial meeting discussion that had been completed for a member of staff. It had objectives that were set by the manager as well as an area that staff could feed in their own objectives. It contained records of competencies that had been completed such as chaperoning, immunisations and aseptic non-touch cannulation technique.
- Four members of the outpatient nursing staff were qualified mentors. The hospital supported student nurses from a local university to undertake placements within the department.
- Nursing staff told us they were being supported to prepare for revalidation. The lead manager held a list of when the outpatient nurses were due to be re-validated.
- Staff told us of learning lunches where consultants would meet with nursing and administrative staff over lunch and talk about their speciality. We were told it was a good way that staff could engage with the visiting consultants.
- We saw the qualifications of the Radiation Protection Supervisor (RPS) and records of training updates they had undertaken.
- Monthly learning sessions were organised within the radiology department. Recent subjects had included the audit process, training on different scans, and support for re-registration requests. In addition, a CT user group had been sent up since February 2016 providing more in depth information about the scan process and looking at dosage reduction.
- We were told of external training that imaging department staff had undertaken, which included catheter laboratory competencies and intravenous cannulation.
- All phlebotomy staff had specific training for carrying out blood tests for children and were able to talk us through the process they would follow.
- Some physiotherapists had undertaken paediatric competencies and had been treating children over 12 years old in the physiotherapy department, until the service was suspended. There were plans for further training prior to this service being restarted, and physiotherapists from other Spire hospitals would provide this.

- A new clinical educator started at the hospital in July 2016 and was focussed on planning paediatric training for staff that required it prior to them restarting children's services. This training had started as one member of theatre staff had recently completed paediatric airway management training.

## Multidisciplinary working

- We observed good multidisciplinary working with effective verbal and written communication between staff. All staff groups told us of the good working relationships between disciplines and departments.
- The managers of the outpatients and the imaging department as well as a physiotherapist attended the hospital daily huddle. This was a cross-organisational group, to identify key operational information that needed to be shared. It included allied health professionals and support staff as well as clinical staff from other departments. The staff who had attended this meeting described the content as useful.
- A multi-disciplinary pre-assessment clinic was held for patients planned to have hip or knee operations. This involved the physiotherapy team and an assessment of the home environment and pre-operation exercises given out in order to improve recovery and enable early discharge.
- Staff in the imaging department told us of the multi-disciplinary cardiac speciality meeting. This included professionals from different disciplines, who met on a quarterly basis to discuss performance as well as clinical case studies.

## Seven-day services

- The outpatients department was open 8am to 9pm Monday to Friday. The department was also open 8am to 2pm on a Saturday.
- The diagnostic and imaging department provided services from 7am to 5pm, Monday to Friday, however planned to extend their service until 9pm. The department also operated an on-call rota, seven days per week for urgent CT, MRI and X-ray requirements.
- The physiotherapy department provided services 7.30am to 8pm Monday to Friday.

## Access to information

- The radiology department provided CT results on the same day for inpatients and within 48 hours for outpatients. MRI results were either typed up or digitally dictated into the computer system so could take longer.

# Outpatients and diagnostic imaging

- The in-hospital laboratory was open between 8am and 8pm and then provided a non-resident on call service in case urgent tests were required.

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

- Consent for minor procedures undertaken in outpatients was completed on the day by the consultant. We saw a blank copy of a checklist that was completed for each procedure which included a check box to show whether verbal or written consent had been obtained which had to be signed by the consultant and additionally by the patient in the case of written consent.

## Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as good because:

- Patients received supportive care and treatment.
- Staffs were very caring towards patients and supported them emotionally.
- Interactions between staff and patients were positive.
- Information about care and treatment was made available when requested by patients.

However:

- The process for clarifying costs of blood tests with the patient was unclear. This could mean that patients were not informed of all the costs of tests taken before agreeing to them.

## Compassionate care

- All the patients we spoke with were happy with the care they had received and were complimentary about the staff. One patient said, "I like coming here as it is very friendly." Another said "I can't fault my care and treatment." A comment card response stated 'the nurses in outpatients are always helpful, kind and caring.' We observed all staff being polite, courteous and friendly with patients at all times.
- Patients told us they were mainly treated with dignity and respect, however some mentioned that the reception desk was small and meant that they could be overheard when discussing their information and

arranging payment with the receptionist. We were told by staff that a private area could be arranged if a patient asked for it and a new desk had been ordered which was intended to improve this issue.

- Patients were greeted by the reception staff on arrival and informed where they should wait.
- The nursing station was situated within the main waiting area and this meant that staff were easily available for patients if they needed any further support or chaperone before, during or after the consultation.
- We saw a thank you letter from a patient who spoke about the outstanding care that he had received from one nurse within the outpatient department. This nurse had attended the clinic the patient was booked in on their day off, in order to support him. This was very much appreciated by the patient.
- The hospital collected feedback from patients using a feedback form and it was not specifically related to the department.
- The satisfaction rates of outpatient nurses for the last six months had been between 95% and 100%, for physiotherapists between 92% and 100% and for imaging staff between 92% and 100%. Each area had at least one month when they were above the Spire average.
- We were told that there was a feedback survey specifically for children and young people to complete prior to the suspension of the paediatric service. However, on request of these results this data could not be found by the hospital. There was a plan to reinstate the survey once paediatric services resumed.
- There were examples given by the booking staff of when they had been given flowers from patients as a thank you for their assistance arranging appointments.

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

- Patients told us they were given clear explanations about their care and treatment. Most said they were given written and verbal information and that they were fully informed of the disadvantages of treatment as well as the benefits. Others said that they hadn't had much information, however had not requested it. One patient wrote on a comment card 'The consultant was polite and answered any questions regarding treatment.'

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- We saw leaflets available for patients that explained some of the procedures and diagnostic scans that were available. We saw a leaflet detailing the costs of self-pay outpatient services.
- Nurses told us that consultants undertook evening 'expert chats' for patients attending their clinics. This gave the patients an additional time to find out more about their treatment options and meet other patients with similar conditions.
- The laboratory would carry out all tests requested by the consultant. Staff working in the laboratory told us that the cost of the tests would be explained to the patient by the phlebotomist and agreement taken then. However, when we asked a phlebotomist to explain their procedures, clarification of costs and final agreement to all tests was not referred to. This could mean that patients were not informed of additional costs of blood tests alongside the reason given for having them.

## Emotional support

- Patients told us they felt well cared for and supported and that staff were pleasant and friendly. A patient told us, "When I had to bring my children in, the nurse helped to look after them."
- One comment received from a patient said "I came to the hospital very anxious. [staff were] so helpful and kind. When I arrived, staff were so welcoming. [The consultant] had such a kind manner."
- Specialist nurses were available when required under practicing privileges and were not employed by the hospital. The outpatient department had a plan to recruit a specialist breast care nurse in the future.
- A cardiac support group held regular events with speakers and was open for patients and their family members to attend.

## Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as good because:

- Services were planned and delivered to meet the needs of the local population. New equipment had been introduced in response to patient needs.

- Services coordinated appointments to enable patients to see a number of health care professionals in one day.
- There were clear examples of changes that had been made following complaints to improve the service provision.

However:

- In a 2016 assessment the department had 11 failures out of 22 dementia-friendly environment measures.

## Service planning and delivery to meet the needs of local people

- The environment was appropriate and patient centred. There was sufficient seating available in the waiting areas where free drinks were available. Patients told us 'it doesn't feel like a hospital.'
- Car parking was free and patients told us they did not have problems finding a space.
- Evening clinics in outpatients, imaging and physiotherapy department were provided Monday to Friday.
- The installation of a hydrotherapy pool and purchase of an anti-gravity treadmill within the physiotherapy department had been to support the rehabilitation of patients following orthopaedic surgery, as this was 70% of the volume of work the department undertook. The use of these facilities was evidenced in research as best practice, for benefits to patients having had total knee replacements and it had been well received.
- An eight week Pilates course had recently been started by the physiotherapy team and was being offered to patients as well as members of the public. This course had been started in response to patient demand.

## Access and flow

- There were no waiting lists for patients to attend radiology, outpatient or physiotherapy appointments with consultants.
- The imaging department reported on two contracts it held where they were tracked on their time to scan results from referral. These were either within 15 working days for one contract and 14 calendar days for the other and it was reported to us that these targets were met.
- Patients told us they were mainly seen on time or within 10 to 15 minutes of their appointment. However, complaints to the department included waiting times and one patient told us that they were not happy at the length of time they had been waiting.



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- Staff told us that if clinics were running over 15 minutes late, they would speak to the patients individually and offer refreshments or the opportunity to reschedule the appointment.
- We were told that clinics were on occasion delayed due to consultants arriving late and that this was logged as an incident if it was delayed by over 30 minutes. There were ten incidents of delayed or cancelled clinics due to consultant lateness on the incident list from January to August 2016. The manager would review these with the consultants. The manager also conducted audits of late start and finish times of clinics. We asked for the results of these audits, however were not provided with these.
- The radiology department and a breast surgeon operated a 'one-stop clinic', once per week, where patients could have a consultation, diagnostic imaging and aspiration or a biopsy if required, during one appointment.
- The utilisation of the clinics in the outpatients department had not been formally reviewed, however the booking system had been moved onto 'Outlook' in order to manage annual leave and requests for extra clinics in one program. There were plans for a review of clinic times in order to improve efficiencies.
- All staff we spoke to carried 'z cards'. These included key information about responding to patients living with dementia and reminders about responding to their particular needs.
- We were told that patients living with dementia would usually attend the hospital with a carer to assist them, and the booking office would inform the department beforehand of any additional needs. The manager said that there was a plan to introduce a dementia lead nurse for the outpatients department. The imaging department had a dementia lead who was looking to carry out training on dementia friends program.
- The hospital had taken part in the Patient Led Assessment of the Care Environment (PLACE) audit for the first time in June 2016. Within this audit, 11 out of 22 measures within the dementia-friendly environment were listed as failures.
- A picture with ceiling light had been put up above the bed in the ultrasound room for patients to look at during scans. Illuminated pictures were also on the wall within the imaging waiting room as the room did not have any external windows.
- Staff told us that air conditioning was planned to be installed within the cardiac physiology room, as the room was an uncomfortable environment for patients having stress testing.
- We observed discussion of specific patient's needs, that were due to attend the outpatients department that day, during the department daily huddle. This meant that staff would prepare appropriately for people attending that may require more time or support.

## Meeting people's individual needs

- Patient Information leaflets were available to patients about their treatment for some clinics. Staff gave these to patients to take away. Information leaflets were available for a number of procedures including local anaesthetic.
- Staff could arrange for face to face interpreting for patients whose first language was not English. We observed this being arranged appropriately and staff waiting for an interpreter, rather than having someone accompanying the patient translate.
- The hospital could be accessed by patients that had a physical disability. There was disabled parking, a lift and access to disabled toilet facilities. Wheelchairs were available at the entrance to the outpatients department.
- There were two examination couches and one chair that were suitable for bariatric patients.
- The hydrotherapy pool was equipped with a mechanical hoist for patients that might have difficulty entering the water.

## Learning from complaints and concerns

- The provider had a policy covering the raising of complaints.
- We saw leaflets available in all waiting areas entitled 'please talk to us'. These outlined the complaints procedure to patients and advised them on how they could provide feedback.
- In response to some negative feedback in a local patient satisfaction survey, the physiotherapy team had developed an information sheet that was provided to patients prior to their first appointment. This included guidance about what clothing the patient should bring with them.
- The most common complaint received was about cost of treatment. In response to this, the hospital had a leaflet available about self-pay, detailing the costs.



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- The hospital had received 87 complaints between January and June 2016. Of these, around 30 involved the outpatients department. Most of these were in relation to billing and charging issues. In the complaints log, there were clear explanations of the actions taken in response to these complaints.

## Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as good because:

- The vision for the hospital was clearly understood by all staff within the department.
- With the change of provider, there had been large-scale changes; however most governance processes now appeared to be robust and working well.
- Staff were focussed on providing the best service they could for all patients.
- There were regular opportunities for staff to communicate with senior managers and all staff told us that there was a friendly and supportive management structure.

However:

- The paediatric governance provisions were not yet in place and the strategy not completed, although the service was intended to re-start within three months.
- Team meetings were not yet planned on a regular basis in the outpatients department, which meant that there was the potential for missing the opportunity to share information.

## Vision and strategy for this this core service

- Staff we spoke to were aware of the vision for the hospital to be a 'shining light' within the Spire hospital group.
- The physiotherapy team had a plan for development of further specialised services, such as women's health.
- The vision for children and young people was to restart paediatric outpatient clinics in November 2016. Following this, as the theatre and ward builds were completed and staff appropriately trained, the hospital intended to restart surgical procedures for children. We saw plans of the proposed ward extensions and viewed the partially constructed theatre areas. It was intended

that the service would start on a small scale and then gradually increase. However; the paediatric draft strategy document that we were provided did not provide a clear plan of how the service would be re-started ensuring that the appropriate training and governance framework was in place.

## Governance, risk management and quality measurement for this core service

- The clinical governance structure was defined, although they had only been in place since April 2016. The executive team used various methods to gain assurances from the ward to the board, including a daily hospital huddle that allowed key issues to be raised across departments.
- The MAC met quarterly and the minutes for the last three MAC meetings demonstrated that key governance areas were discussed including incidents and practising privileges.
- Managers attended quarterly clinical governance meetings. We saw minutes of these that clearly stated lessons learned from incidents and other governance topics. Sub-committees including a quality improvement committee, reported to the clinical governance committee.
- Staff told us how the change, after Spire took over as the provider, had been positive. Many said how this had led to improvements with governance and had 'tightened things up' but not at the expense of patient care. They said as it was a large corporate provider, there was far more opportunity for information sharing and benchmarking which was a great benefit.
- Consultants told us that their practicing privileges were renewed annually and that the hospital was very strict on the process for this. If the paperwork was not submitted in time, they would be suspended from working at the hospital until it was completed.
- A daily operational huddle was held each morning with senior managers. This concentrated on information about operational issues, but offered the opportunity for cross department information sharing and resource sharing where appropriate. The imaging department had a staff huddle immediately following this meeting in order that key information was cascaded to the staff.
- Previously, there had been no separate governance process for paediatrics at the hospital. We were told that paediatrics was on the agenda at MAC meetings, quarterly governance meetings and clinical

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effectiveness meetings. However, in reviewing minutes provided to us, we did not see this within all meetings. Managers we spoke with agreed the previous process had not been robust. The paediatric service was currently suspended and we were told about the plans for the new governance structure, which involved joining a national paediatric steering group meeting in October 2016. A paediatric anaesthetist was now part of the MAC representing paediatric services.

- A daily lunchtime handover meeting between the early and late shift nurses within outpatients gave an opportunity for information to be shared.
- The outpatient department risk register had been written at a joint corporate event with other Spire hospitals. The outpatient manager had done this initially in February 2016, with a subsequent review in July 2016. We were told this meant that each department had ownership of their own risks, whilst being able to consider whether risks identified in other hospitals were relevant. There was some conflict within the risk register. Use of chemotherapy drugs within the outpatients department was referred to, however we were told that this actually was related to administration of monoclonal antibodies and that this was not undertaken within the outpatients department.
- The imaging department's risk register did not contain any reference to ageing equipment. However when we asked the senior imaging managers what their biggest concerns were, ageing equipment was the main response.
- The laboratory was responsible for quality control and training for point of care testing, such as coagulation, glucose and blood gases. There was not a point of care committee active within the hospital as is recommended for best practice. However any new point of care equipment could only be introduced after evaluation by the laboratory.

## Leadership / culture of service

- Staff we met were all welcoming, helpful and friendly. They enjoyed working at the service and many mentioned how the focus on patients was a key part of this.
- Many staff had worked at the hospital a number of years, so had been there throughout the change of

ownership and the subsequent changes that followed. They were all positive about the changes and one said that the staff that had stayed 'felt empowered' which contributed to the positive steps forward.

- All staff we spoke with felt valued and said their managers were supportive and approachable. They felt that they were encouraged to be open about concerns. One said 'I'd recommend (it to) anyone to come and work here.' Another said 'everybody knows everybody, I really like that.'
- We were told of a quarterly party held in the hospital for staff who had celebrated their birthday within those three months. Invitations were also given to staff who had been awarded an inspiring people award, following nomination by a patient or another staff member and presentations were made at this event.
- Staff reported an open and transparent culture which was apparent during our inspection.
- Staff told us of regular invitations to a coffee morning with the hospital director that staff were supported to attend. Additionally, all staff we spoke with said the hospital director was always visible and approachable at other times, for instance by going into each department in the morning to greet staff.
- Consultants told us that there were some social functions arranged where they would be introduced to new colleagues. However they said there were no formal processes to meet new consultants.

## Public and staff engagement

- The hospital carried out a patient satisfaction survey that patients were encouraged to complete in order to improve services. Results were compiled into a monthly report.
- The physiotherapy team had conducted a separate patient satisfaction survey in February 2016 and responded directly to the comments. We saw records of the responses received and actions made where the responses had been negative and included clearer information provided about billing.

## Innovation, improvement and sustainability

- The executive team were responsive to requests and suggestions for improvement.
- All staff were focussed on improving the quality of care that they were providing.
- The physiotherapy service had recently started offering patients the use of an anti-gravity treadmill for

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rehabilitation. This was only available in a few locations across London and has been shown to be beneficial in speeding up recovery time for patients who have had a hip or knee replacement by increasing their confidence and reviewing walking technique.

- As part of the main theatre refurbishment, a new hybrid interventional theatre had been installed.

# Outstanding practice and areas for improvement

## Outstanding practice

- The design of the new theatres and the training programme being developed for staff

## Areas for improvement

### Action the provider **MUST** take to improve

- Improve all its governance processes, so that patients receive safe and effective care. For example: ensure there are effective systems to monitor and review all patient deaths and other adverse events, including involving the medical advisory committee; ensure risks are tightly managed with clear mitigation; ensure compliance with practising privileges policies.
- Implement a robust governance structure for paediatric services and ensure that hospital staff and consultants are all appropriately trained prior to re-starting all paediatric care.

### Action the provider **SHOULD** take to improve

- Review and close incidents and complaints promptly to ensure learning to improve the service is identified at the earliest opportunity,
- Assess all risks and record, monitor and review actions to control risks,
- Ensure effective multidisciplinary working take place across all specialities.
- Review national audits and identify those in which they are eligible to take part to ensure practice and patient outcomes are benchmarked against national standards.

- Review the process of pre-operative assessment to ensure all patients requiring one have this sufficiently far ahead of the surgery procedure date for results to be available.
- Continue to control surgery bookings so that procedures do not overrun and that doctors do not add patients late to the list.
- Ensure staff receive feedback about incidents and complaints to help them learn and improve.
- Ensure nurse documentation of patient observations is accurate.
- Staff should review the appropriateness of a cross being automatically provided on the wall in patient rooms.
- Staff should consider a means of capturing informal complaints raised by patients, and improve the timeliness of complaints handling.
- The hospital should ensure that cosmetic surgeons were following the recommended procedures for patients to have appropriate assessments before reaching a decision to proceed.
- Some self-paying patients were anxious about unanticipated costs and the hospital should review its charging arrangements.
- The hospital should review its support elderly patients and those living with dementia to ensure staff have an understanding of how to assess and meet the needs of this group of patients.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>Systems or processes were not established and operated effectively to ensure compliance with the requirements of the regulation because:</b></p> <ol style="list-style-type: none"><li>1. Systems to monitor and review all patient deaths and other adverse events lacked rigor.</li><li>2. Compliance by consultants with hospital policies related to patient safety were not strictly enforced.</li><li>3. Not all risks were identified and most did not have clear, time-bound mitigation.</li><li>4. There was not a robust governance structure for paediatric services.</li></ol> <p><b>Regulation 17 (2)(a)(b)</b></p>