

Spire Fylde Coast Hospital

Quality Report

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Date of inspection visit: 6 to 7 September and 15 September 2016
Date of publication: 30/05/2017

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

Spire Fylde Coast Hospital is operated by Spire Healthcare Ltd. The hospital has 26 single rooms and 11 day care beds which are provided in two single sex bays. Facilities include three operating theatres, 10 consulting rooms, physiotherapy treatment rooms, medical imaging services and outpatient and diagnostic facilities. Outpatient clinics are also provided from a small clinic in Lytham, approximately 20 minutes away. Facilities for plain x-ray diagnostic tests are also available in this clinic.

The hospital provides surgery and outpatients and diagnostic imaging services. We inspected both of these services. The services for children and young people had been reviewed by the provider and were suspended at the time of this inspection.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 and 7 September 2016, along with an unannounced visit to the hospital on 15 September 2016.

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

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

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

We rated this hospital as requires improvement overall. This was because:

- At the time of our inspection there were insufficient numbers of staff deployed in theatre in accordance with the association of perioperative practitioners (AFPP) guidelines. Action was being taken to improve this.

- Staff were not adhering to the controlled drugs regulations 2001 when controlled drugs were being administered.
- Hospital staff were not consistently implementing the World Health Organisation (WHO) surgical safety checklist for the administration of joint injections, to ensure safety checks were completed.
- Staff at the hospital were not fully implementing the controls to mitigate the risk to patients who were identified as at an increased risk of bleeding.
- Competency assessments had not been fully completed and documented appropriately for staff undertaking the role of the surgical first assistant
- Risks and areas of poor compliance were not always correctly identified or dealt with in a timely way.
- Medicines were not consistently stored within the recommended temperature range and any variation in this was not always acted upon appropriately.
- Compliance rates with some specific key training areas was low.
- One department had not reported clinical and non-clinical incidents on the electronic system to ensure improvements could be made when needed.
- Department of Health standards were not being met in respect of the provision of hand wash basins within patient areas.
- There was no equipment checklist for theatre to ensure equipment was checked appropriately prior to surgery being undertaken.
- Control of substances hazardous to health (COSHH) legislation was not consistently followed when storing flammable liquids.
- Theatre access was not restricted, therefore there was a potential that unauthorised persons were able to enter unsupervised.
- Consultant signatures were not consistently timed and dated in all patient records.

Summary of findings

- The 'sign out' phase of the World Health Organisation (WHO) surgical safety checklist was not always being completed following surgical procedures.
- Staff we spoke with were unaware of any policy or standard operating procedure to provide guidance on appropriate staffing levels. Additionally, there was no escalation guidance for staff to ensure it was clear when a manager should be contacted during out of hours.
- Compliance with fasting guidance prior to surgery was not consistent.
- There was a low level of compliance in completion of annual staff appraisals to ensure their performance was reviewed and improvements made where needed.
- There was a lack of clarity in the records we reviewed if the two week 'cool off' period was adhered to for patients undergoing cosmetic surgery.
- The hospital had not adapted facilities to support people living with dementia.
- The monitoring of governance processes was not robust.
- A new corporate risk register had been recently introduced in the hospital and staff were not yet familiar with the management of the documentation.

However:

- In the outpatients department there were sufficient numbers of nursing and support staff to meet patients' needs and we observed effective multidisciplinary working by competent staff
- We saw that care and treatment was provided in a kind, compassionate way. Staff treated all patients with dignity and respect during their time at the hospital.
- We found suitable medical cover at all times from a resident medical officer and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues.
- There was an effective system for managing complaints and concerns.
- There was an open culture with staff able to raise concerns or issues.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with six requirement notices that affected both surgery and outpatients and diagnostic services.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Surgery

Requires improvement



We rated this service as 'requires improvement'. This was because;

- We found that, between July 2016 and the time of inspection, the member of staff completing the surgical first assistant (SFA) role was in replacement of one of the scrub nurses. This meant that the theatre team was continuously one scrub practitioner short of the Association for Perioperative Practitioners (AFPP) guidelines when an SFA was required.
- There were no clear escalation guidelines for nursing staff to follow which determined when a manager should be called.
- Only 20% of theatre staff were up to date with their annual appraisal, which meant there had been limited opportunity for staff to have their performance reviewed.
- There were some areas of risk that had not been dealt with appropriately or in a timely way. Controls that had been put in place to reduce this risk had not always been followed and the senior management team were unaware that this was the case.

However,

- The hospital used care pathways that had been designed by Spire and were followed when delivering care and treatment to patients. A care pathway was in place for all treatments provided.
- Spire had an overall vision and strategy. The values highlighted in this statement were caring, succeeding, driving excellence, doing the right thing, delivering on promises and keeping it simple.

Outpatients and diagnostic imaging

Requires improvement



We rated this service as 'requires improvement'. This was because;

Summary of findings

- There were systems for keeping people safe, including the reporting and investigation of safety incidents.
- We found suitable nursing and medical cover at all times to meet the needs of patients.
- There were sufficient numbers of nursing and support staff to meet patients' needs and we observed effective multidisciplinary working by competent staff.
- We saw that care and treatment was provided in a kind, compassionate way. Staff treated all patients with dignity and respect during their time at the hospital.
- There were arrangements to ensure that the individual needs of patients were met, for example, interpreters could be booked for patients and the hospital was wheelchair accessible.
- There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams. There was appropriate management of quality and governance at a local level.

However:

- Mandatory training rates, including safeguarding adults and children were below those expected by the organisation.
- The temperature of the room where medicines were stored within the outpatients department was noted to be frequently above the recommended maximum temperature of 25 degrees centigrade.
- There was personal identifiable information within an unlocked cupboard in the physiology exercise room, which was potentially accessible to the general public.

Summary of findings

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Requires improvement



Spire Fylde Coast Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Spire Fylde Coast Hospital

Spire Fylde Coast Hospital is operated by Spire Healthcare Ltd. It is a private hospital in Blackpool, Lancashire. The hospital has been operating for over 32 years (opening in 1983). It is located 400 yards from a local NHS trust main acute site. It is on the outskirts of the town of Blackpool and about one mile from the seaside promenade. Blackpool and the wider Fylde Coast have a population of around 350,000. The hospital primarily serves the communities of Blackpool and the Fylde Coast; however it also accepts patient referrals from outside this area.

The hospital is registered to provide diagnostic and screening procedures, surgical procedures and treatment of disease, disorder and injury. The hospital has a

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

This hospital was inspected in February 2014.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 and 7 September 2016, along with an unannounced visit to the hospital on 15 September 2016. We visited the Lytham outpatient clinic as part of the announced inspection.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

Our inspection team

The team that inspected the service comprised an inspection manager, CQC lead inspector, two other CQC inspectors and specialist advisers with expertise in operating theatres and governance. The inspection team was overseen by Ann Ford, Head of Hospital Inspection.

Information about Spire Fylde Coast Hospital

The main service at this hospital was surgery. The consultant surgeons could have seen the patient at this hospital in the outpatient department or in an NHS setting. The patient would then be scheduled for their surgery and have their pre-operative assessment at this hospital. The patient's post-operative care would be provided either as an inpatient or a day case patient at this hospital.

The outpatient department provided an environment for patients to see specialist consultants and have minor procedures if that was suitable within an outpatients treatment area.

During the inspection, we visited the inpatient ward, day care ward, outpatient clinics, operating theatres and

diagnostic imaging facilities. We spoke with 10 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with five patients and two relatives. During our inspection, we reviewed four sets of patient records including medication charts. There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

In the reporting period April 2015 to March 2016, there were 7,298 inpatient and day case episodes of care recorded at the hospital. Of these, 81% were NHS funded

Summary of this inspection

and 19% were funded by other means. Sixteen percent of all NHS funded patients and 25% of all other funded patients stayed overnight at the hospital during the same reporting period.

There was a total of 30,940 outpatient attendances in the same reporting period, of these 86% were NHS funded and 14% were funded by other means.

There were 141 consultants who worked at the hospital under practising privileges. There were two regular resident medical officers (RMO) who worked on a week on and week off rota. At 1 April 2016, there were 17.2 full time equivalent registered nurses and four health care assistants working in the inpatient departments of the hospital. In the outpatient department there were four registered nurses and 6.7 full time equivalent health care assistants. The accountable officer for controlled drugs (CDs) was the registered manager.

There had been one never event in the reporting period April 2015 to March 2016. This was a wrong site anaesthetic block. In the same reporting period, there

were 268 clinical incidents. Of these, 170 resulted in no harm, 56 low harm, 40 moderate harm, two severe harm and none in death. There were no serious injuries during this reporting period.

There were no incidences of hospital acquired methicillin-resistant *Staphylococcus aureus* (MRSA) or methicillin-sensitive *Staphylococcus aureus* (MSSA) in the reporting period April 2015 to March 2016. In the same period there were no incidences of hospital acquired *Clostridium difficile* (C.diff) or hospital acquired E-Coli. There were 102 complaints in the reporting period April 2015 to March 2016.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Pharmacy ordering and delivery services
- Interpreting services
- Laser protection service
- Maintenance of medical equipment
- Pathology and histology

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as requires improvement because:

- We found the decontamination department were using paper incident reporting forms rather than the electronic incident reporting system. These had not been raised with the theatre management team.
- On the ward area, there was only one hand basin in the patient bedrooms.
- Theatres were accessed by double doors which were unsecured. This meant that members of the public could gain access unsupervised. Following the inspection we were provided with assurance that improvements were being made.
- Equipment did not always have up to date stickers which highlighted when they were due for service. This meant that it was unclear to staff if they were safe for use.
- We found flammable substances stacked against the wall instead of being stored in the designated flammable liquid cupboard. This provided a risk to both staff and patients in that current legislation was not being adhered to.
- Controlled drugs were not being managed in accordance with the controlled drugs regulations 2001.
- The service did not have a fridge for storing blood at the time of inspection. This had broken down in April 2016 and had not yet been fixed.
- The management had identified a risk to patients that blood was not readily available for use in an emergency situation. A risk assessment had been completed and included a number of controls to mitigate this. However, we found that these controls were not being followed consistently.
- We found that, between July 2016 and the time of inspection, the member of staff completing the surgical first assistant (SFA) role was in replacement of one of the scrub nurses. This meant that the theatre team was continuously one scrub practitioner short of the Association for Perioperative Practitioners (AFPP) guidelines when an SFA was required.
- Two members of the management team we spoke with were unable to provide any escalation guidelines for nursing staff to follow which determined when a manager should be called.
- The temperature of the room where medicines were stored within the outpatients department was noted to be frequently above the recommended maximum temperature of 25 degrees centigrade.

Requires improvement



Summary of this inspection

- There was personal identifiable information within an unlocked cupboard in the physiology exercise room, which was potentially accessible to the general public.
- Staff in all areas were not compliant with the hospital target for mandatory training including both safeguarding adults and children training, with the worst compliance being in diagnostic imaging with only 30% of staff being compliant in safeguarding children training.

However:

- There were systems for the reporting and investigation of safety incidents that were well understood by most staff. Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.
- We found suitable medical cover at all times from a resident medical officer and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues.
- There were sufficient numbers of nursing and support staff on the inpatient ward and outpatient areas to meet patients' needs.

Are services effective?

We rated effective as requires improvement because:

- We found that the efficiency of pain medication had not been documented within all patient records.
- Staff were not following Spire guidelines with nutrition and hydration, particularly in terms of compliance with patients being nil by mouth two hours prior to surgery.
- The hospital did not use a nationally recognised tool to collect patient satisfaction information with breast augmentation and blepharoplasty operations. This meant there was limited oversight of the quality of cosmetic surgery that had been undertaken.
- There was no evidence that staff who completed the role of the surgical first assistance had completed an assessment of their competence.
- Only 20% of theatre staff were up to date with their annual appraisal, which meant there had been limited opportunity for staff to have their performance reviewed.
- Communication between the theatre and ward teams was not always effective.
- When a patient was discharged, an electronic discharge form was sent to the patient's GP. However, information about implants was not sent as part of this, which was against national guidance.

Requires improvement



Summary of this inspection

- The records that we reviewed lacked clarity of whether the two week 'cool off period' was being adhered to when we reviewed the case notes of patients who had undergone cosmetic surgery
- No staff appraisals had been completed for staff working in the outpatient departments during the current appraisal year (January 2016 to December 2016).

However:

- The hospital used care pathways that had been designed by Spire and were followed when delivering care and treatment to patients. A care pathway was in place for all treatments provided.
- The hospital's outcomes for primary knee replacements and primary hip replacements were similar to outcomes reported by similar services nationally.

Are services caring?

We rated caring as good because:

- We saw that care and treatment was provided in a kind, compassionate way. Staff treated all patients with dignity and respect during their time at the hospital.
- Patient led assessments of the care environment (PLACE) showed that 93% of patients thought that their privacy and dignity had been maintained during their time at the hospital.
- The hospital took part in the NHS Friends and Family test for all patients who were NHS funded. This showed that between October 2015 and March 2016, monthly averages, for patients who would recommend the service, varied between 95% and 100%. However, response rates during these periods had been low, ranging from 11% to 34%.

Good



Are services responsive?

We rated responsive as good because:

- The hospital had access to translation services and interpreters if required. The needs of the patient and family were assessed during the initial assessment and a translator or an interpreter was booked if needed.
- There was access to psychological services that were provided by another hospital if required.
- The hospital had adapted some facilities to accommodate bariatric patients who were undergoing treatment. This included a modified wheelchair and the inpatient ward had access to two bariatric beds if needed.

Good



Summary of this inspection

- The hospital had a policy for managing complaints and concerns. Staff that we spoke with were able to tell us about the complaints process and that if a complaint or concern was raised, it was escalated to the department manager.
- The provider met the target of 92% of patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 2015 to March 2016).
- The provider met the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period before the targets were abolished (April 2015 to May 2015). Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 2015 to March 2016).
- The hospital had no patients waiting longer than six weeks for Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) or non-obstetric ultrasound during the reporting period (April 2015 to March 2016).

However:

- The hospital was unable to provide shower facilities in some rooms as modernisation of some facilities on the ward was still in progress.
- The hospital had not made any formal adjustments to the facilities that met the needs of patients living with dementia. The service had recently provided dementia training to staff as part of the e-learning course that was available.

Are services well-led?

We rated well-led as requires improvement because:

- The hospital did not have any clear policies or guidelines determining staffing levels on the inpatient ward or in theatre. However, in theatre, staffing levels did not meet the guidelines set by the Association for Perioperative Practitioners (AFPP).
- There had been no audit process undertaken to provide assurance of compliance with actions implemented as a result of a never event.
- There were some areas of risk that had not been dealt with appropriately or in a timely way. Controls that had been put in place to reduce this risk had not always been followed and the senior management team were unaware that this was the case.
- The clinical governance team were not always aware of incidents that had occurred. This meant that the management team were unaware of some incidents and they were not investigated to ensure improvements could be made.

Requires improvement



Summary of this inspection

- Staff turnover had been consistently high between the period April 2015 and March 2016, which was a significant increase from the period of April 2014 to March 2015.
- The rate of sickness for outpatient nurses was varied when compared to the average of other independent acute hospitals we hold this type of data for during the reporting period (April 2015 to March 2016). The rate was particularly higher than the average in January 2016 to March 2016.

However:

- Spire had an overall vision and strategy. The values highlighted in this statement were caring, succeeding, driving excellence, doing the right thing, delivering on promises and keeping it simple.
- The hospital had set its own objectives based on these values. These included delivering high quality care, enhancing relationships with partners to promote services to the local population and improving the hospital's survey scores.
- The management team had also developed a strategy for each individual department which included theatres and the ward area. Staff were aware of the strategy for their area.
- The hospital used departmental risk assessments to highlight and manage areas of risk. Significant risks were escalated to the hospital risk register.
- Incidents and complaints were investigated by the appropriate members of staff and oversight of this process was provided by the clinical governance coordinator. Outcomes and learning from incidents and complaints was disseminated to staff through team meetings or by email.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Surgery

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

Are surgery services safe?

Requires improvement 

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

We rated safe as requires improvement.

Incidents

- The hospital had an up to date incident reporting policy that was available on the intranet. Staff we spoke with were able to identify examples of things that were reported as incidents.
- The hospital used an electronic reporting system and staff were able to demonstrate how this was used. All substantive staff who were employed by the hospital and consultants had access to the system. However, agency staff did not. They told us that, if they wanted to report an incident, they would escalate it to a manager to do it for them.
- We found that the decontamination department were using paper incident reporting forms that we found to be filed away in the department. Staff confirmed these incidents had been discussed as part of their own meetings but had not been raised with the theatre management team. This was of concern as five of the incidents that we reviewed included things such as lost equipment following a surgical procedure. The missing equipment had not been found and at the time of inspection, these incidents had not been investigated.

When we returned to complete the unannounced part of the inspection, we were shown evidence that these incidents had been added to the electronic system and were being investigated.

- Between the period of April 2016 and August 2016, the hospital had reported one ‘never event’ (never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented) and no serious incidents.
- The never event had been reported as a result of a wrong site anaesthetic block. We reviewed the route cause analysis (RCA) that had been completed and found that the appropriate members of staff had been involved in the investigation. Actions had been taken to ensure the risk of it happening again was minimised.
- A number of other RCAs had been completed following incidents such as venous thrombo-embolism (a blood clot) or as a result of a surgical site infection occurring. These RCAs also had actions so that improvements could be made.
- Staff confirmed they had received feedback after submitting an incident report. We were given examples of how learning from incidents had been disseminated. Examples of this included via email or as part of the daily handover.
- Between the period of April 2015 and March 2016, there had been 200 clinical incidents reported by staff from theatres and the inpatient ward. Additionally, there had been 54 non-clinical incidents reported during the same period.
- We reviewed a sample of incident reports between the period of March 2016 and August 2016. The majority of incidents reported had been as a result of surgery cancellations, unplanned transfers, surgical site infections and medication errors.

Surgery

- Morbidity was discussed as part of the medical advisory committee meetings which were documented.
- The hospital had a duty of candour policy which was available on the intranet. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The management team had knowledge of this and we saw evidence of the duty of candour being instigated when required.
- The hospital had two theatres which used a laminar flow system. Laminar flow is a system that is used to circulate filtered air in order to reduce the risk of airborne contamination and exposure to chemical pollutants. If staff were to enter or leave theatre during an operation, they had to use the anaesthetic room so that the air flow in theatre was not affected. We found the system in both theatres to be working well.
- The number of surgical site infections that were acquired during operations was monitored by the management team. Between April 2015 and March 2016, there had been 16 incidences of surgical site infections reported. These had been investigated using an RCA and had been reported to the infection and prevention control group as well as the medical advisory committee.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital submitted data to the NHS safety thermometer for NHS funded patients who had received care and treatment. The NHS safety thermometer measures levels and numbers of patient harm.
- Between April 2015 and March 2016, there had been one reported incident of venous thromboembolism (VTE). Guidelines from the National Institute for Health and Clinical Excellence (NICE) recommend that all patients should be VTE risk assessed on admission and reassessed 24 hours after surgery. Records indicated that between January 2016 and June 2016, monthly compliance with the initial risk assessment being completed correctly had varied from 75% to 100%. Similarly, compliance with reassessments having been completed varied between 60% and 100%. There was no evidence of an implemented action plan to improve this.
- Patients were also assessed for the risk of falls and pressure ulcers on admission to the hospital. Between January 2016 and June 2016, compliance with this had varied between 90% and 100%.
- The hospital had reported no incidences of hospital acquired infections between the period between April 2015 and August 2016. This included infections such as methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C.diff), methicillin-sensitive Staphylococcus aureus (MSSA) and carbapenemase producing enterobacteriaceae (CPE).
- The hospital had a decontamination suite that was located next to the theatre area. Staff were available during normal working hours, six days a week and were responsible for the decontamination of all surgical equipment that required sterilisation following a surgical procedure. Once equipment had been decontaminated, a green 'I am clean' sticker was attached so that staff were able to identify equipment that was ready for use.
- Additionally, the service had facilities to decontaminate and store endoscopes appropriately. This included the use of a sterilisation machine and the scopes were vacuum packed once cleaning had been completed. Contaminated scopes returning from theatre were placed in red packaging to ensure they were easily identifiable.
- Theatres were deep cleaned once every 12 months. This service was provided by an external company.
- Patients were screened for infection as part of the pre-operative clinic. If a patient was positive for having an infection such as methicillin-resistant Staphylococcus aureus (MRSA), the infection control

Cleanliness, infection control and hygiene

- The hospital had an infection control policy which was available on the intranet. Staff were able to locate this when needed. The hospital also had an infection and prevention control lead.
- We observed both the theatre and ward areas to be visibly clean. Housekeepers were available during normal working hours, seven days a week and were responsible for cleaning the ward and theatre areas. The management team confirmed that if housekeepers were not available out of hours then a room or area would be closed until the following morning.

Surgery

policy stated what precautions had to be implemented. This included using appropriate personal protective equipment (PPE) and managing the patient in individual bedrooms.

- We found that staff were compliant with 'bare below the elbow' guidance and that personal protective equipment (PPE) was used on a regular basis in line with hospital policy. PPE was also provided for visiting relatives when needed.
- When preparing to go to theatre, patients were asked to shower, to remove any hair around the site that surgery would take place (with staff guidance) and were given the appropriate gowns to wear.
- In theatre we found that surgical staff showed consideration to infection prevention and control procedures and best practice guidance (NICE CG74) in using sterile gowns and gloves as well as the use of incise drapes and antiseptic skin preparation.
- On the ward area, there was only one basin in the patient bedrooms we inspected. It is recommended that a minimum of one clinical hand wash basin is available in each single room, in addition to the general hand wash basin for personal hygiene in the en-suite facility (Health building note 00-09, Infection control in the built environment, Department of Health). There were no additional hand wash basins on the ward corridors for patients, the public or staff to use.
- There were hand gel dispensers at the entrance to every area where patient treatment was carried out. We observed staff using these.
- Observational hand washing audits were completed by the management team on a quarterly basis. Records indicated that between April 2016 and June 2016, theatre staff were 100% compliant and nursing staff 86% compliant with this. However, an overall target had not been set by the hospital.
- The hospital took part in patient led assessments of the care environment (PLACE). Between February 2015 and June 2015, 98% of patients had given positive feedback about the cleanliness of the hospital facilities.

Environment and equipment

- All areas of the hospital were on the ground floor. There were 26 individual en-suite rooms as part of the ward area. Ten of these were awaiting refurbishment in which there were only baths available. Additionally, there were two open ward areas that had a total of 11 beds.
- Theatres were accessed by double doors which were unsecured. This meant that members of the public could gain access unsupervised. We were given assurance following the inspection that improvements were being made.
- Each theatre had its own anaesthetic room. There was a three bedded recovery area as part of theatres which was used to recover patients post-surgery.
- Both the ward area and theatres had access to two resuscitation trolleys, a difficult airway trolley and a major haemorrhage trolley. Staff told us that it was the responsibility of the night staff to ensure these had been checked. Tamper tags were present on all of them which meant that staff were assured that nothing had been used since the last time they were checked. We found resuscitation equipment was kept in the resuscitation trolleys in line with hospital policy. However, for the month of August 2016 we found there were three occasions when the resuscitation trolley for theatre had not been checked.
- The service had equipment that was used to transfer a patient to another hospital when needed. This equipment included things such as a portable ventilator. We found this had been stored securely and was sealed with a tamper tag. However, over a 12 week period leading up to the inspection there had been 14 occasions when this had not been checked.
- Staff checked equipment in the anaesthetic room by completing a daily checklist. This was in line with guidance from the Association of Anaesthetists (2009) for the safe management of anaesthetic related equipment. However, there were no formal arrangements for checking equipment in theatre. This meant that there was limited assurance that equipment was being checked for things such as service dates before use.
- The management team told us there had been some issues servicing equipment in the past as it was done through a number of service level agreements. However, the hospital employed two technicians who had recently developed a database to monitor hospital assets.
- We checked a sample of equipment for compliance with servicing and portable appliance testing (PAT). We found two pieces of equipment that had out of date service stickers on them which included a tourniquet machine and a suction unit. The management team

Surgery

provided assurance that they had been serviced.

However, this had not been identified and re-labelled by staff prior to the inspection despite the equipment being used.

- In theatre three we found flammable substances stacked against the wall instead of being stored in the designated flammable liquid cupboard. This provided a risk to both staff and patients in that the control of substances hazardous to health (COSHH) legislation was not being adhered to. We highlighted this to the management team who took immediate action to store them appropriately.
- Waste was managed appropriately in dirty sluice rooms. Clinical waste was segregated from domestic waste and dirty linen bins were used. However, on one occasion we saw that a dirty linen bin had been left on a corridor that was accessible to patients and relatives. Additionally, we found a sharps box that was full and left open in an anaesthetic room.
- Staff were positive about the availability of the correct amount of equipment. We found that staff rotated disposable equipment so that the risk of them going out of date was reduced.
- The service used a paper based recording system to identify serial numbers of implants that were used. This provided a system to identify patients if a safety alert about the implant that had been used was received.

Medicines

- The hospital had an up to date policy for the safe storage, recording of, administration and disposal of medicines. This was available on the intranet.
- There was a pharmacy department that was open during normal working hours, five days a week. The hospital employed a pharmacist who was responsible for ensuring that medications were available when required and dispensed appropriately.
- Outside of these hours, the resident medical officer was able to access the pharmacy when required. The hospital policy stated that they had to be accompanied by a nurse if any medication was withdrawn.
- Controlled drugs were not being managed in accordance with the organisations' policy "safe management of controlled drugs". This stated "The amount of controlled drug used and discarded must be completed in all records in all cases". Between 1 August 2016 and 16 September 2016 in theatre one, there had been 27 occasions when the amount of controlled drugs

administered and disposed of had not been recorded in line with this policy. We also found a similar issue on the ward. Additionally, records of audits undertaken between January 2016 and June 2016, showed compliance with this had been continually poor, with results ranging from 16% to 50%. We inspected cupboards on the ward and in theatre and found the correct number had been recorded. We saw evidence of action plans being implemented to make improvement but these had not been effective.

- At the time of our inspection, we found fridge temperatures were all within normal ranges which meant that medicines were stored at the correct temperature. Staff completed daily fridge temperature checks in line with the hospital policy. However, between 1 and 16 September 2016, we found that daily checks had not been completed on six occasions in theatre three. Additionally, records indicated that between January and June 2016, fridge temperature checks had been inconsistent.
- The service did not have a fridge for storing blood at the time of inspection. This had broken down in April 2016 and had not yet been fixed. The management team told us that one was on order, but as a result, the hospital was unable to store blood on site. However, the management team had completed a number of scenarios to assess the level of risk to patient safety. This included assessing how long it took to receive blood from a nearby hospital.
- General medicines were stored and prepared appropriately in locked clinical areas. A lockable trolley was used when medication rounds were undertaken. Members of staff completing this were highlighted through the use of a red tabard which reminded other staff not to disturb them.
- Lockable cupboards were available in each room so that patient's medication was stored appropriately. This medication was added to the patient's prescription card and administered by a member of staff.
- We checked a sample of prescription cards and found that allergies were documented and that they had all been completed correctly.

Records

- The hospital used a paper based records system. We found that records were kept appropriately in a secured staff area. Additionally, records were also kept by the

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patients' bedside. These records consisted of charts listing physiological signs, risk assessments, medications prescribed and the treatment pathway that the patient was following.

- We inspected ten sets of records and found they had been completed correctly on most occasions. These included clinical notes, anaesthetic records, surgical records and post operation care plans. Risk assessments such as those for venous thromboembolism (VTE), falls and pressure ulcers had all been completed. However, the free text in three records was illegible and on all occasions, the consultants had not documented their general medical council (GMC) number when signing the documentation. This was not in line with guidance from the General Medical Council which recommends that this should be done to ensure all records are legible.
- Theatre registers were completed for every procedure undertaken. We found these records were not completed fully in that not all the team members were listed and their role was not documented. For example, it was unclear who had been the scrub nurse and who had been the surgical first assistant.

Safeguarding

- The hospital had a safeguarding policy which was based on the intranet. Staff we spoke with knew how to locate this. Staff were able to describe what constituted a safeguarding concern and were able to describe how it would be escalated. However, staff were unable to tell us about female genital mutilation (FGM).
- Staff had access to a safeguarding level two module which had to be completed via e-learning. This met guidance from the Royal College of Nursing (2016), which recommends that all staff who have direct patient contact should have a minimum of safeguarding level two. Records indicated that staff in theatres and on the inpatient ward were 77% compliant with level two safeguarding for adults. This met the provider's target of 75% for quarter three.
- There was a safeguarding lead who was trained to level three for adults and children. They were available during normal working hours, five days a week. If a safeguarding issue had been identified as part of a pre-operative assessment or as a result of an inpatient

stay, the information was passed to the lead for review. There was also a 24 hour contact number for safeguarding referrals for staff to use and were highlighted as part of the safeguarding policy.

- We were given an example of when a safeguarding referral had been made and the actions which had been put in place to protect the patient whilst they were under the care of the hospital.
- The service also had a resident medical officer on site 24 hours a day, seven days a week who was trained to level three safeguarding for adults and children.

Mandatory training

- Mandatory training was available to all hospital staff and was mainly completed via e-learning. The e-learning modules had been developed by the Spire education team and were available to all Spire staff.
- As part of the e-learning programme, there were eight standard modules that all staff had to complete. These included fire safety, health and safety, compassion in practice, manual handling, equality and diversity, safeguarding adults, safeguarding children and infection control. Overall compliance with these was 73% for staff in theatre and on the inpatient ward.
- Additionally, role-specific training was provided which included things such as blood transfusion, managing violence and aggression, mental capacity and management of controlled drugs. We found that compliance with these modules varied. For example, in theatres only three members of staff were up to date with training in blood transfusion and six members of staff in the management of controlled drugs. We were unable to calculate the overall compliance for these as the management team did not provide a number of staff who had been identified to complete this.
- Records indicated that compliance with adult basic life support training was low. Only 48% of staff had achieved this. Hospital policies stated that everyone working on the inpatient ward and in theatre should be trained in basic life support. Additionally, only 32% of staff had been trained in immediate life support. Records indicated that the resident medical officer had completed and was up to date with adult advanced life support training. Resuscitation training was provided by a Spire member of staff who was based at a different hospital. This was not highlighted on the risk register and we did not see a formal plan of action to improve compliance with this.

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- Mandatory training for agency and medical staff was completed by their agencies. The management team kept training records for the resident medical officers and monitored the training for consultants as part of the appraisal process.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- All patients received a pre-operative assessment in line with National Institute for Health and Care Excellence (NICE) guideline CG3. Staff were following the hospital policy indicating the level of assessment that patients required. As part of the first consultation, patients were required to complete a medical questionnaire which was reviewed by a member of staff. This then led to either a nurse led telephone consultation or a face to face appointment. If a patient had been scored as high risk, a referral was made to the anaesthetist for further review.
- On admission, risk assessments were completed for all patients including assessments for venous thromboembolism (VTE), falls and pressure ulcers. Pregnancy testing was also available for patients of child bearing age.
- All patients were pre-assessed for treatment to ensure they could be safely treated at the hospital including assessment by an anaesthetist where relevant. Patients were then re-assessed by an anaesthetist and surgeon on the day of surgery to identify patients with any new medical conditions or those deemed at risk of developing complications after surgery and a decision was made whether they could be operated on at the hospital.
- A theatre team brief was held before each theatre list was started. This meeting highlighted all procedures that were being undertaken and allowed staff to confirm that the appropriate equipment was available to complete this. Additionally, any areas of risk were discussed and plans were made to manage this.
- The management had identified a risk to patients that blood was not readily available for use in an emergency situation. A risk assessment had been completed and included a number of controls to mitigate this. However, we found that these controls were consistently not being followed. This was because the risk was not discussed as part of the team brief and consideration had not been given to whether cross matched blood should be brought to site before surgery began.

Additionally, we checked a sample of team brief sheets and found that this had not been documented on previous occasions when it had been required. This meant we had limited assurance that the service had taken all reasonable actions to mitigate this risk.

Following the inspection, we requested and received assurance that these systems had been improved and that the appropriate protocols were being followed.

- Pre-operative marking is required to promote correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level. NHS Improvement and the Royal College of Surgeons (RCS) strongly recommend that the mark should subsequently be checked against reliable documentation to confirm it is correctly located, and still legible. This checking should occur at each transfer of the patient's care and end with a final verification prior to commencement of surgery. All team members should be involved in checking the mark. This was completed for the procedures observed and site marking had been completed by the consultant prior to attending theatre.
- The World Health Organisation (WHO) safer surgery checklist identifies three phases of an operation: before the induction of anaesthesia (sign in), before the incision of the skin (time out) and before the patient leaves the operating room (sign out). In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation. In the five procedures that we observed, we found that 'sign in' and 'time out' was completed on all occasions. However, 'sign out' was not. This meant that details of the procedure and any concerns for recovery staff were not discussed.
- The hospital did not consistently use a WHO checklist as part of the process for joint injections being administered. This meant there was a risk that the injection could be administered into the incorrect site. We observed a hip injection being administered in the recovery area on one occasion without the use of the WHO checklist.
- Records indicated that between January 2016 and June 2016, compliance with the WHO checklist had varied on a monthly basis. Results ranged between 74% and 100%. An action plan had been developed to increase compliance with this.
- Additionally, the service had implemented a 'stop before you block' procedure. This had been introduced

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following a never event involving a wrong site anaesthetic being administered. Posters had been displayed in the anaesthetic rooms to remind staff to follow this.

- Following their surgery, patients were recovered by staff who had achieved the appropriate competencies following surgery. This was done on a one to one patient to staff ratio. Recovery staff followed policy and procedures when transferring a patient to the ward.
- Paper charts were used to record baseline observations. The anaesthetist completed this during the operation and this was then continued in recovery and on the ward. This allowed staff to see any changes in a patient's condition.
- The hospital used the early warning score (EWS) to identify a deteriorating patient. Staff were aware of this and were able to describe when they would ask for a patient to be reviewed. This was in line with hospital policies and procedures. EWS charts and guidance were included as part of each individual observation chart. Records had indicated that EWS scores had been completed correctly on between 75% and 100% of occasions between January 2016 and June 2016.
- A sepsis screening tool was used to identify patients who were suffering from septic shock. This criterion was based on patients' baseline observations. If the criteria was met, the patient was reviewed immediately by the resident medical officer (RMO). Sepsis recognition training was delivered to staff through the acute illness management course (AIMS).
- The hospital was a member of the Cheshire and Mersey Critical Care Network and had a formal written transfer agreement in place with the network. This was to ensure patients could be transferred to a local acute trust if needed, as required by the Independent Healthcare Advisory Services (2015). Staff had access to contact details for the local trust if they were required to transfer a patient. An emergency ambulance was requested to complete the transfer.

Nursing and support staffing

- A planning meeting took place once a week between the Ward Manager and the Theatre Manager to determine how many staff were required to safely care for patients. This was based on the number and types of operations that had been scheduled as well as the needs of the individual patients undergoing treatment.

- In theatre, staffing levels did not meet guidelines set by the Association for Perioperative Practice (AfPP). These guidelines state that if there is more than one procedure on the theatre list, the staffing requirements are a circulating nurse, an operating department practitioner (ODP), two scrub practitioners and a recovery nurse. The AfPP guidelines also state that if an operation requires a surgical first assistant (SFA), then they must be in addition to the numbers previously mentioned.
- We found that between July 2016 and the time of inspection, the member of staff completing the surgical first assistant role was in replacement of one of the scrub nurses. This meant that the theatre team was continuously one scrub practitioner short of the AfPP guidelines when an SFA was required.
- The use of agency staff in theatre had been high. Between August 2015 and March 2016, the monthly average varied between 15% and 21%. Additionally, there were currently two whole time equivalent (WTE) scrub practitioner vacancies that had been advertised. The management team told us that recruiting theatre staff had been a continual problem and that the recruitment team from Spire were involved in supporting them to find a solution to this.
- The hospital did not have any clear policies or dependency tools that indicated a definitive number of staff that were required for the inpatient ward. The use of an acuity tool had been trialled in the past but it had not matched the needs of the service provided.
- The management team had set informal staff to patient ratios of 1:5 in the morning, 1:6 in the afternoon and 1:7 in the evening. However, members of the management team were unable to tell us where this guidance had come from. There were sufficient numbers of staff on the ward at the time of inspection to provide safe care and treatment. Additionally, we reviewed rotas for two months before the inspection and found that during this period there were sufficient numbers of staff.
- There was a senior member of staff on duty during the day, seven days a week. Out of hours, the ward area was staffed by a number of registered nurses and health care assistants and there was an on call manager available if required. However, there were no clear escalation guidelines for nursing staff to follow which determined when a manager should be called.

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- Nursing staff handed over the patients who they were responsible for at the end of every shift. We attended a nursing handover and found that a set handover structure was followed and that the handover process was robust.
- A low number of agency nurses were used on the ward. The average monthly use of agency nurses varied from 4% to 8% between June 2015 and March 2016. The hospital had an induction checklist that a member of agency staff undertaking their first shift had to complete and sign. This included things such as receiving an orientation. However, the checklist did not include the hospital medicines management policy. This was important as agency staff administered medicines as part of their responsibilities. We raised this with the management team who instigated the process of adding this to the induction checklist.
- Sickness rates for nursing staff had been low between April 2015 and March 2016, with the highest monthly average being 6.8%. However, staff turnover was high. Between the same periods, 26% of nursing staff had left their employment at the hospital. This was for a variety of reasons including retirement and career progression.

Medical staffing

- Care and treatment was consultant led. The surgical team included a consultant and an anaesthetist who were engaged via practicing privileges. This is sometimes referred to as admitting rights and meant that the hospital had agreed to them providing care and treatment based on their experience and qualifications.
- Once a patient had undergone surgery, the consultant who had undertaken the operation was responsible for the continued care of the patient. This included responding to a change in a patient's condition or if any advice was sought. If the consultant was unavailable, the hospital had a procedure for another consultant to be contacted if there were any problems. Similarly, there was also a named anaesthetist who was also able to attend if required.
- There was an emergency on call theatre team covering out of hours periods and were able to attend if a patient needed to return to theatre.
- The hospital had two resident medical officers (RMO) who were employed through an agency. The RMO was available 24 hours a day, seven days a week and were resident on site. If the RMO was unable to fulfil their

duties, another RMO from the same agency was provided. We saw that the RMO had an induction to the hospital and their training records were kept on site and included training such as advanced life support.

Emergency awareness and training

- There was a corporate policy for major incidents that was available on the intranet. A table top exercise had been undertaken by staff at the hospital prior to the inspection.
- Major incident training had not been included as part of the mandatory training that staff received. Staff that we spoke to, including members of the management team were unsure of what their role was in the event of a major incident.
- The hospital had a backup generator which was used in the event of a power failure. This had been tested regularly by the on-site maintenance team.

Are surgery services effective?

Requires improvement 

Evidence-based care and treatment

- The hospital used care pathways that had been designed corporately by Spire and were followed when delivering care and treatment to patients. A care pathway was in place for all treatments provided. If a new treatment was added, a care pathway was requested from the Spire corporate team to reflect this. All care pathways had been developed in accordance with National Institute for Health and Care Excellence (NICE) guidelines and The Royal College of Surgeons guidelines. These were available on the intranet and were printed and placed in patient records for use. The care pathways incorporated the majority of documentation, including pre-admission, risk assessments and discharge records.
- Regular updates were also received from Spire, including updates on NICE guidance as well as safety and drug alerts.
- The management team followed an audit timetable that had been developed by Spire. These audits included compliance with the World Health Organisation (WHO) checklist, completion of records and risk assessments as well as compliance with blood transfusion pathways.

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- An enhanced recovery programme had been introduced, which meant the hospital was working towards shortening the number of days a patient spent in the hospital post-surgery. This was achieved by completing thorough pre-operative assessments and patients were encouraged to be mobile as soon after surgery as possible.
- The hospital used a paper based system to record all implants used. However, they had registered with the Health and Social Care Information Centre (HSCIC) to be involved in the national breast and implant register when the system is up and running. This was in line with the regulations stated in the Department of Health (2016) Review of the Regulation of Cosmetic Interventions (2016) which require that hospitals keep electronic details of implants used and should be easily accessible in the case of a product recall.

Pain relief

- Pain relief and pain management was discussed at the pre-operation assessment stage. Consultants had different preferences of pain relief and these were tailored to the needs of individual patients.
- Once medication to control pain had been prescribed, it was the responsibility of the resident medical officer and the nursing staff to review how effective this had been. Staff told us that if they had concerns, they were able to have the medication reviewed by the consultant.
- Pain relief was recorded as part of the observation record sheet. Different levels of pain were scored. This prompted a review by a clinician if it exceeded a specified level. Nursing staff completed intentional rounding which was completed hourly (intentional rounding is a process which is used to ensure that patients are checked on a regular basis and that their needs were being met).
- We looked at ten sets of records and found that initial pain scores had been documented on all occasions. However, on six occasions the efficacy of the medication given had not been documented. This was not in line with NICE guidance or Spire policy.
- Patients who we spoke with were positive about the way that their pain had been managed.
- Pain management was reviewed by the management team on a regular basis. Records indicated that between April 2016 and June 2016, 70% of patients had their pain

managed appropriately. An action plan had been implemented to make further improvements which included for staff to improve overall compliance with the pain management algorithm.

- Pain management was taken into consideration prior to discharge and staff ensured that patients were happy with the arrangements that had been made. Pain medication that was prescribed on discharge was included in the discharge letter.

Nutrition and hydration

- Patients were required to have not eaten for six hours or to drink clear fluids for two hours prior to surgery in line with Spire and NICE guidelines. This was included as part of the patient treatment pathway. However, records indicated that compliance with this had been particularly poor between January 2016 and August 2016, ranging between 5% and 40%. Actions had been put in place to improve compliance with this target.
- Food and fluid intake was monitored using food charts and fluid balance charts. However, we saw that four out of ten records that we inspected did not have fluid balances documented in line with Spire guidelines. Additionally, audits that had been undertaken between January 2016 and August 2016 showed that compliance with this had been constantly poor, ranging from 36% to 80%.
- There was access to a dietician who was employed by another hospital. All bariatric patients received a referral to the dietician for assessment.

Patient outcomes

- The hospital had collected patient reported outcome measures (PROMS) and had participated in audits undertaken by the National Joint Registry (NJR). Records indicated that outcomes for primary knee replacements and primary hip replacements had been similar to outcomes reported by similar services nationally.
- PROMS data had also been collected for varicose vein surgery but the hospital had not been able to compare outcomes for this nationally as there had only been 30 cases between April 2014 and March 2015.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on patient reported outcome measures for cosmetic surgery (Q-PROMs) for all patients receiving procedures such as breast augmentation (enlargement) and

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blepharoplasty(cosmetic surgery to the eyelids) . Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations. The hospital did not use the Q-PROMS recognised tool to collect patient satisfaction with the operation. This meant that there was limited oversight of the quality of cosmetic surgery that had been undertaken.

- The Private Healthcare Market Investigation Order (2014) requires every private healthcare facility to collect a defined set of performance measures and to supply that data to the Private Healthcare Information Network (PHIN). The hospital was fully engaged with this process and were in a position to provide data when it had been officially launched.
- Between April 2015 and March 2016, there had been four unplanned returns to theatre. Additionally, between April 2015 and March 2016, there had been seven unplanned readmissions out of a total of 7,298 procedures. This was not high when compared to a group of independent acute hospitals which submitted performance data to the CQC.

Competent staff

- Not all staff received an annual appraisal so that achievements, development opportunities and areas for improvement were discussed. The Spire target for this was 90%. Records indicated that 90% of staff on the inpatient ward had completed this. However, only 20% of theatre staff were up to date. This meant that there had been limited opportunity for staff in theatre to have their performance reviewed.
- The perioperative care collaborative (PCC) had set out clear guidance for competencies of surgical first assistants (SFA). The surgical first assistant role involved assisting consultants with key skills such as retraction and the movement of internal organs during procedures. These skills were in addition to those of a scrub practitioner. The PCC position statement regarding the surgical first assistant (2012) stated that this must be undertaken by someone who has successfully achieved a programme of study that has been benchmarked against nationally recognised competencies underpinning the knowledge and skills required for the role.
- The management team were unable to provide written evidence of staff achieving these competencies. This meant that we were unsure if staff had been assessed as

being competent to perform this role by an appropriate person. However, a log book was kept by staff which was a record of the frequency of surgical first assistant skills used. Each member of staff also had a named mentor and a job description detailing the roles and responsibilities of a surgical first assistant. The management team acknowledged the gap in documentation and had considered providing a surgical first assistant toolkit for all staff undertaking the role. Accredited surgical first assistant courses delivered by a local university had also been considered for staff to attend.

- All other members of staff had a personal file that included competency books. Competencies were assessed for all roles including but not limited to health care assistants, registered nurses, operating department practitioners and scrub nurses. We sampled a number of these and found they had been completed.
- There was evidence that staff had been encouraged to progress within their role. This had included theatre health care assistants being supported to complete associate theatre practitioner courses and scrub nurses undertaking operating department practitioner roles.
- The hospital had a policy for staff commencing employment at the hospital. New staff received a hospital induction as well as a supernumerary period. This meant staff had the opportunity to work alongside a more experienced member of staff without having the responsibility of looking after patients. Staff confirmed they had received these.
- The hospital had a system to check competencies of consultants who had applied to work under practicing privileges. All applications had been reviewed by the medical advisory committee who ensured that they had undertaken the treatment they had applied to provide on a regular basis. Additionally, all consultants received an annual appraisal which provided a review of their performance. Any concerns regarding care and treatment provided were discussed with the appropriate person so that improvements were made and lessons learnt.

Multidisciplinary working

- The theatre and ward managers held a weekly planning meeting that was used to discuss the individual needs of patients who attended for treatment. Topics such as staffing numbers and equipment required were discussed during this meeting.

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- We observed a theatre team huddle, which was well organised. Any issues for the day were discussed as were the needs of the patients.
- The physiotherapists, resident medical officer and pharmacist attended the daily afternoon nursing handover. This allowed them to discuss progress of the patients in the hospital and were able to coordinate patient assessment and discharge more effectively.
- Staff liaised with a number of different services when coordinating a patient's discharge. This included hospitals and community services, depending on where the patient was from.
- Communication between the theatre and ward teams was not always effective. An example of this was fasting guidelines not being adhered to. There was no daily meeting between the two teams and the nursing staff on the ward were sometimes unaware of the time which patients were due to have treatment. The management team told us there were plans for a member of nursing staff to attend the theatre team brief on a daily basis so that this was improved.
- When a patient was discharged, a discharge letter was given to the patient that included information about implants that had been used. However, this information was not included in the electronic discharge form that was sent to the patient's GP. This was not in line with the Review of the Regulation of Cosmetic Interventions (2014) which stated that details of the surgery and any implant used must be sent to the patient's GP.

Seven-day services

- Surgery was scheduled between Monday and Saturday on a weekly basis. The inpatient ward area was open and staffed 24 hours a day, seven days a week. The hospital had a 24 hours a day theatre on-call team available if patients needed to return for further treatment.
- The consultant and anaesthetist responsible for delivering treatment were on-call 24 hours a day if further advice was needed. In the event of them not being available, they arranged cover that was provided by another consultant who worked in the hospital. The resident medical officer confirmed there had not been any problems contacting someone if required.
- The hospital had 24 hours a day on-call cover for radiography, if required. Pharmacy services were

available six days a week during normal working hours. Procedures were in place for the resident medical officer to access medication if pharmacy was closed alongside a registered nurse.

- Other diagnostics such as pathology (blood testing) were available from a different Spire hospital during normal working hours.

Access to information

- Access to information within the hospital was sometimes difficult. There were a limited number of computers on the inpatient ward for staff to use. Additionally, agency staff were unable to use any of the electronic systems which meant they were unable to view hospital policies and procedures or access the incident reporting system.
- Hospital policies and patient care pathways were accessible for staff who had access to the electronic system. Continuity of patient care was maintained as all individual patient records and medication charts were paper based, so all staff were able to use them.
- On discharge, an electronic GP form was completed. This included information about treatment that had been provided and any changes to medication.
- Patient records were kept in the hospital for three months following a patient discharge. They were then archived at a central location. If a patient re-attended for further treatment, staff were able to request the old records if, required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a policy for consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This was available for staff on the intranet.
- The hospital had a lead for mental capacity who was available during normal working hours, seven days a week. If staff had concerns at the weekend or out of hours, advice was sought from the resident medical officer or the on-call manager. Staff who we spoke with had a basic understanding of the Mental Capacity Act 2005 and DoLS and what their responsibilities were if they found that a patient lacked the capacity to make a decision.
- Consultants completed consent forms at different times. Some completed them at the pre-admission stage and they were then confirmed on the day of treatment.

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Others completed them on admission, which included patients undergoing cosmetic surgery. This was important as it documented that the patient was aware and understood all aspects of their treatment.

- There was no formal guidance for consultants to adhere to the 'two week cool off period' which is recommended by the Royal College of Surgeons Professional Standards for Cosmetic Surgery (2016). On reviewing a sample of seven patient records who had undergone cosmetic surgery, we found this had not been adhered to on three occasions. This meant that treatment had been undertaken within the two week period of the initial consultation and date of treatment. However, staff confirmed that information was given to patients about their right to cancel during the initial consultation.
- We reviewed a sample of ten patient records and found that consent had been obtained on all occasions. Patients who we spoke with confirmed their treatment had been discussed with them which included any potential risks that were present as a result of their treatment.

Are surgery services caring?

Good



Compassionate care

- We saw that care and treatment was provided in a kind, compassionate way. Staff treated all patients with dignity and respect during their time at the hospital.
- We observed privacy and dignity being maintained when a patient had been anaesthetised. Staff ensured that patients remained covered as much as possible throughout their treatment. This included during their time in recovery post-operatively.
- Patient Led Assessments of the Care Environment (PLACE) showed that 93% of patients thought that their privacy and dignity had been maintained during their time at the hospital.
- Patients we spoke with reported that 'staff could not be better' and 'they did everything possible to help'. Patients were allocated named members of staff during their stay and patients were aware of who these staff were.

- When a patient was being examined or treatment was being discussed, doors to their rooms were closed or curtains were drawn to maintain privacy.
- Additionally, the hospital took part in the NHS Friends and Family test for all patients who were NHS funded. The majority of patients who had undertaken this had recommended the hospital for the level of care and treatment provided. Between October 2015 and March 2016, monthly averages varied between 95% and 100%. However, response rates during these periods had been low, ranging from 11% to 34%.

Understanding and involvement of patients and those close to them

- Consideration was given to the ongoing needs of the patient and their relatives during the pre-admission assessments. Records indicated that arrangements for discharge were often made during this initial assessment.
- Patients told us they felt well informed prior to their admission to the hospital. Information about their procedure including any risks had been discussed. On one occasion, a patient told us that a member of staff had spent extra time explaining something they had not understood.
- Relatives were encouraged to visit when possible. When a patient was discharged, staff involved relatives when providing information of what to do over the next few days or if there were any concerns.
- We spoke to a privately funded patient who told us that prices of treatment they had received had been discussed and made clear prior to treatment being undertaken.

Emotional support

- Staff provided regular support to patients by completing comfort rounds on an hourly basis. This included checking if a patient needed anything, including food and drink and pain relief.
- Staff spent time with patients, discussing any fears or anxieties they had before, during or after treatment. We saw members of staff comforting patients on their way to theatre and in the anaesthetic room. Additionally, we saw staff providing emotional support to patients when they were recovering from an anaesthetic.

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- Physiotherapists provided support when mobilising patients following surgery. We saw on a number of occasions that reassurance and encouragement was given, when needed.
- Patient's psychological wellbeing was discussed as part of the pre-operative assessment. This was particularly important for patients undergoing cosmetic surgery and access to external psychological services were available if required.
- Contact details were given to patients when they were discharged. They were able to contact staff at the hospital 24 hours a day, seven days a week if they had any concerns or anxieties.

Are surgery services responsive?

Good



Service planning and delivery to meet the needs of local people

- Referrals to the service were mainly from GPs and this was done electronically. Once a referral had been made, an appointment was made to see the consultant who was able to provide the treatment required.
- At the initial assessment stage, the service was able to assess whether they had the correct staff and resources to provide the care and treatment that was needed. If they did not, then the patient was referred back to the GP and treatment was provided by a different service.
- The hospital used Spire care pathways when planning and delivering treatment. This meant that things such as discharge planning and pain control were discussed at the initial assessment stage. For example, if a patient was having a joint replacement, consideration was given to the type of accommodation they lived in and how much support they had from carers, family members or friends. This allowed appropriate arrangements to be made for discharge before the patient received treatment.
- The hospital provided individual en-suite rooms for inpatients which allowed privacy to be maintained. However, the hospital was unable to provide shower facilities in some rooms as modernisation of some facilities on the ward was still in progress. This meant that services had to be planned carefully to ensure that rooms with a bath were not allocated inappropriately.
- There were two ward areas for day case surgery which were open bay areas. Curtains were used to maintain privacy and dignity. Each of these areas had their own toilet facilities for patients to use. The service ensured that guidance on mixed sex accommodation was adhered to.
- In theatres, the doors to the anaesthetic rooms had tinted windows which had been designed to stop people looking in when a patient was receiving treatment.

Access and flow

- The hospital reported that over 90% of admitted NHS patients began treatment within 18 weeks of referral for each month between April 2015 and March 2016. Elective waiting times were reviewed by staff to identify patients approaching the 18 week wait period and these patients were prioritised so they could begin treatment prior to breaching the 18 week wait time target.
- Between April 2015 and March 2016, there had been a total of 7,298 attendances to theatre. Of these, 6,028 were day case attendances and 1,270 had been inpatient admissions.
- The Spire admissions policy provided clear guidelines relating to pre-operation assessments. As part of a patient's initial consultation, they completed a medical questionnaire which was reviewed by a member of the pre-operation assessment team. Patients would be booked for a face to face or telephone nurse led consultation should anything need to be discussed or clarified further or tests were required in advance of treatment.
- Admission times were staggered throughout the day so that patients did not have to wait for a long period of time once admitted. The hospital had completed an audit measuring this between February 2016 and June 2016. Records indicated that during this period, treatment had been delayed on 53 occasions. Reasons for this included operations taking longer than anticipated, consultants arriving late for clinic and patients requiring further diagnostic tests following admission. We spoke to a number of patients who told us that if this had happened, they had been kept informed of what was happening by a member of staff. Between April 2015 and March 2016, a small number of procedures had been cancelled as a result of this.

Surgery

- The duration of a patient stay was estimated during the admission assessment and was based on the individual need of the patient as well as the type of treatment that was being provided.
- The service had attempted to keep the number of cancellations for treatment to a minimum. The hospital recorded all incidents of cancellations for either clinical or non-clinical reasons so that future improvements were made. Between April 2015 and March 2016, the hospital reported 35 procedures that had been cancelled for clinical reasons and 30 that had been cancelled for non-clinical reasons. All patients that had procedures cancelled were offered another appointment within 28 working days.
- Between April 2015 and March 2016, there had been 16 transfers to another hospital which were mainly as a result of a patient deteriorating or requiring a higher level of care than the hospital was able to provide.
- There was access to psychological services that were provided by another hospital if required. If a patient was having cosmetic surgery, the consultants providing the treatment made referrals to their own preferred services if needed. Staff told us that consideration to the use of psychological services was assessed during the initial assessment.
- The hospital had adapted some facilities to accommodate bariatric patients who were undergoing treatment. This included a modified wheelchair and the inpatient ward had access to two bariatric beds if needed.
- Additional dietary advice or special requirements were discussed with the patient on arrival to the ward and daily throughout their admission. The majority of patients we spoke with said they were happy with the standard and choice of food available. We saw there was a comprehensive selection of meals available from a menu which was available for patients.
- There were no formal processes in place for recognising patients who had become delirious during their stay. Staff that we spoke with had a limited understanding of this. Delirium is a state of confusion that sometimes occurs following an anaesthetic being administered, with the risk being higher for older patients.

Meeting people's individual needs

- The hospital provided a range of information leaflets about different conditions and treatments. For example, there was a leaflet for having a knee replacement which described what to expect before, during and after treatment. These leaflets were only available in English. However, we were informed that leaflets in other languages could be requested if required.
- The hospital had not made any formal adjustments to the facilities that met the needs of patients living with dementia. The service had recently provided dementia training to staff as part of the e-learning course that was available. Staff were able to give some examples of how a patient living with dementia would be managed. We were informed that patients living with dementia did not usually meet the hospital admissions criteria which had been developed to ensure that patients admitted had access to the right level of care during their stay.
- There was easy access for patients or relatives who used a wheelchair. However, there were no en-suite rooms that had been adapted for a patient in a wheelchair to use. There was an open shower room on the inpatient ward but staff told us this was regularly being used as a storage area.
- The hospital had access to translation services and interpreters if required. The needs of the patient and family were assessed during the initial assessment and a translator or an interpreter was booked if needed.

Learning from complaints and concerns

- The hospital had a policy for managing complaints and concerns. Staff that we spoke with were able to tell us about the complaints process and that if a complaint or concern was raised, it was escalated to the department manager.
- Spire policy stated that complaints must be responded to within 20 days of receipt. This was monitored in management team meetings, ensuring that the hospital met this target. The management team told us that if it was taking longer than this, communication was made with the complainant and a new timescale was agreed.
- The number of complaints that the hospital had received had increased every year since 2013. There had been 35 complaints received between April 2013 and March 2014, 87 between April 2014 and March 2015 and 102 between April 2015 and March 2016. Records indicated that the management team had acknowledged the complaint was justified and improvements needed to be made in 54 of the 102 complaints that had been made.

Surgery

- All complaints had been added to the incident reporting system which provided a foundation for learning to take place when required. However, we spoke to six staff members who were unable to give us examples of when outcomes of complaints and concerns had been disseminated. Minutes of meetings indicated that complaints and concerns were discussed at management team meetings and as part of the medical advisory committee (MAC) meetings.
- If the response to the complaint had not been satisfactory, advice was given for contact to be made with the Independent Healthcare Sector Adjudication Service (ISCAS). Similarly, NHS funded patients had access to make referrals to the NHS Parliamentary and Health Service Ombudsman (PHSO). However, we reviewed ten responses to complaints. We found that this information was not detailed in any of the responses given.
- Records indicated that between April 2015 and March 2016, there had been no referrals made to ISCAS for further investigation.

- The management team had developed a strategy for each individual department which included theatres and the ward area. This was based on challenges that the service currently faced and areas that had been highlighted for improvement.
- The hospital director had staff forums where the strategy was part of the discussions. Staff that we spoke to in theatre and on the inpatient ward were able to identify with the areas that had been highlighted for improvement going forward.

Governance, risk management and quality measurement.

- The governance structure within the hospital had been reviewed with a change to roles and responsibilities. There was a split into the senior management team and the hospital management team with clearly defined roles and lines of accountability.
- The senior management team included the head of clinical services, the hospital director, the finance and commercial manager, business development and business services managers.
- The senior management team met twice monthly with the agenda split into a clinical meeting and an operational/ business meeting. The ward manager, theatre manager and outpatient manager attended these meetings. This meant there was an opportunity to have a more thorough discussion about both areas with the relevant team members.
- A more informal weekly meeting was held with the SMT to discuss hospital performance, incidents, complaints and feedback in a more timely manner each Tuesday.
- The head of clinical services and the clinical governance coordinator were responsible for the oversight of all clinical governance activities.
- Departmental quality reports had been introduced so that compliance with performance targets was highlighted. Results from these were fed to the senior management team meeting and the medical advisory committee (MAC) who had overall oversight.
- However, we found not all clinical issues identified were monitored through the governance processes. We reviewed minutes from four senior management team clinical meetings and the ongoing action tracker. Areas where concerns had been previously highlighted were

Are surgery services well-led?

Requires improvement 

Vision and strategy

- Spire had an overall vision and strategy. The values highlighted in this statement were caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on promises and keeping it simple. The hospital had also set its own objectives based on these values. These included delivering high quality care, enhancing relationships with partners to promote services to the local population, and improving the hospital's patient and staff survey scores.
- We reviewed minutes of the senior management team clinical meetings and saw the values were carried through in discussions. This included monitoring delivery of promised improvements within specific departments.
- There were posters in the hospital to inform patients of the vision, mission and values of Spire Healthcare organisation. This included measures of how the hospital objectives would be achieved.

Surgery

not discussed at subsequent meetings. This included practices on the ward audit scorecard where poor compliance had been ongoing throughout those months.

- Risks were controlled and monitored through departmental and a hospital wide risk register. Staff responsible for managing this told us they were not yet fully conversant with all aspects of the document and how it worked. This included updating the risks and completing all sections. We saw for one risk which had a resolution date of 1 August 2016 this was ongoing. Whilst actions had been taken to mitigate the risks these were not documented. The control rating was recorded as “inadequate” by the hospital; however the gaps in control column were blank. There was no date this risk was entered on the register. The hospital used departmental risk assessment registers to highlight and manage areas of risk. If the risk scored 15 and above the risk was escalated to the senior management team meeting.
- There were some areas of risk that had not been dealt with appropriately or in a timely way. This included staff not following the controls that had been outlined in the risk assessment for patients at risk of bleeding (VTE). Controls that had been put in place to reduce this risk had not always been followed and the senior management team were unaware that this was the case. Following the inspection, we requested and received assurance that these systems had been improved and that the appropriate protocols were being followed.
- Systems for clinical governance were not always robust. Records showed there had been continual poor compliance with pre-surgery fasting guidance as well as the monitoring of intra-operative temperatures during surgery with no improvements made despite actions being implemented.
- The management team had implemented an action plan following a never event that had occurred for a wrong site anaesthetic block being administered. There had been an audit process undertaken of two sets of records to provide assurance of compliance with actions implemented.
- Incidents and complaints were investigated by members of staff who had oversight of this process. Outcomes and learning from incidents and complaints was disseminated to staff through team meetings or by email. However, the clinical governance team were not aware of incidents that had occurred in one of the departments. The decontamination department had not reported incidents on the electronic reporting system. This meant that the management team were unaware of these incidents and they had not been investigated to ensure improvements could be made.
- A Spire audit plan was used to monitor levels of compliance in the care and treatment provided. Results of these were discussed as part of clinical effectiveness meetings and were also discussed at the medical advisory committee meetings. Additionally, compliance with treatment provided to NHS funded patients was monitored through key performance indicators. However, data measuring clinical effectiveness was limited in some areas such as cosmetic surgery. The hospital did not submit data to Q-PROMS, which was used to measure patient satisfaction and compare the data provided by similar services nationally.
- Annual Spire quality reports were used to measure the effectiveness of services provided against other Spire hospitals nationally.
- The medical advisory committee (MAC) had clear terms of reference which included consultants from different specialities being asked to attend, where required. We saw minutes of these meetings and found that topics such as National Institute for Health and Care Excellence (NICE) guidance, incidents and complaints and mortality were discussed. The chair of the medical advisory committee was able to identify the key risks and challenges that the hospital currently faced. The MAC also had oversight for reviewing applications for consultants to work at the hospital under practising privileges.
- The hospital ensured that all consultants working under practising privileges had the appropriate indemnity cover. We reviewed ten personnel files and evidence of this was documented.
- The hospital had not made any arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT. SNOMED-CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems and is recommended as best practice by the Royal College of Surgeons.

Leadership / culture of service

Surgery

- There had been some recent changes to the leadership of the hospital prior to the inspection. The head of clinical services had been in post five weeks prior to the inspection and the theatre manager started their post between the announced and unannounced inspection.
- There had been a period of inconsistency with the leadership in the operating theatres and staff we spoke with welcomed the new members of the team and looked forward to permanent post holders.
- There were clear lines of responsibility and accountability for the heads of department with clinical governance leads, the hospital director and the medical advisory committee.
- Staff spoke of the senior management team as being visible and approachable. They felt that when they had concerns they were listened to.
- We saw staff in theatre and on the inpatient ward working and communicating well together. This included consultants. This indicated a positive working culture.
- There was an open and honest culture in the service. When things had gone wrong, patients had received an apology, an investigation had taken place and improvements had been made.
- Staff turnover had been consistently high. Between April 2015 and March 2016, it was 43% between operating department practitioners and health care assistants. Turnover was 26% of nursing staff from the inpatient ward. Records showed these had increased from the period of April 2014 to March 2015.
- The hospital also monitored feedback from patients who had self-funded. The results of these were published in the quarterly reports and showed that results were comparable to those from the NHS Friends and Family test.
- Heads of departments held staff forums where staff could discuss the operation of their department. At these meetings they were encouraged to give feedback on any changes to policy and practice. Those we spoke with said they were encouraged to participate in the running of their department.
- The hospital director conducted a weekly “walk around” in each department. During this time staff were encouraged to discuss any concerns and issues in an informal way.
- Feedback from consultants had been requested on an annual basis.





Innovation, improvement and sustainability (local and service level if this is the main core service)

- The hospital director had introduced some practices which had not been in place from the wider organisation, but had been recognised as good practice within the wider organisation. These included the splitting of the senior management team meetings into clinical and operational.
- The introduction of the new head of clinical services manager and theatre manager was hoped to provide some stability within the clinical team. Both of these managers had ideas for improvements in the short time they had been employed; however, these had not been put into place at the time of the inspection.
- Staff told us they could make suggestions for improvement in their areas of work. These could be discussed on a one to one with the head of department or at team meetings.
- The hospital director had plans to expand some services at the hospital and introduce new ones. They were aware of the part they played and how this could continue and grow within the local health economy.

Public and staff engagement

- The hospital asked all patients to complete a patient satisfaction questionnaire. Patients either completed this in the hospital or were able to complete it at home and return it to the hospital by post.
- The service took part in the NHS Friends and Family test for NHS funded patients. Overall results had been positive, however, the number of patients completing this had been consistently low. Between October 2015 and March 2016, between 95% and 100% of patients had recommended the hospital as a place of care. The hospital was engaged with a plan to improve the number of patients providing feedback.

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement 

Incidents

- There were 59 clinical incidents within the outpatient and diagnostic imaging service between April 2015 and March 2016. In the same reporting period there were 26 non-clinical incidents, for example relating to estate issues.
- The rate of clinical incidents was similar to the rate of other independent acute hospitals during the same period.
- We reviewed an investigation report into an incident in the X-ray department which led to an over-exposure of ionising radiation for the patient. This had involved all relevant staff members, recommendations were made and actions taken with steps for ongoing monitoring of improvement.
- Incidents in the diagnostic imaging department were discussed at both the X-ray department meeting and heads of department meetings, including lessons learnt and changes to practice.
- For the reporting period April 2015 to March 2016, there had been no reported never events for the outpatient or diagnostic imaging department. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death.
- The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor (RPS), who in turn would log the incident on the hospital's electronic

incident reporting system. The rules and policy set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive. We saw that these had been signed and dated appropriately.

Cleanliness, infection control and hygiene

- The outpatient and diagnostic imaging departments' main reception areas were visibly clean, tidy and free from clutter.
- For the reporting period April 2015 to March 2016, there had been no reported cases of healthcare-associated infections such as methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (C.diff) or, methicillin-sensitive *Staphylococcus aureus* (MSSA) for the outpatients and diagnostic imaging department. These are all infections that could cause harm to patients.
- The hospital took part in patient led assessments of the care environment (PLACE). Between February 2015 and June 2015, 98% of patients had given positive feedback about the cleanliness of the hospital facilities.
- Personal protective equipment such as aprons and gloves was available in the outpatient clinic consulting rooms. We saw these used appropriately.
- A cleanliness audit which took place in June 2016 within the physiotherapy department, identified there was full compliance with cleanliness.
- A hand hygiene audit which took place between April and June 2016 showed there was 86% compliance with the hand hygiene procedure with the diagnostic imaging department. An action plan was in place to address the areas of concern, including the non-touch technique when using taps and staff wearing rings which was against hospital policy.

Environment and equipment

Outpatients and diagnostic imaging

- A medical equipment champion had recently been appointed to ensure medical equipment was serviced and maintained appropriately.
- The hospital had a routine maintenance imaging equipment checklist that clearly identified dates when maintenance checks were due and when these checks were subsequently completed. This meant that all diagnostic imaging equipment was fully maintained.
- The provider had two appointed radiation protection supervisors (RPS) and a radiation protection adviser (RPA) in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations. This meant the hospital had an independent annual audit of the imaging services.
- We saw copies of the independent annual audits (radiation protection adviser audit) of the imaging services. We saw in the 2015/16 audits that the department was compliant and no improvements were required.
- There was an emergency trolley and automatic external defibrillator (AED) in the main outpatients department. We saw it was checked on a daily basis by reviewing the sign-off record. Additionally there was an AED at the Spire Lytham site (a satellite clinic run by Spire Fylde Coast), which had also been checked in line with policy.
- Resuscitation equipment was stored on the main waiting area near to reception. This ensured it was accessible when required in an emergency. Anaphylaxis kits were available with an expiry date of 2017. These were locked and fully checked as per the policy. We checked the resuscitation trolley and all equipment and medicines were up to date. The trolley was checked daily and this was recorded.
- There was no resuscitation trolley within the diagnostic imaging department. However, there was a crash call button (an alarm to indicate immediate medical assistance was required) in the X-ray rooms, which staff were familiar with. Resuscitation equipment was subsequently brought to the department from the main waiting area, when required.
- Within the outpatient clinic audit, June 2016, a ripped mattress was identified. This was addressed as a high priority area and a replacement mattress was immediately purchased.
- All radiography staff wore radiation monitor badges to show the level of radiation exposure. Staff told us there had been no incidents where a negative reading had been recorded from these.

- There were lead gowns seen in radiology which protects staff member from radiation exposure. Staff were aware of the gowns and what they were used for.

Medicines

- See surgery section for main findings.
- Medicines were stored securely in both the outpatients and diagnostic imaging departments. However, the temperature of the room where the medicines were stored was noted to be above the recommended maximum temperature of 25 degrees centigrade on 11 occasions out of 24 checks within the month prior to the inspection. This was raised within the medicines audit and the identified action was for staff to report any temperatures out of the recommended range to the estates department and pharmacy.
- Prescription pads for the outpatient department were kept securely in a locked cupboard. Staff recorded the prescription numbers and this was audited. The audits showed full compliance in this area.
- Medicines audits were undertaken in both the diagnostic imaging and outpatients departments. The audits showed total compliance in the diagnostic imaging department with the exception of one consumable item in the outpatients department which was found to be out of the expiry date in May 2016.
- There were no controlled drugs stored within the outpatients department.

Records

- See surgery section for main findings.
- A single patient record had been introduced from April 2016 across the whole of the outpatients department and a green medical file containing all relevant paperwork was available for every patient attending their outpatient appointment.
- The medical records department collated all files and cross matched them with the clinic lists the day before clinic was due to ensure all files were present. Any patient who had previously attended the hospital as an in-patient had a medical record, the previous three months were stored on site and anything prior to this was stored off site at the Spire national distribution centre (NDC). If a file was stored off site at the NDC this was retrieved for clinic following the NDC hospital instruction document for calling notes. Where the

Outpatients and diagnostic imaging

patient was new to the hospital the file was created by either the NHS administration team or the private patient bookings administration team containing the GP referral.

- In the physiology exercise tolerance room, there was personal identifiable information within an unlocked cupboard which was potentially accessible to the general public. This concern was raised to managers at the time of the inspection and was rectified immediately by fitting a lock on the cupboard.
- We reviewed ten sets of medical records and found they were fully completed in accordance with the Spire policy.

Safeguarding

- See the surgery section for main findings.
- Staff had access to a safeguarding level two training module which had to be completed via e-learning. This met guidance from the Royal College of Nursing (2016), which recommends that all staff who have direct patient contact should have a minimum of safeguarding adults level two.
- Records indicated that staff in the outpatients department were 66% compliant with level two safeguarding for adults and children. This was worse than the organisational target of 100%
- Within diagnostic imaging, 38% of staff were compliant with level two safeguarding adults training and 30% were compliant with safeguarding children training. Both of which were worse than the organisational target of 100%.

Mandatory training

- See the Surgery section for main findings.
- As part of the e-learning course, there were eight standard modules that all staff had to complete. These included fire safety, health and safety, compassion in practice, manual handling, equality and diversity, safeguarding adults, safeguarding children and infection control.
- Compliance with some key mandatory training was below the Spire target of 100%.

Nursing staffing

- The rate of sickness for outpatient nurses was varied when compared to the average of other independent

acute hospitals we hold this type of data for during the reporting period (April 2015 to March 2016). The rate was particularly higher than the average in January 2016 to March 2016.

- The use of bank and agency staff for outpatient nurses was lower than the average of other independent acute hospitals we hold this type of data for during the reporting period April 2015 to March 2016.
- The use of bank and agency staff for outpatient health care assistants was similar to the average of other independent acute hospitals during the same reporting period.
- No agency staff were used in the outpatient departments in the last three months of the reporting period April 2015 to March 2016.
- There were no full time equivalent vacancies for staff working in outpatient departments.

Medical staffing

- The hospital had a resident medical officer (RMO) on site 24 hours a day, seven days a week to support the clinical team in the event of emergencies or with patients requiring additional medical support.
- There were 141 consultants who had been granted practising privileges at the hospital, all of whom had been undertaking work at the hospital for over 12 months. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. This is sometimes known as admitting rights.

Emergency awareness and training

- See the Surgery section for main findings.
- Staff undertook a skills and drills exercise to ensure the responsiveness of staff within an emergency situation.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- See the Surgery section for main findings.
- Pathways were in place in areas such as radiologists' procedure list, preparations for imaging examination and booking procedures that may require intravenous

Outpatients and diagnostic imaging

(IV) contrast. All care pathways and procedures were noted to follow relevant National Institute for Health and Care Excellence (NICE) and were within their review date.

Pain relief

- None of the patients we spoke with required pain relief at the time of our inspection. Staff told us they would escalate any concerns around pain relief to the resident medical officer (RMO).

Nutrition and hydration

- Patients attending the outpatients and diagnostic imaging departments had access to free tea, coffee and water and were provided with light refreshments if their treatment was delayed. This had been a change made following feedback received from the NHS Friends and Family test where patients identified this as an area for improvement.

Patient outcomes

- Within the yearly booking audit (2015), for diagnostic imaging, an average of 82% of referrals were booked within five working days of being received within the department, with the lowest being in March, September and October 2016 being documented as 60% received.
- The diagnostic imaging department had a comprehensive audit programme which included referral audit, reporting audit, general X-ray peer audit, mammography peer audit, mammography reject rate audit, booking audit and MRI audit. We reviewed the results of these and found these demonstrated that procedures were delivered in line with best practice.
- All mammography testing was double checked by another radiographer to ensure correct diagnosis and there were peer reviews of diagnostic imaging reports.

Competent staff

- There were training opportunities for staff in the outpatient department who could request external training as part of the appraisal process. The link nurse system was part of staff development. Examples given of external training included service development course, general anaesthetic course and mammography.
- There were three health care assistants working in the outpatients department who were being supported to work towards their Regulated Qualifications Framework (RQF). This will enhance their skills within the role.

- In September 2016, there were five pre-assessment staff who had attended pre-assessment training in assessing the elderly frail patient.
- There was an induction checklist in place to ensure new staff in post at the hospital gained the correct competencies within their role.
- There was a competency check list which formed the basis of staff appraisals. This ensured all staff had the correct level of competency for their role.
- No staff appraisals had been completed for staff working in the outpatient departments during the appraisal year January 2016 to December 2016. This meant there had been limited opportunity for staff in outpatients to have their performance reviewed. However appraisal rates for January 2015 to December 2015 were 100%.
- There were dedicated champions for specific issues and these were displayed in the reception area, including, female genital mutilation, dementia, Deprivation of Liberty Safeguards, infection control and enhanced recovery.

Multidisciplinary working

- There was a strong multi-disciplinary team approach across all of the areas we visited. We observed good collaborative working and communication amongst all staff in and outside the department. Staff reported they worked well as a team.
- All staff described good working relationships with the consultants and staff said that they felt able to ask for advice or information if necessary.

Access to information

- There were computers available around the departments so that staff could access the hospital intranet and other information. However, some staff identified that access to computers could be limited which had an impact on their ability to report incidents and access emails.
- Consultants had access in all consulting rooms to the picture archiving and communication system (PACS). PACS is a medical imaging technology which provides storage and access to images from multiple modalities. This enabled consultants to view any images for the patient on line during the consultation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- See the Surgery section for main findings.

Outpatients and diagnostic imaging

- Staff undertook mental capacity act training. Training compliance in this area was 69% in the diagnostic imaging department and 76% in the outpatients department.

Are outpatients and diagnostic imaging services caring?

Good



Compassionate care

- The hospital took part in the NHS Friends and Family test for all patients who were NHS funded. Results from this had been positive. Between October 2015 and March 2016, monthly averages of patients who would recommend the provider to their friends and family varied between 95% and 100%. However, response rates during these periods had been low, ranging from 11% to 34%.
- We observed examples of compassionate care given to patients and those close to them based on individual needs. Staff provided reassurance and comfort to parents who were anxious or worried about their treatment.
- Patients were well supported whilst in the hospital. An example of this was that chaperones were offered to all patients who were well advertised in posters which were visible in areas around the outpatient department and inside the consultation rooms. We also saw posters in the radiology department and staff showed us where to locate the hospital chaperone policy. Consultants were allocated a chaperone for each clinic session.
- Patient led assessments of the care environment (PLACE) showed that 93% of patients thought their privacy and dignity had been maintained during their time at the hospital.

Understanding and involvement of patients and those close to them

- Consideration was given to the ongoing needs of the patient and their relatives during the pre-admission assessments. Records indicated that arrangements for discharge were often made during this initial assessment.

- We spoke to a privately funded patient who told us that prices of treatment that they had received had been discussed and made clear prior to treatment being undertaken.

Emotional support

- Throughout our visit we observed staff giving reassurance to patients both over the telephone and in person.

Are outpatients and diagnostic imaging services responsive?

Good



Service planning and delivery to meet the needs of local people

- The hospital had recognised a need for a physiotherapy gym. Staff were in the process of putting proposals together to allow them to gain more space to accommodate this.
- A Spire healthcare mobile magnetic resonance imaging (MRI) scanner service visited the site three days per week providing MRI scanning and there was a service level agreement with a local NHS trust for the provision of computed tomography (CT) scanning. The provider was working with the corporate team to increase the provision of MRI scanning due to the waiting time.
- All patients who had undergone hip or knee replacement surgery were routinely X-rayed two days post operatively. This was also accommodated at the weekend.

Access and flow

- The provider met the target of 92% of incomplete patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 2015 to March 2016).
- The provider met the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period before the targets were abolished (April 2015 to May 2015). Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 2015 to March 2016).

Outpatients and diagnostic imaging

- The hospital had no patients waiting longer than six weeks for magnetic resonance imaging (MRI), computed tomography (CT) or non-obstetric ultrasound during the reporting period (April 2015 to March 2016).
- The hospital had identified a need to improve its access and waiting times to access MRI and CT scanning. This service was dependent upon mobile units and was therefore limited to three days per week. The hospital was planning and discussing this with corporate teams to enable them to improve the provision.
- There were no available figures for outpatient and diagnostic imaging did not attend (DNA) rates, but staff felt there were more patients who did not attend than there used to be. This was more significant for NHS patients than private patients. The departments had a three strike (if a patient had not attended for three appointments) rule for private patients and a two strike (if a patient had not attended for two appointments) rule for NHS patients.
- There was a radiographer on call 24 hours each day. This radiographer was based at the local NHS trust and there was a standing operating procedure in place to facilitate this.

Meeting people's individual needs

- See surgery section for main findings.
- There was a procedure in place for the care of patients with special needs. However, this procedure was noted to be vague, containing only six points over one page. The procedure did not specify what was meant by 'patients with special needs' and mainly related to critically ill or infectious patients. However no critically ill patients were cared for at Spire Fylde Coast.
- Within the Lytham clinic audit in January 2016, it was identified that there was no accessible entrance. This was immediately rectified by installing an external ramp for patients living with mobility difficulties.
- Staff knew how to access interpreter services for patients whose first language was not English.
- There was specific bariatric equipment available within the outpatients department including specialist couches, chairs and weighing scales.
- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away and we saw staff including these leaflets in the letter envelopes to be sent out.

Learning from complaints and concerns

- See the Surgery section for main findings.
- Some staff within outpatients reported they did not receive any feedback as a result of complaints.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

Vision and strategy for this this core service

- See the Surgery section for main findings.

Governance, risk management and quality measurement

- See surgery section for main findings.
- There were three risks on the departmental risk register including over exposure to radiation, non-compliant patient group directions and clinical waste management. The risk register identified mitigation factors and was regularly monitored.
- A new monthly quality report was produced which included areas such as governance, risk management, human resources, stock management, service development, clinical review outstanding actions and staff development. However, the report was noted to contain minimal information. An example of this was the September 2016 report which identified the outpatient expiry date audit was not completed by the audit team in July 2016 but there was no reason given for this or no forward steps identified.
- There were monthly health and safety meetings where governance issues were discussed. There was evidence that incidents were shared from other hospitals to ensure lessons learned were shared across the organisation as well as across the hospital.
- There were monthly team meetings within the outpatient and diagnostic imaging departments, which were recorded. These were sent to staff via email and a read receipt was requested to ensure all staff had read them.

Leadership and culture of service

- See surgery for main findings.

Outpatients and diagnostic imaging

- Staff turnover was 20% for outpatient nurses and 0% for outpatient health care assistants during the reporting period (April 2015 to March 2016). The rate of staff turnover for outpatient nurses was higher than the average of other independent acute hospitals during the same period.
- There was a positive culture within both the outpatients department and diagnostic imaging and all staff we spoke with reported they worked well together and felt engaged with the management team.
- A prize was being offered for the first department to have 100% completion of the staff survey to encourage staff to complete this.
- Examples were given from 'you said, we did' patient feedback, including feedback on patient experience of feeling unsteady getting changed in the changing rooms, therefore hand rails were installed.

Innovation, improvement and sustainability

Public and staff engagement

- See surgery for main findings.
- See surgery for main findings.
- Photographs of staff who had achieved excellent work were displayed to celebrate their achievement.

Outstanding practice and areas for improvement

Outstanding practice

- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Areas for improvement

Action the provider **MUST** take to improve

- The hospital must ensure that appropriate numbers of staff are deployed in theatre in accordance with the Association of Perioperative Practitioners (AfPP) guidelines.
- The hospital must ensure that the controlled drugs regulations 2001 are adhered to when controlled drugs are being administered.
- The hospital must implement a World Health Organisation (WHO) surgical safety checklist for the administration of joint injections, ensuring that appropriate checks are completed to prevent injections being administered in the incorrect site.
- The hospital must ensure that controls mitigating the risk to patients who are at risk of bleeding are implemented correctly on all occasions.
- The hospital must ensure that competency assessments for staff undertaking the role of the surgical first assistant are completed and documented appropriately.
- The hospital must ensure medicines are stored within the recommended temperature range at all times and any variation in this must be acted upon appropriately.
- Medicines must be stored appropriately in both the outpatients and diagnostic imaging departments.
- The hospital must ensure that staff are compliant with mandatory training, including safeguarding adults and children.
- The hospital must ensure that actions that have been implemented following a never event are monitored so that there is assurance that improvements have been made.
- The hospital must ensure that all risks and areas of poor compliance that have been identified are managed in an appropriate and timely way.

- All actions to mitigate clinical issues and risks identified must be monitored through the governance processes.

Action the provider **SHOULD** take to improve

- The management team should make sure that all clinical and non-clinical incidents are reported to the electronic system so that improvements can be made when needed.
- The hospital should consider providing extra sink units in patient areas which are in addition to the facilities provided in bathrooms. This is so that Department of Health standards are met.
- The management team should consider implementing an equipment checklist for theatre so that equipment is checked appropriately prior to surgery being undertaken.
- The service should ensure that the control of substances hazardous to health (COSHH) legislation is followed at all times when storing flammable liquids.
- The hospital should consider restricting access to theatre so that unauthorised persons are unable to enter unsupervised.
- The service should consider using stamps for consultants so that signatures which are timed and dated are recorded in all patient records.
- The management team should ensure that staff complete all required mandatory training in a timely manner.
- The service should ensure that the 'sign out' phase of the WHO surgical safety checklist is completed following the completion of all surgical procedures.

Outstanding practice and areas for improvement

- The management team should monitor and improve compliance with the early warning score. This is so that deteriorating patients are always identified in a timely manner.
- The management team should consider introducing a policy or an operating procedure which provides guidance on appropriate staffing levels. Additionally, the service should consider providing escalation guidance for staff to use so that it is clear when a manager should be contacted during out of hours.
- The hospital should ensure that all free text in records is legible and that consultant signatures include a record of their GMC number in line with guidance.
- The service should make sure that the efficacy of pain relief is measured and documented appropriately.
- The management team should consider ways in which to improve compliance with fasting guidance prior to surgery.
- The management team should ensure that all staff in theatre have access to an annual appraisal so that their performance is reviewed and improvements made when needed.
- The hospital should consider adapting facilities that would support people living with dementia.
- The hospital should include prosthesis and implant information as part of the discharge letter sent to the GP following surgery.

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
Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1):</p> <p>Safe Care and Treatment</p> <p>How the regulation was not being met:</p> <p>Care and treatment was not always delivered in a safe way for service users.</p> <p>This was because the WHO surgical safety checklist was not being used to confirm the correct site for the administration of joint injections.</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (b): Safe Care and Treatment</p> <p>How the regulation was not being met:</p> <p>Staff had not done all that was reasonably practicable to mitigate risk.</p> <p>This was because controls were not being followed, reducing the level of risk to patients at high risk of bleeding prior to surgery.</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (g): Safe Care and Treatment</p> <p>How the regulation was not being met:</p> <p>Medicines were not managed in a safe and proper way.</p> <p>This was because documentation was not being completed correctly following the administration of controlled drugs.</p>

Requirement notices

Medicines were not stored appropriately in the outpatient and diagnostic imaging services.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (2) (c)

How the regulation was not being met:

Safe Care and Treatment: Ensuring that person providing care or treatment to service users has the qualifications, competence, skills, and experience to do so safely.

The hospital could not be assured of the skills, qualifications and competence of first assistants.

Regulated activity

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2) (a): Good Governance

How the regulation was not being met:

The service had not assessed, monitored and improved the quality and the safety of services provided.

This was because there had been areas of poor compliance that had been identified through audits which had not been dealt with in an appropriate or timely way.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2) (a): Good Governance

How the regulation was not being met:

The service had not assessed, monitored and improved the quality and the safety of services provided.

There had been a lack monitoring regarding compliance with actions implemented following a NEVER Event incident that had involved a wrong site anaesthetic block being administered.

This section is primarily information for the provider

Enforcement actions

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.