Classic Hospitals Limited

Spire Hull & East Riding Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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 hospital	Requires improvement
Medical care	Not sufficient evidence to rate
Surgery	Requires improvement
Critical care	Requires improvement
Services for children and young people	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Hull and East Riding Hospital is operated by Classic Hospitals Limited. Facilities at the hospital site include four operating theatres, a three bedded critical care unit and the hospital is registered with CQC for 56 beds. There are also x-ray, outpatient and diagnostic facilities. We inspected this hospital as part of our independent hospital inspection programme. The inspection was conducted using the Care Quality Commission's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following five core services at the hospital: medicine, surgery, critical care, children and young people and outpatient and diagnostic imaging. We carried out the announced part of the inspection on the 14, 15, 16 September 2015 along with an unannounced visit to the hospital on 23 September 2015.

Overall we rated children and young people's services, surgery and critical care as requires improvement and outpatient and diagnostic imaging services as good. We inspected but did not rate medical care. This was because: we did not have sufficient evidence, the small size of the service and, most evidence relating to medical inpatient services was included within the surgical report as these were co-located within the surgical ward area.

Are services safe at this hospital/service

The hospital was visibly clean but there were gaps in assessing and auditing of infection prevention and control procedures. Most staff were aware of the duty of candour. Incidents were reported however, the quality of root cause analysis (RCA) investigations was inadequate. Staff received mandatory training in the safeguarding of vulnerable adults and children and the nursing and medical staff we spoke to were aware of their responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children. The resident medical officer (RMO) was based in the hospital 24 hours. We reviewed RMO cover and found it to be sufficient. We reviewed five RMO records and found that three had no DBS check: there was a lack of evidence in the files to provide assurance that the checks required for each RMO, as part of the service level agreement with the employing organisation, had been recorded. Two RMOs had no evidence that safeguarding training had been completed. There was no effective tool used to assess staffing levels within the ward area. There was no specific patient acuity tool. A projected occupancy ratio was used by the hospital as a basis to plan the staffing levels required however this did not take into account dependency or acuity. Additionally there was high throughput of patients on a daily basis who required care from registered nurses. Mandatory training was in place for all employed staff. Spire healthcare used a 12 month training programme with target compliance of 95% at the end of December 2015. Data we reviewed during the inspection showed that some areas of training fell below Spire's expected compliance levels for the current period of time. For the medical staff, with practice and privilege rights, the mandatory training records were not always completed or checked with substantive employers; there were only three, out of 10, which we checked that had training evidence logged. There was inclusion/exclusion criteria in place for accepting surgical patients. The hospital undertook the 'five steps to safer surgery' checks. During the inspection, we observed an episode of non-compliance with these checks. Additionally two 'never events' had been reported in 2014/2015, both were as a result of wrong site surgery following inappropriate patient marking. We informed the manager at the time of the inspection of our concerns and formally wrote to the provider requesting further information and actions to ensure patients were safe. The bed spaces and facilities in the critical care unit did not fully comply with current Department of Health building note 04-02.

Are services effective at this hospital/service

Patients mostly were cared for in accordance with evidence-based guidelines. However, not all documentation in critical care was updated to reflect current evidence based best practice. Critical care staff did not have the appropriate postgraduate training but actions to address this in 2016 were in place. Consent procedures were in place and training compliance rates for the Mental Capacity Act 2005 were good. Policies were mostly developed nationally. There were clinical indicators, which were monitored and compared across the Spire locations through the publication of a

quarterly clinical scorecard. However, there was no evidence to show the children's and young people's service monitored specific patient outcomes for children. The hospital held meetings where mortality and morbidity was discussed. The hospital participated in a number of in-house and national audits for surgical patients, such as the National Joint Registry (NJR) and Health Protection Agency (HPA) post-operative surgical wound healing. There were 17 cases of unplanned readmission within 29 days of discharge in the reporting period (Apr 14 to Mar 15) which was 'similar to expected' compared to the other independent acute hospitals. Consultants working at the hospital were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital); these, with appraisals were reviewed every year by the senior management team. However, there were gaps in this process identified at the inspection.

Are services caring at this hospital/service

Patients were cared for in a positive and compassionate way. Patients and relatives we spoke with all gave positive examples of caring. We observed positive interaction of staff with patients and staff appeared genuine, supportive and kind. There were high (scores above 85) for the Friends and Family Test (FFT), however the response rate fluctuated from high levels (above 61%) to low levels (less than 30%). Internal organisational patient surveys showed positive responses around care received, discharge information, and privacy and dignity. Patient records we reviewed took into account patient preferences and patients felt they were involved with information and decisions taken about them. There were psychological assessments prior to cosmetic surgery being undertaken and evidence of General Practitioner involvement pre surgery was noted.

Are services responsive at this hospital/service

The service had grown in demand from when the hospital was first developed with further anticipated growth. Plans were in place to build and expand the site. Referral to treatment times (RTT) data for the reporting period April 2014 to March 2015 showed that the provider had exceeded the target of 90% of admitted patients beginning treatment within 18 weeks every month. However, a small number of patients were cancelled on the day of surgery due to over booking of theatre lists, list overruns and staff or equipment not being available. Theatre utilisation was low: utilisation was noted as being 51.66% over a 12 month period for all four theatres. Patients' individual needs were mostly met. An increased number of complaints had been received in 2014 for the hospital and these had been rated as an amber risk on the corporate scorecard. However, for quarters one and two of 2015 the percentage of complaints responded to within the policy timescales was at 93% and none had been escalated to stage two. Complaints trends were monitored and actioned. There was an active group of volunteers working within the hospital who supported patients through their patient journey.

Are services well-led at this hospital/service

There was a vision and strategy in place for the hospital. However there was a lack of vision and strategy for the smaller core services and staff could not articulate the strategy for these services. Whilst there were governance structures in place for the provider and locally within with the hospital these were not effectively implemented; there was a perceived high element of trust between staff and as a consequence a low formal assurance culture. There was a hospital clinical governance committee in place. This committee fed directly into the medical advisory committee (MAC); the MAC averaged 50% clinical attendance at each meeting. It also had direct links into the senior management team and the hospital l group governance arrangements. We reviewed the hospital business risk register and the hospital risk analysis register. Open risks were noted with the oldest of the risks being documented in 2010. The monitoring system to ensure the doctors' safety to practice within the hospital, especially the RMOs, was not effective at the time of the inspection, for example, not all the DBS checks were up to date. There was a lack of effective oversight and action to ensure that incident investigations were of a high standard and root causes identified. Staff described leadership and culture of the hospital in a positive manner. Staff were encouraged to suggest ways to make departments run more effectively and

Summary of findings

efficiently and we saw examples of where staff had made small changes, which made a big difference to patients. The management team actively engaged in proactive recruitment and retention of staff including recent staff incentive packages. The development of a neighbouring site had been identified as necessary to address increasing space constraints within outpatients and also to improve and extend services in response to increased demand.

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

Importantly, the provider must:

1. Ensure compliance with the 'five steps to safer surgery' procedures and World health organisation audit, specifically for interventional radiology.
2. Ensure that infection prevention and control policies and procedures are in place and audited specifically in relation to observational audits for hand hygiene, and theatre dress codes.
3. Ensure that there is robust and effective root cause analysis following a serious incident and to share any learning across all services.
4. Take action to ensure that the appropriate checks and records as per HR policies are in place and recorded for the doctors working at the hospital including Disclosure and Barring Service (DBS) checks, mandatory training and appraisals.
5. Ensure that the bed spaces and facilities in the critical care unit fully comply with current Department of Health building note 04-02 for Critical Care Units published in March 2013 and Health Building Note 00-09: Infection control in the built environment (March 2013).
6. Ensure that care pathway documentation in critical care is updated to reflect current evidence research based best practice.
7. Ensure that Midazolam and oxygen are correctly prescribed on a medication chart and signed post administration and that that all CD entries into the CD medicine book are dated within the endoscopy unit.

In addition there were a number of areas where the provider should take action and these are listed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Not sufficient evidence to rate 	Due to the small size of the service we did not have sufficient, robust information to rate the service. The hospital had a single ward area. All medical inpatients and surgical patients were cared for in the same ward area and therefore, some aspects of the medical core service report were reflected under the core service surgery report. We mainly reviewed the endoscopy and chemotherapy services therefore most of our evidence and conclusions relate to these services. There was limited opportunity to talk with patients and relatives about the care given as there were no medical inpatients on the announced inspection. We did speak with four patients who were having endoscopic procedures and their comments were positive. The controlled drug register within the endoscopy unit had four entries which were not dated. Prescription charts were not written up for the medications used during medical procedures. Decontamination processes for endoscopies were in-line with best practice guidance.
Surgery	Requires improvement 	We rated surgical services as requires improvement overall because: There were omissions in infection control audits; policy implementation and policy into practice audits did not occur. Observational hand hygiene compliance or technique data audits were not performed. Due to the design of the main theatre suite, principles of theatre cleanliness, flow and theatre etiquette were compromised. Overall, limited assurance to support compliance with the hygiene code was provided.

Summary of findings

Two wrong site surgeries were reported in 2014/15, both of which were reported as a 'Never event' which had resulted in some changes in practice. The hospital used the 'five steps to safer surgery' checks, however, during the inspection an incident occurred where there was no marking of a patient prior to surgery and we reported this to the senior management team. The quality of root cause analysis (RCA) investigations following incidents was inadequate: we found a poor level of investigation, lack of medical involvement and a lack of conclusions and root causes being identified. This meant little evidence for learning or assurance to prevent re-occurrence.

Paper records we reviewed showed variable levels of completeness. We noted incomplete records for intentional rounding, missed medications, theatre checklists and pre-operative sign in. Assessments were often completed as part of the pre-operative assessment and not re-assessed post admission or surgery.

There was no effective patient acuity tool in use on the ward; instead a projected occupancy ratio was used by the hospital as a basis to plan the staffing levels. It did not take into account acuity and dependency of patients; therefore, the management could not effectively assure themselves that staffing was safe.

Staff received mandatory training however compliance rates in a number of areas, at the time of inspection, were recorded as below the hospital's expected levels; especially in resuscitation training with below 50% attendance on life support courses. Medical personnel records we reviewed had variable levels of compliance with the HR policies. DBS checks were not performed in line with Spire's policy and in three sets of records we reviewed no check was recorded. Mandatory training records

Summary of findings

and certification seen from substantive employers were not always documented as checked, and full sets of references were not always available.

Critical care	**Requires improvement**		We rated critical care services as requires improvement overall because: The unit staff were reporting incidents and there was some evidence of some verbal feedback but processes needed to be formalised. There was limited evidence of monitoring of infection control procedures such as hand washing. The unit did not meet the recommended guidelines in terms of the built environment. Bed spaces were smaller than recommended and there was a lack of hand washing facilities and specialist equipment. Patient risks were identified but there was limited evidence that actions were taken to mitigate risks. There was no lead intensivist although there was a lead anaesthetist. Nursing staff on the unit had not undertaken postgraduate critical care training although following our inspection this was discussed with the hospital management team and we were assured that actions had been put in place to address the nurse competency issues. Local pathways and guidelines had not been reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were not implemented. Staff were not aware of key quality performance indicators. Staff were aware of their responsibilities regarding the mental capacity act. There had been no complaints about the unit for more than eighteen months. The number of emergency transfers to the local NHS trust for intensive care was low. Staff were not aware of any vision or strategy for the unit. The lead anaesthetist and nurse manager oversaw the clinical management of the critical care unit. There was little evidence of quality monitoring processes or monitoring of actions taken on

Summary of findings

identified risks. The unit was described by some staff as a higher observation unit rather than a high dependency unit and there was a lack of clarity about the unit's purpose. Information gathered indicated that predominantly short term level two care was provided in the unit.

Services for children and young people

Requires improvement

We rated services for children and young people as requires improvement overall because:
The service was not carrying out observational hand hygiene audits. No incidents had been reported which involved children and young people. The environment was visibly clean and personal protective equipment was available.
Nurse staffing for children and young people was predominantly two part time contracted children's nurses, one of whom was leaving for another position, and bank staff. The service planned elective surgical cases according to availability of appropriately trained staff. Senior staff told us they planned to recruit more children's nurses.
The environment and equipment were well maintained and mandatory training was up to date. This enabled staff to carry out their roles effectively and safely.Training included awareness of safeguarding procedures and child protection.
Procedures were in place for assessing and responding to patient risk, including risk assessment of rooms where child assessments took place. However, patient identification sheets, which were located in the front of each patient's care records, all had missing entries which meant patients may not always be kept safe.
Children and young people had access to appropriate pain relief as and when required. Staff caring for children and young people had their competencies checked and received professional development, including an annual appraisal. Parents told us the care their

Summary of findings

children received was supportive and the staff were kind, caring and friendly. Both staff and parents told us they would recommend the service to their families and friends. The service had not received any complaints.
Senior nursing staff were unable to tell us about the vision and strategy for the children's service. Governance, risk management and quality measurement within the service were not well developed and there was no evidence of continuous quality improvement. The hospital did not carry out any audits relating to services specifically for children and young people. Feedback from staff about the culture within the service, teamwork, staff support and morale was positive.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging services as good overall because: Incidents were reported, investigated and lessons were learned and shared across the hospital. Risk assessments were up to date and protective measures were put in place where necessary. Staff adhered to policies and procedures and there was sufficient well-trained and competent nursing, allied health professional (AHP) and medical staff within the departments to deliver care safely.
The outpatient and diagnostic imaging departments offered appointments weekdays, evenings and Saturday mornings. Support services such as physiotherapy and radiology were in place 24 hours a day, seven days a week. The department participated in a number of local and national audits; however, information submitted for the inspection did not always include interpretation, benchmarking or actions for either improving or sustaining performance. Patients told us they were treated with kindness and compassion and that staff were courteous and respectful. Receptionists were reported as excellent

Summary of findings

and chaperones were offered. Patients felt that confidentiality was excellent. Patients spoke very highly of the service provided by the pain clinic.
Patients could be seen quickly for urgent appointments if required and departments offered flexibility around clinic times. Clinics were rarely cancelled at short notice and waiting times for appointments were well within target timescales.
Staff and managers had a vision for the future of their services and staff felt empowered to express their opinions or concerns. Staff were engaged with the organisation's mission to deliver the highest quality patient care and patients were given opportunities to provide feedback about their experiences of the services provided.

Requires improvement

Spire Hull & East Riding Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; Critical care; Services for children and young people and Outpatients & diagnostic imaging.

Detailed findings

Contents

Background to Spire Hull & East Riding Hospital

Spire Hull and East Riding Hospital is operated by Classic Hospitals Limited. The hospital opened in 1986. It is a private hospital situated in Anlaby, located in the west of Hull. Spire Hull and East Riding Hospital primarily serves the communities of the East Riding of Yorkshire and Hull. It also accepts patient referrals outside of this catchment area.

Facilities at the hospital site include an operating suite containing four operating theatres all with laminar flow. The suite also offers an integral, accredited sterile services department and two recovery areas consisting of nine bays in total. There was a three bedded critical care unit in close proximity to the operating suite. Spire Hull and East Riding Hospital is registered with CQC for 56 beds, of which 55 are in use; 49 inpatient beds and six day case beds. There are also x-ray, outpatient and diagnostic facilities.

In 2014 the parent company Classic Hospitals Limited acquired Spire Hesslewood Clinic, which is located approximately one and a half miles south of Spire Hull and East Riding Hospital and is operated as a satellite to Spire Hull and East Riding and is under the same management structure. After a six month commissioning period Spire Hesslewood Clinic began caring for patients from February 2015 on a 'walk in, walk out' basis. There are two minor procedures theatres and outpatient consulting rooms at the clinic, which offer services for dermatology, Botox, chronic migraine, dietetics, podiatry, orthotics, rheumatology and outpatient ophthalmology.These services had previously been offered at Spire Hull and East Riding Hospital. Staff are 'flexed' across the two sites, which also share the same Medical Advisory Committee, Senior Management Team, a single medical records storage site, policies and procedures. The two sites also have a combined data collection process and clinical dashboard, meaning that data is not available at a site level for Spire Hesslewood Clinic. The two sites are registered separately with CQC.

The hospital's ward has 34 single rooms, all with en-suite facilities, and a specifically designed suite which consists of three, four and five bedded bays offering single sex accommodation. There is a day case suite which provides six bays. The outpatient department has: 13 consulting rooms; one treatment room; one phlebotomy room; pathology services; imaging (with mobile MRI) and CT service; a cardiac service; and physiotherapy services. Children are treated at Spire Hull and East Riding Hospital from the age of three and upwards for outpatient services, elective day case or overnight surgery. Children under three are treated in Dermatology Outpatients Clinics, however, no interventional treatment is given. There is also a restaurant providing food for patients, staff and visitors.

Detailed findings

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during 2014/15. The hospital has been inspected four times, and the most recent inspection took place in November 2013 which showed the hospital was meeting all standards of quality and safety it was inspected against. We inspected this hospital as part of our independent hospital inspection programme. The inspection was conducted using CQC's new comprehensive inspection methodology. It was a routine planned inspection. For this inspection, the team inspected the following five core services at Hull and East Riding hospital:

- Medicine
- Surgery
- Critical care
- Children and young people
- Outpatient and diagnostic imaging

In August 2015 the longstanding manager of five years was de-registered due to a promotion within the company. At the time of the inspection a new manager was in place and was registered with CQC in September 2015.

Our inspection team

Our inspection team was led by:

Inspection Manager: Karen Knapton, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultants in surgery and anaesthetics, a senior manager from another independent provider and nurses.

How we carried out this inspection

We carried out the announced inspection on the 14, 15, 16 September 2015 along with an unannounced visit at the hospital on 23 September 2015. We talked with patients and members of staff, including managers, nursing staff (qualified and unqualified) medical staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patients' clinical records.

Prior to the announced inspection, we reviewed a range of information we had received from the hospital. We also distributed comment cards for patients to complete and return to us. Also we asked the local clinical commissioning groups to share what they knew about the hospital.

Facts and data about Spire Hull & East Riding Hospital

Activity (April 2014 to March 2015)

- 3,410 overnight inpatients
- 9,838 day case patients
- 12,681 visits to the operating theatre (a combined figure for Spire Hull and East Hospital and Spire Hesslewood Clinic)
- Other limb surgery not including hip or knee was noted as the highest type of surgery performed with 3,612 episodes
- 1,268 Infusion therapy procedures
- 745 Injections of substance into skin
- 476 Cryotherapy (skin) procedures.

Core Services Offered

- Critical care
- Diagnostic imaging*
- End of life care
- Medical care
- Refractive eye surgery
- Termination of pregnancy

Detailed findings

- Bupa Health and Well
- Cosmetic treatments
- Podiatry and orthotic service*
- Pharmacy
- Physiotherapy

* Services offered to children and young people

Staffing (Doctors & dentists headcount and otherwise FTE)

Staff are deployed across the two sites and figures were not available at a site level:

- Doctors and dentists working under rules or privileges:223
- Doctors and dentists employed: 1
- Nurses: 55
  - Inpatient departments: 28
  - Theatre departments 17
  - Outpatient departments: 10
- Operating department practitioners (theatre): 13
- Care assistants: 22
  - Inpatient departments: 12
  - Theatre departments: 4
  - Outpatient departments: 6
- Other hospital wide staff: 118
- Allied health professional: 11
- Administrative and clerical staff: 75
- Other support staff: 31

At the time of the inspection the registered manager, Karen Newton was the accountable officer for controlled drugs.

Services accredited by a national body:

- Bupa accredited breast cancer, bowel cancer, MRI, critical care, chemotherapy, paediatric and ophthalmology services
- Macmillan quality environment mark accreditation
- SGS Accreditation for Sterile Services Department.

Outsourced Services:

- Clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser service
- Laundry
- Maintenance of medical equipment
- Non-clinical waste removal
- Occupational health
- Pathology and histology
- Radiation protection
- RMO provision
- Staff agency
- Blood Transfusion

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Surgery	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. Due to the small size of the service we did not have sufficient, robust information to rate the domain/ service.
3. There were no or minimal patients available to speak with at the inspection therefore we were unable to rate caring for these core services.

Requires improvement

Are services safe?

Our findings

- The hospital was visibly clean but there were gaps in assessing and auditing of infection prevention and control procedures. Most staff were aware of the duty of candour. Incidents were reported however, the quality of root cause analysis (RCA) investigations was inadequate. Staff received mandatory training in the safeguarding of vulnerable adults and children and the nursing and medical staff we spoke to were aware of their responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children. The resident medical officer (RMO) was based in the hospital 24 hours. We reviewed RMO cover and found it to be sufficient. We reviewed five RMO records and found that three had no DBS check: there was a lack of evidence in the files to provide assurance that the checks required for each RMO, as part of the service level agreement with the employing organisation, had been recorded. Two RMOs had no evidence that safeguarding training had been completed. There was no effective tool used to assess staffing levels within the ward area. There was no specific patient acuity tool. A projected occupancy ratio was used by the hospital as a basis to plan the staffing levels required however this did not take into account dependency or acuity.

Additionally there was high throughput of patients on a daily basis who required care from registered nurses. Mandatory training was in place for all employed staff. Spire healthcare used a 12 month training programme with target compliance of 95% at the end of December 2015. Data we reviewed during the inspection showed that some areas of training fell below Spire's expected compliance levels for the current period of time. For the medical staff, with practice and privilege rights, the mandatory training records were not always completed or checked with substantive employers; there were only three out of 10 which we checked that had training evidence logged. There was inclusion/exclusion criteria in place for accepting surgical patients. The hospital undertook the 'five steps to safer surgery' checks. During the inspection, we observed an episode of non-compliance with these checks. Additionally two 'never events' had been reported in 2014/2015, both were as a result of wrong site surgery following inappropriate patient marking. We informed the manager at the time of the inspection of our concerns and formally wrote to the provider requesting further information and actions to ensure patients were safe. The bed spaces and facilities in the critical care unit did not fully comply with current Department of Health building note 04-02.

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Good

Are services caring?

Our findings

Patients were cared for in a positive and compassionate way. Patients and relatives we spoke with all gave positive examples of caring. We observed positive interaction of staff with patients and staff appeared genuine, supportive and kind. There were high (scores above 85) for the Friends and Family Test, however the response rate fluctuated from high levels (above 61%) to low levels (less than 30%).

Internal organisational patient surveys showed positive responses around care received, discharge information, and privacy and dignity. Patient records we reviewed took into account patient preferences and patients felt they were involved with information and decisions taken about them. There were psychological assessments prior to cosmetic surgery being undertaken and evidence of GP involvement pre surgery was noted.

Good

Are services responsive?

Our findings

The service had grown in demand from when the hospital was first developed with further anticipated growth. Plans were in place to build and expand the site. Referral to treatment times (RTT) data for the reporting period April 2014 to March 2015 showed that the provider had exceeded the target of 90% of admitted patients beginning treatment within 18 weeks every month. However, a small number of patients were cancelled on the day of surgery due to over booking of theatre lists, list overruns and staff or equipment not being available. Theatre utilisation was low: utilisation was noted as being 51.66% over a 12 month period for all four theatres. Patients' individual needs were mostly met. An increased number of complaints had been received in 2014 for the hospital and these had been rated as an amber risk on the corporate scorecard. However, for quarters one and two of 2015 the percentage of complaints responded to within the policy timescales was at 93% and none had been escalated to stage two. Complaints trends were monitored and actioned. There was an active group of volunteers working within the hospital who supported patients through their patient journey.

Requires improvement

Are services well-led?

Our findings

There was a vision and strategy in place for the hospital. However there was a lack of vision and strategy for the smaller core services and staff could not articulate the strategy for these services. Whilst there were governance structures in place for the provider and locally within with the hospital these were not effectively implemented; there was a perceived high element of trust between staff and as a consequence a low formal assurance culture. There was a hospital clinical governance committee in place. This committee fed directly into the medical advisory committee (MAC); the MAC averaged 50% clinical attendance at each meeting. It also had direct links into the senior management team and the hospital l group governance arrangements. We reviewed the hospital business risk register and the hospital risk analysis register. Open risks were noted with the oldest of the risks being documented in 2010. The monitoring system to ensure the doctors' safety to practice within the hospital, especially the RMOs, was not effective at the time of the inspection, for example, not all the DBS checks were up to date. There was a lack of effective oversight and action to ensure that incident investigations were of a high standard and root causes identified. Staff described leadership and culture of the hospital in a positive manner. Staff were encouraged to suggest ways to make departments run more effectively and efficiently and we saw examples of where staff had made small changes, which made a big difference to patients. The management team actively engaged in proactive recruitment and retention of staff including recent staff incentive packages. The development of a neighbouring site had been identified as necessary to address increasing space constraints within outpatients and also to improve and extend services in response to increased demand.

Medical care

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

Information about the service

Information provided by the hospital indicated that they cared for 356 medical patients in the period August 2014 to August 2015 although verbally we were told that only 40 medical patients were admitted each year. Of these 356, 349 were cardiology patients, one nephrology patient and six oncology patients.

There was one ward at the hospital which accommodated both medical and surgical patients.

We visited the ward area and the endoscopy suite. The endoscopy unit provided, in the main, diagnostic endoscopy only. On occasion, during flexible colonoscopies, small polyps were removed where appropriate. We spoke to one of the two chemotherapy nurses who came in to the hospital to speak to us on her day off; we spoke to the registered medical officer, the endoscopy lead and one of the consultants working within the endoscopy department.

Due to the small number of in-patients were unable to speak with many patients receiving medical care. There were no admitted patients on the announced inspection. During our unannounced inspection we were able to speak with four patients who were having endoscopic procedures.

Summary of findings

We inspected but did not rate medical care because we did not have sufficient robust evidence due to the small size of the service. Additionally, most of the evidence relating to medical inpatient services is within the surgical report as the hospital had a single ward area and all medical inpatients were cared for in the same ward area as the surgical patients. We mainly reviewed the endoscopy and chemotherapy (oncology) services and therefore most of our evidence and conclusions relate to these services.

There was limited opportunity to talk with patients and relatives about the care given as there were no medical inpatients on the announced inspection. We did speak with four patients who were having endoscopic procedures and their comments were positive.

The oncology service was very responsive and we received very complimentary written feedback from patients. Decontamination processes for endoscopies were in-line with best practice guidance. The controlled drug register within the endoscopy unit had four entries which were not dated. Prescription charts were not written up for the medications used during medical procedures.

Medical care

Are medical care services safe?

Not sufficient evidence to rate

Due to the small size of the service we did not have sufficient, robust information to rate the service.

The controlled drug register within the endoscopy unit had four entries which were not dated. In three of six sets of notes there were no medication charts but the patient was given oxygen and midazolam which was signed on the pathway. Prescription charts were not written up for the medications used during medical procedures.

Incidents

- There was insufficient evidence to comment specifically on incidents relating to medical services.
- We spoke to a chemotherapy nurse who told us that learning from incidents comes from the ward manager through team meetings which were minuted and evidenced within the ward communication file. We were told that this member of staff had only ever submitted one Datix report.
- The endoscopy lead told us that she attended general management meetings where incidents were discussed.

Duty of Candour

- All staff we spoke with were aware of the duty of candour and described it as the need to inform patients if an incident or mistake had occurred and to be open and honest with patients.
- Staff were able to provide us with specific examples about its use.

Safety thermometer

- The NHS Safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It looks at risks such as falls, pressure ulcers, blood clots (VTE), and catheter and urinary tract infections. There was no separate data regarding medical patients.
- Spire Hull & East Riding commenced submitting data in July 2012 and had submitted data on a monthly basis since. All patients (100%) audited had all been rated as harm free. This is better than the England average of 93%.
- The hospital did not have a separate corporate clinical scorecard for the medical patients and the corporate clinical scorecard covered all departments across hospital. The corporate clinical scorecard for quarter two 2015 indicated that:
  - VTE risk assessment compliance was 100%. The hospital had not reported any incidences of VTE.
  - There had been no pressure ulcers of category 2 or above.
  - The percentage of patients who had any slip, trip or fall (for each1000 bed days) was 2.2% which was slightly worse than the hospital target of 1.9%.
  - Information pertaining to UTI's (Urinary tract infections) in catheterised patients was not included on the scorecard however this information was evidenced on the Spire Quality Dashboard which showed that between April to July 2015 there had been no reported cases of patients developing a UTI following catheterisation.
- In the reporting period June 2014 to August 2015 no harms had been reported under the safety thermometer reporting system.

Cleanliness, infection control and hygiene

- The ward environment was clean and tidy, and all bed spaces, once clean, to provide assurance of cleanliness, had a leaflet placed on them which had the name of the cleaner on it and wasdated.
- Facilities cleaning staff were aware of their roles and responsibilities. Staff we spoke with said they had adequate equipment and training to allow them to carry out their job including the provision of a safe water supply and the requirements for control of waterborne bacteria. The hospital had a good system of flushing, recording and escalating problem areas.
- The provider reported no cases of Methicillin resistant staphylococcus aureus MRSA, Clostridium difficile C.difficile or Methicillin sensitive staphylococcus aureus MSSA infections from April 2014 to March 2015 at the hospital.
- Decontamination processes for the flexible endoscopes were in-line with best practice guidance and included a manual cleaning process, manual leak test followed by an automated (pass through) chemical disinfection process. The 'dirty' endoscope cleaning processes were

appropriately segregated from the 'clean' processes. Endoscope buttons were kept with their corresponding endoscope as a unique set; this also followed best practice guidance.
- All endoscopy accessories were single patient use.
- Appropriate personal protective equipment was available for use during procedures and endoscope decontamination; this included eye protection.
- The water feeding in to the automated disinfection machine was treated using reverse osmosis water purification technology; rinse water was tested weekly to ensure its quality. The inside of the automated machine and endoscope channels were periodically tested to ensure the efficacy of the decontamination processes.
- During procedures, clean and dirty endoscopes were managed appropriately and a tray system was used; these ensured clean and dirty endoscopes were appropriately covered when being transported within the unit.
- A drying cabinet was used and this enabled clean (ready to use) endoscopes to be stored for a specific and extended period of time, of up to 72 hours.
- The endoscopy lead told us that she attended the hospital infection control meeting.

Environment and equipment

- The inpatient environment was tidy, however some communal fixtures were found to be damaged with laminate peeling off and varnish chipping present.
- All rooms had access to showers and toilet facilities.
- Storage for equipment was an issue and we noted clean equipment stored in the sluice area.
- Resuscitation equipment was checked and found to be in working order and checks undertaken.
- The endoscopy suite was visibly clean and well maintained. This unit was part of the main theatre suite.

Medicines

- Access to pharmacy was available on-site, and a member of pharmacy staff attended and reviewed medications for ward based patients on a daily basis.
- Pharmacy out of hour's flow chart and arrangements were available, and staff were aware of how to access medication out of hours using on-site or off-site arrangements.
- Medicine cupboards we reviewed were found to be secure, organised, clean, tidy and with good stock rotation.
- Controlled drugs in the ward area were stored appropriately according to legal requirements. However, we found that the controlled drug register within the endoscopy unit had four entries which were not dated.
- In three sets of notes Midazolam and oxygen were documented as being administered on the relevant pathway documentation used but these were not prescribed on a medication chart. The pathway states 'Drugs administered (tick drugs used) NB: This is not a prescription'. The pathway then lists eight medications including midazolam, fentanyl and pethidine. Oxygen and throat spray sections were also available within the pathway.HHowever we found no evidence that oxygen had been prescribed on the patients' medication charts within the notes.

Records

- We reviewed six sets of notes for medical patients who had been recently cared for in the hospital and found the following:
  - Two sets of notes for oncology patients were completed appropriately. A comprehensive pathway booklet was evident and this had been fully completed. VTE assessment was completed. There was a record of cannulation and patient allergies. The medication charts were completed and all medications were signed for appropriately. The notes contained a consent form: again this was fully completed. The notes showed evidence of an MDT meeting. There was evidence that concerns were escalated to medical staff where appropriate.
  - The third set of notes was for a patient who had renal failure. The medication chart had one omission. The patient had a 1250mls fluid restriction however two fluid balance charts within the notes were incomplete.
  - In the fourth set of notes the safer surgery checklist for a procedure was incomplete (step 3 sign out). There was no medication chart but the patient was given oxygen and midazolam. This was recorded on the procedure pathway but not a medication chart.
  - There were gaps within the fifth set of notes: there was no VTE assessment form within the notes. There was no medication chart but the patient was given oxygen and midazolam which was signed on the

pathway. Midazolam must be prescribed and signed for on a prescription chart. There was no VIP score recorded despite pathway stating VIP score (please state)

- Within the final set of notes there was a printed out cytology report. On this, 'middle' is crossed out and replaced with 'upper' written above.This alteration is signed but the name is not printed so it is not evident who did this. There was no medication chart relating to this admission, however midazolam had been given and this was documented in the procedure notes. There was also evidence of a previous admission earlier in the year. There was a medication chart for this admission however the allergy status was blank.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction followed by yearly safeguarding refresher training. Hospital compliance data showed that 63% of theatre staff and 56% of nursing staff had completed safeguarding refresher at the time of our inspection. The deadline for remaining staff to have completed this training was the end of December 2015. Specific numbers for medical staff training were not held.
- Data supplied by the hospital showed that no safeguarding concerns were recorded in the last 12 months.
- A specialist chemotherapy nurse we spoke with was aware of the process for safeguarding concerns and told us that she would escalate any concerns to senior staff.

Mandatory training

- As part of induction, staff received appropriate training for their role such as fire, IPC and manual handling. Staff also completed refresher training every year. Mandatory training was delivered as a mixture of face to face and e-learning training. Staff we spoke to all said they had undertaken all mandatory training required for their role.
- Spire healthcare used a 12 month training programme with target compliance of 95% at the end of December 2015. At the end of month eight the expectation would be that approximately 67% of staff would have completed mandatory training, in line with the calendar year training programme. Data we reviewed during the inspection showed that some areas of training fell below Spire's expected compliance levels for the current period of time. Examples included level 2 blood transfusion training and attendance at resuscitation training which was noted to be low; 38% compliance for basic life support, 51% for basic life support level 2, and Immediate Life Support (ILS, course for first responders) was 30%. Following the inspection the hospital informed us that the 2014 full year training results showed above 95% compliance with all mandatory training modules.
- For clinicians that were employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with Spire Hull and East Riding hospital, mandatory training was usually undertaken by the substantive employer and monitored by the hospital. However, during review of the personnel documents we had little assurance this monitoring was being undertaken.
- We reviewed 10 sets of medical personnel records: mandatory training records were not always completed or checked with substantive employers; there were only three records with training evidence logged.

Assessing and responding to patient risk

- The hospital had a policy for the inclusion/ exclusion criteria for patients accepted for treatment at the hospital. This helped to risk assess patients prior to agreeing any treatment plan.
- The endoscopy service only provided treatment for non-complicated patients.
- The hospital had recently introduced the national early warning score (NEWS) assessment.
- There was a 'blue light' process in place for emergency transfers out to another hospital. The hospital had a comprehensive flow chart and a patient checklist for staff to use when these events occurred.

Nursing staffing

- Any medical inpatients were cared for by the general ward staff who for the majority of the time cared for surgical patients.
- No specific patient acuity tool was used on the ward, but a projected occupancy ratio was used by the hospital as a basis to plan the staffing levels required. Due to the high throughput of patients, under different

clinical specialities, on a daily basis who required care from registered nurses, this might not have been effective. It was not uncommon for 40 day case and inpatients to be admitted for theatre on a daily basis.
- There were two specialist trained nurses who provided the day patient chemotherapy service.

Medical staffing

- Medical treatment and procedures were carried out by medical staff who were mainly employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice in hospital).
- Medical cover on the wards was provided by the consultants in charge of the patients' care 24 hours a day for their admitted patients. Consultants had to arrange cross-cover when required for their patients from suitably trained colleagues, with practising privileges. A spreadsheet was available with consultant contact details for emergency contacts and staff we spoke to were aware how to access this document.
- The resident medical officer (RMO) was based in the hospital 24 hours a day. We reviewed RMO cover and found it to be sufficient, and staff we spoke to appeared to have the correct skills.

Major incident awareness and training

- The hospital was not a receiving area for major incidents.
- The hospital business continuity plan was in use at the start of the inspection, due to a generator problem which occurred during routine testing. This was resolved during the inspection, and senior staff said the plan had been implemented successfully.
- Five resuscitation scenarios had been carried out throughout the hospital.

Are medical care services effective?

Not sufficient evidence to rate

Due to the small size of the service we did not have sufficient, robust information to rate the service.

There was no patient outcome data available for comparison and evaluation for the individual medical specialities at hospital level or across the Spire group.

The hospital was working towards a national accreditation programme for the endoscopy service.

Evidence-based care and treatment

- We were told by the endoscopy lead that the department participated in the BUPA endoscopy audit. The hospital was a BUPA quality accredited provider for bowel conditions. The hospital was reviewed against national standards in the following areas: services and facilities; endoscopy unit; surgeons and the team; patient support and audit and guidelines. The last assessment was completed in December 2014.
- They were also working towards JAG (Joint Advisory Group on endoscopy) accreditation and had completed a gap analysis to assist with this. We were advised that new reporting equipment was due to be introduced in December 2015 and this would enable them to evidence compliance with more of the criteria needed to achieve the accreditation, especially in relation to patient experience and comfort scores.
- The majority of the operational policies were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- When a new organisational policy was received, staff and the MAC reviewed the policy and undertook a gap analysis on the policy, and information relevant to the site was added in; nothing was allowed to be removed from the policies. Policies were available in hard paper format on the unit and in electronic format on the intranet.

Pain relief

- There was not sufficient evidence available to comment on pain relief.

Nutrition and hydration

- There were no issues observed or noted following discussion with the two specific medical services we reviewed.

Patient outcomes

- There was no outcome monitoring specific to patients' medical conditions within the hospital.
- Additionally we were not informed of any monitoring of medical outcomes nationally within the Spire group of hospitals.

Medical care

- General patient outcomes were monitored and compared across the company through the publication of a quarterly clinical scorecard. This document was RAG rated, which allowed the hospital to compare its outcomes with other Spire sites. It included VTE risk assessment, patient falls, surgical site infections, hospital acquired infections, readmissions, return to theatre, critical care transfers and pressure ulcer incidents.

Competent staff

- A chemotherapy nurse told us that they had an up to date appraisal.
- The chemotherapy nurses had completed a graduate certificate in cancer care accredited through Leeds University.
- The endoscopy lead had attended a decontamination course. This was a complete endoscope decontamination process (EDP32) course.
- The medical inpatients were nursed on the single ward where the majority of patients were having surgical procedures. There was a lack of exposure for nursing staff to maintain their competencies in caring for patients with medical conditions because of the small number of inpatients treated at the hospital.

Multidisciplinary working

- A chemotherapy nurse told us that a multidisciplinary team meeting takes place for chemotherapy patients. This was evident in the notes we reviewed.
- We were told that working relationships were positive within the chemotherapy team.
- The endoscopy lead told us that all staff work well within the team.
- The lead consultant for endoscopy told us that working relationships were good within the team.

Seven-day services

- The chemotherapy nurses provided an on-call service for patients Monday to Friday 8AM to 9PM and 8AM to 1PM on a Saturday. Out of these hours patients were directed to the ward for triage and their consultant contacted directly.
- The hospital also has a service level agreement for 24 hour cover with the local NHS hospital for pathology, transfusion, pharmacy and transfer of deteriorating patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In the notes we reviewed consent forms were appropriately signed.

Are medical care services caring?

Not sufficient evidence to rate

We were unable to rate caring due to the small number of in-patients we were able to speak with who received medical care. There were no admitted patients on the announced inspection. During our unannounced inspection we were able to speak with four patients who were having endoscopic procedures. All of the patients we spoke with told us that staff were caring and that they had an understanding of their treatments.

Compassionate care

- During our inspection we invited service users to compete comment cards. We found that four of the cards completed were specifically related to the chemotherapy nurses. These cards remarked positively on the quality of care and efficiency in oncology specifically. All of the comments were positive and praised the staff who worked in this team.
- During our unannounced inspection we spoke to four patients who were having endoscopic procedures**.** All of the patients we spoke to told us that staff were caring.

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

- All of the patients we spoke to during our unannounced inspection told us that they had received written information about their procedure and that they had discussed their care with staff. We also spoke to two relatives who told us that they had found the service good.

Emotional support

- The patients we spoke with felt supported.
- From conversations with the chemotherapy nurses it was evident that they provided good emotional support to patients.

Medical care

Are medical care services responsive?

Not sufficient evidence to rate

Due to the small size of the service we did not have sufficient, robust information to rate the service.

There was no specific service planning documentation to review for medical care. The chemotherapy nurses were very responsive to people's needs.

Service planning and delivery to meet the needs of local people

- There was no specific service planning documentation to review for medical care.
- We were told that medical patients were sometimes admitted following routine follow-up in the out patients department. fFor example a patient might have attended and the consultant might admit the patient due to suspecting a chest infection or deterioration in a medical condition which required further investigation or treatment.
- The chemotherapy service was available twice a week in the hospital on a Tuesday and a Thursday.

Access and flow

- Endoscopy services operate Monday to Friday.
- Chemotherapy patients routinely attended as day cases on Tuesdays and Thursdays. Beds on the ward were used while they received their treatment. However, staff were able to flex according to the needs of the patient if they were unable to attend Tuesdays or Thursdays.

Meeting people's individual needs

- We were told by one of the chemotherapy nurses that MacMillan leaflets were given to chemotherapy patients and that these could be obtained in other languages. We did not see any examples of these during the inspection.
- Any patients requiring translation within the endoscopy service were identified at the pre- assessment stage. We were told that the unit would not use patients' families to provide this service.
- The chemotherapy nurses carried a mobile phone and provided an out-of-hours and weekends triage service for the patients undergoing chemotherapy at the hospital.
- Patients whose first language was not English could access an interpreter. Staff could describe to us how to access translation services. They spoke about times when they have cared for patients in rooms with an interpreter present.
- Bariatric services were offered at the hospital and specialised beds, chairs and wheelchairs were available. All bariatric patients were referred to a dietitian for aftercare.
- The hospital had developed dementia awareness champions. We saw posters raising awareness of this role. Staff were not sure if they had had appropriate training for nursing patients with dementia, learning disability or for patients with complex needs. Post inspection we were told that the hospital used a module from NHS compassion in practice, this module was mandatory for all staff and included information on dementia.
- We reviewed patient led assessment of the care environment (PLACE) results and noted that the dementia care was scored at 91% compared toa national average of 74%.
- We did not observe any rooms specifically designed or decorated for patients living with dementia.
- We noted that on every bed a leaflet called 'HELP' was provided. This stood for 'handling and moving, environment, loo and pain'. This was an initiative encouraging patients to tell staff if they were not comfortable or needed assistance.
- We were told that the endoscopy service used service specific information leaflets from a company which actively collaborated with leading organisations to make sure patient information leaflets are of the highest quality.

Learning from complaints and concerns

- There had been no complaints relating to the chemotherapy service.

Are medical care services well-led?

Not sufficient evidence to rate

Due to the small size of the service we did not have sufficient, robust information to rate the service.

There was no specific strategy for medical care at the hospital.

Medical care

Vision and strategy for this this core service

- There was a vision and strategy in place for the Spire Hull and East Riding hospital.
- There was no specific strategy for medical care at the hospital.

Governance, risk management and quality measurement for this core service

- There was no specific governance structure for medical care due to the small nature of the service. The hospital MAC included representation for endoscopy, cardiology, dermatology and oncologyWe were told that attendance at these meetings was 100%, however during review of the minutes we noted that attendance was lower, about 50%, with apologies noted from medical staff at all three of the meeting minutes we reviewed.
- Governance and risk management processes were as outlined in the report for surgery services.
- There were no specific quality measures used to monitor the medical services, for example,there were no measurable outcomes for the chemotherapy services.

Leadership and culture of service

- The chemotherapy nurses were managed by the ward sister.
- The chemotherapy nurse we spoke to was passionate about the care provided to oncology patients and she was proud of the service provided.
- This nurse also told us that she felt well supported.

Public and staff engagement

- The endoscopy lead told us that patient feedback is obtained through the Spire patient satisfaction survey but that this was something that she would like to change in the future to gather service specific information.

Innovation, improvement and sustainability

- We were told that the chemotherapy nurses were both coming up to retirement. Sustainability of this service would only be possible if other staff were trained to provide this. There were only two chemotherapy nurses and a bank nurse who covered holidays. This could lead to a reduction in the service if long term absence occurred within the team.

Surgery

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

Information about the service

Spire Hull and East Riding Hospital was opened in 1986 and provides day surgery and inpatient treatment for NHS and private patients across a range of specialities, including Orthopaedics, Ophthalmology and general surgery. There are 49 overnight beds, six day case beds and four operating theatres available. The Wilberforce suite (a multi-bedded area) was opened in 2006.

Between April 2014 and March 2015 there were 3,410 overnight inpatients and 9,838 day case patients admitted with 12,681 visits to theatre. Patients are admitted to the hospital for surgical procedures from 7.00 am. In the same period, procedures performed included: other limb surgery 3,612; abdominal surgery 765; knee surgery 603; pelvic surgery 318; hip surgery 424; head and neck surgery 319; and cardiothoracic surgery 160. Patient activity was 8,000 in 2012 and 14,000 in 2014.

Surgery was provided for both adults and children. The hospital had a policy for the inclusion/ exclusion criteria for patients based on hospital guidelines.

As part of our inspection, we visited the ward, the day case unit and the theatre suite. We spoke with a range of staff at different grades from domestic staff to consultants and the senior management team. We observed care and treatment and spoke with 10 patients and looked at 10 patients' medical records.

Summary of findings

We rated surgical services as requires improvement overall because:

There were omissions in infection control audits; policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were not performed. Due to the design of the main theatre suite, access to the critical unit for patients, staff and visitors was by using theatre corridors therefore the principles of theatre flow and theatre etiquette were compromised. Overall, limited assurance to support compliance with the hygiene code was provided.

Two 'Never events' were reported in 2014/15. Both were wrong site surgery, one of which had resulted in some changes in practice. The hospital used the 'five steps to safer surgery' checks, however, during the inspection an incident occurred where there was no marking of a patient prior to surgery and we reported this to the senior management team. The quality of root cause analysis (RCA) investigations following incidents was inadequate: we found a poor level of investigation, lack of medical involvement and a lack of conclusions and root causes being identified. This meant little evidence for learning or assurance to prevent re-occurrence.

Paper records we reviewed showed variable levels of completeness. We noted incomplete records for intentional rounding, missed medications, theatre

checklists and pre-operative sign in. Assessments were often completed as part of the pre-operative assessment and not re-assessed post admission or surgery.

There was no effective patient acuity tool in use on the ward; instead a projected occupancy ratio was used by the hospital as a basis to plan the staffing levels. It did not take into account acuity and dependency; therefore, the management could not effectively assure themselves that staffing was safe.

Staff received mandatory training however compliance rates in a number of areas, at the time of inspection, were recorded as below the hospital's expected levels for the time of year; especially in resuscitation training with below 50% attendance on life support courses. Medical personnel records we reviewed had variable levels of compliance with the HR policies. DBS checks were not always performed in line with Spire's policy. Mandatory training records and certification seen from substantive employers were not always documented as checked, and evidence of full sets of references were not always available.

Are surgery services safe?

Inadequate

We rated surgical services as inadequate because:

There were omissions in infection control audits; policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were not performed. Due to the design of the main theatre suite, access to the intensive care unit for patients, staff and visitors was by using theatre corridors therefore the principles of flow and theatre etiquette were compromised. Overall, limited assurance to support compliance with the hygiene code was provided.

Two 'Never events' were reported in 2014/15. Both were wrong site surgery, one of which had resulted in some changes in practice. The hospital used the 'five steps to safer surgery' checks, however, during the inspection an incident occurred where there was no marking of a patient prior to surgery; this was not in line with national guidelines. Once highlighted the patient was marked. We reported this to the senior management team during the inspection. The quality of root cause analysis (RCA) investigations following incidents was inadequate; we found a poor level of investigation, lack of medical involvement and a lack of conclusions and root cause being identified. This meant little evidence for learning or assurance to prevent re-occurrence.

Paper records we reviewed showed variable levels of completeness. We noted incomplete records for intentional rounding, missed medications, theatre checklists and pre-operative sign in. Assessments were often completed as part of the pre-operative assessment and not re-assessed post admission or surgery.

There was no effective patient acuity tool in use on the ward; instead, a projected occupancy ratio was used by the hospital as a basis to plan the staffing levels. It did not take into account acuity and dependency; therefore, the management could not effectively assure themselves that staffing was safe.

Staff received mandatory training however compliance rates in a number of areas, at the time of inspection, were recorded as below the hospital's expected levels; especially in resuscitation training with below 50% attendance on life

support courses. Medical personnel records we reviewed had variable levels of compliance with the HR policies. DBS checks were not performed in line with Spire's policy and on three occasions no check was recorded. Mandatory training records and certification seen from substantive employers were not always documented as checked, and a full set of references were not always available.

Incidents

- Never events are serious incidents, which are wholly preventable as guidance and safety recommendations that provide strong systemic protective barriers are available at a national level. Two never events were reported in 2014/15.Both were wrong site surgery.Staff told us that changes in practice were noted as a result of one never event and staff we spoke to were aware of the never event and other incidents. During the inspection we observed a potential incident due to no marking of a patient prior to surgery. This was reported to the senior management team. The pre-operative assessment had been completed and signed to say it had been marked. Spire Healthcare Clinical Services Circular 02 was not followed in terms of marking the patient,this states: "how to mark - an indelible marker pen will be used".
- Spire Hull and East Riding hospital reported two serious incidents in the reporting period April 2014 to March 2015.
- The commission received one statutory notification of a serious injury reported in the reporting period April 2014 to March 2015 (in November 2014). Since March 2015, CQC have received four further notifications of serious injuries and these were all reviewed.
- The hospital had reported 28 incidents requiring root cause analysis (RCA) review in 2014. On reviewing five recent surgical RCA reports,we noted a poor level of investigation, lack of medical involvement, a lack of conclusions and root cause being identified. This meant little evidence for learning or assurance to prevent re-occurrence. We saw that some incidents had been closed on the reporting system although the RCA had yet to be completed. The senior management told us that RCA training had recently been introduced for all senior staff carrying out RCAs. The senior management team told us that they wanted to improve the RCA process, timescales and clinician involvement. RCA data was currently sitting as amber on the corporate scorecard due to timeliness of the RCA process.
- Incidents were reported using a centralised national computer system. Senior nursing staff told us they reviewed the incidents reported and analysed the data to identify any trends. Staff told us that learning from incidents was shared internally through displays on walls, staff meetings and a shared minutes computer drive.
- Hospital wide learning from incidents was shared through governance and clinical effectiveness meetings. We reviewed three sets of minutes from the ward and pre-assessment team meeting and noted average attendance, complaints and incident themes were discussed. Theatre team meetings had variable attendance, and incidents or complaints themes were not discussed.
- Overall the hospital and Hesslewood clinic reported 364 clinical incidents during the reporting period April 2014 to March 2015. The number of clinical incidents reported each month has been consistent, and the overall rate of clinical incidents (for each 100 inpatient discharges) over the period has remained consistent at around three for each 100 discharges. Reporting has increased in recent months with 497 incident reports completed to July 2015.
- Nursing staff we spoke to were all aware of the centralised system: members of medical staff were not always aware of the reporting system and spoke about escalating issues verbally rather than completing incident reports. All incidents were initially reviewed by the Matron and governance manager and then circulated to ward manager and senior nursing staff for investigation. Nursing staff were aware of their roles in relation to incidents and there need to report, or provide evidence, take action, triage or investigate, as required.
- Safety huddles took place through the day to update staff about changes to care and treatment of patients. During the unannounced inspection we witnessed a co-ordinator handover. This handover took place behind a closed door to maintain confidentiality. Staff did not use a pre-populated printed handover sheet, but specific issues relating to each patient were discussed.
- One unexpected death in the reporting period April 2014 to March 2015 was noted at Spire Hull and East Riding hospital. Within the hospital no specific mortality and morbidity meetings were held. The hospital told us that individual cases were discussed (where necessary) at

the governance and or MAC meeting. Post inspection the hospital informed us that they would now be discussed as a standing agenda item at governance committee, effectiveness committee and at the medical advisory committee.

Duty of Candour

- All staff we spoke with were aware of the duty of candour and described it as the need to inform patients if an incident or mistake had occurred and to be open and honest with patients.
- Staff were able to provide us with specific examples about its use.

Safety thermometer

- The NHS Safety thermometer is a nationally developed improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It looks at risks such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections.
- Spire Hull & East Riding commenced submitting data in July 2012 and had submitted data on a monthly basis. All patients (100%) audited had all been rated as harm free. This is better than the England average of 93%.
- The corporate clinical scorecard included data for all departments in the hospital.
- The corporate clinical scorecard for quarter two - 2015 indicated that:
  - VTE risk assessment compliance was 100%. The hospital had not reported any incidences of VTE.
  - There had been no pressure ulcers of category 2 or above.
  - The percentage of patients who had any slip, trip or fall (for each 1000 bed days) was 2.2% which was slightly worse than the hospital target of 1.9%.
  - Information pertaining to UTI's (Urinary tract infections) in catheterised patients was not included on the scorecard however this information was evidenced on the Spire Quality Dashboard which showed that between April to July 2015 there had been no reported cases of patients developing a UTI following catheterisation.
- In the reporting period June 2014 to August 2015 no harms had been reported under the safety thermometer reporting system; however this information was not displayed for patients to view.

Cleanliness, infection control and hygiene

- The environment was clean and tidy, and all bed spaces, once clean, had a leaflet placed on them to provide assurance of cleanliness, which was named and dated.
- Facilities cleaning staff were aware of their roles and responsibilities. Staff we spoke with said they had adequate equipment and training to allow them to carry out their job including the provision of a safe water supply and the requirements for control of waterborne bacteria. The hospital had a good system of flushing, recording and escalating problem areas.
- A weekly cleaning sheet was checked but had significant gaps in signing.
- Carpet lined the main corridor areas to the inpatient bays; this is difficult to clean and is not best practice to maintain IPC principles.
- Quarterly IPC environmental spot checks commenced in June 2015. We reviewed data supplied by the hospital and noted the majority of checks were compliant.
- Since the inspection we have been supplied with a ward IPC environmental audit dated September 2015. It was based on a recognised national tool and most areas were compliant.
- The provider reported no cases of Methicillin resistant staphylococcus aureus MRSA, Clostridium difficile C.difficile or Methicillin sensitive staphylococcus aureus MSSA infections April 2014 to March 2015. MRSA and MSSA pre-operative screening was undertaken in the hospital and differing policies were in place for NHS patients and non- NHS patients. Documents we reviewed indicated concerns with policy compliance due to patients not collecting prescriptions, and booking not allowing sufficient time to screen and treat patients. The IPC lead confirmed that no formal screening compliance audit was carried out in relation to MRSA decolonisation policy compliance. The management team told us that with NHS patients they were contractually obliged to carry out the same level of care that an NHS patient would receive in an NHS hospital in relation to MRSA control. MAC minutes reviewed indicated two patients had been cancelled because they had not been supplied suppression MSSA.
- Surgical site infection (SSI) data was reviewed. Performance targets were in place to benchmark SSI with other Spire hospitals. SSIs were reported through incident reports and discussed internally in the IPC committee. Information provided by the hospital showed that infection rates for each surgical procedure performed were high when compared with national

data for similar numbers of operations. Data from 2014/15 indicated that knee surgery was higher than the national average. However, data supplied for quarter one of 2015/16 indicated that for knee arthroplasty this was on target and below the national benchmark of 0.6%.

- We reviewed the number of surgical site infections and noted SSIs were detected by the IPC lead interpreting post discharge patient questionnaires. SSIs per types of surgery was available and this had been benchmarked with other Spire hospital sites.The hospital carried out 469 primary knee replacements from April 2014 to March 2015 with five SSIs detected. National data indicates that the average number of infected wounds in every 100 inpatients or re-admissions following operation is less than one in 100. RCA investigations were commenced for some SSIs, but there was no routine medical involvement in the RCA process. This was confirmed by staff we spoke with. We noted one SSI RCA where no root causes could be identified.
- We reviewed incident data from the hospital for SSI patients and noted a high level of antibiotic usage. For example, of the 23 SSIs reported between September 2014 to August 2015, 19 received antibiotic therapy, and for two we were unable to confirm whether antibiotics were prescribed. Antibiotic stewardship was limited in the hospital. An operational policy had recently been developed and had been implemented by the management team. Trends of antibiotic prescribing were not monitored for each clinician.
- Specialised ventilation is a statutory requirement in operating departments and a clinical requirement to reduce surgical site infections. Increased health risks to patients will occur if ventilation systems do not achieve and maintain the required standards. The link between surgical site infection and air quality is well established. (Health technical memorandum 03-01: specialised ventilation for healthcare premises). The 'Health Act 2006: code of practice for the prevention and control of healthcare associated infections', sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment and where the risks of infection is kept as low as possible. We reviewed six ventilation verification reports and noted that two had significant issues in relation to airflow in the theatre environment. However, action plans were in place to improve this and we were told that to manage the risk theatre 4 had been closed until the work was completed.
- We also noted a number of incident forms where clinical sets used for operations were wet/ damp post the sterilising process. Leaving instruments wet can harbour bacteria and increase the risks of surgical site infections.The hospital informed us post the inspection any sets found wet would not be used.
- Due to the design of the main theatre suite being the access for patients, staff and visitors into the intensive care unit, theatre flow and etiquette principles were compromised. Patients being transported also crossed each other in lobby areas pre- and post anaesthetic. Theatre dress etiquette was poor; we witnessed people walking in theatre clothes on the ward and sat having lunch in the restaurant. Staff entering the inpatient ward from theatres did so in theatre clothes,and some staff still had a theatre mask draped around the neck. We questioned the hospital policy with staff and they were able to describe to us what the policy was, however during the inspection, we only saw one member of staff comply with the policy.
- We reviewed patient led assessment of the care environment (PLACE) results and noted that the environment was scored at 100% compared to a national average of 97%
- Equipment cleaning frequencies were displayed, but the sluice area was cluttered with multiple items labelled as clean stored within the dirty area. Equipment we checked was visibly clean and cleanliness assurance labels were in use but this was not consistent. We also noted glove and apron access within the sluice area for use when handling dirty items. We checked three mattresses internally and found two to be stained and one that should not have been in use. Once this was reported staff took immediate action to rectify.
- Compliance with IPC policies was variable and staff were seen not wearing gloves and aprons appropriately. Staff were not always bare below the elbows on entering the inpatient area. However, we observed compliance while delivering direct patient care.
- No hand wash basins were available in the single patient rooms. However, basins were available in the bathroom area of these rooms and hand gel was available in every patient bedroom

- We asked to review observational hand hygiene compliance audit scores, or hand hygiene technique audits, however these were not audited by the hospital. The hospital did produce product usage data, that is, of hand sanitisers, and compared its consumption against other hospitals in the Spire group.
- Alcohol gel was available in all rooms we visited and in communal areas. In some of the beds in the bay, placement was behind the bed, making usage difficult.
- IPC training was delivered both face to face and by using e-learning. This training was delivered by a member of staff with no formal IPC qualification. Compliance rates were reviewed and were noted to be 44% for e-learning and 75% face to face.
- The IPC lead for the clinic was also the governance manager. In addition we were told that this person supported 13 other Spire IPC leads/ sites within the group for infection prevention specialist advice. Nationally Spire healthcare has a service level agreement with a consultant microbiologist to provide advice and support. There was also a contract in place for emergency microbiology result advice. We reviewed minutes of the IPC committee. Attendance was good, and medical input was noted to some meetings using the organisational microbiologist, however no on-site clinician attendance was noted.

Environment and equipment

- The inpatient environment was tidy, however some communal fixtures were found to be damaged with laminate peeling off and varnish chipping present. All rooms had access to showers and toilet facilities. Staff spoke to us about the room sizes being too small and being too tight in some rooms, especially in emergency situations, although the inspection team did not see any adverse events to support this view.
- Storage for equipment was an issue and we noted clean equipment stored in the sluice area.
- Resuscitation equipment was checked and found to be in working order and checks undertaken.
- The theatre environment had recently been refurbished. Equipment such as patient trollies and other equipment were stored in corridors.
- The theatre transfer room was cluttered with patient positioning equipment, theatre shoes and filing cabinets stored within the patient waiting area.

Medicines

- Access to pharmacy was available on-site, and a member of pharmacy staff attended and reviewed medications for ward based patients on a daily basis.
- Pharmacy out-of-hours flow chart and arrangements were available, and staff were aware of how to access medication out of hours using onsite or off-site arrangements.
- Medicine cupboards we reviewed were found to be secure, organised, clean, tidy and with good stock rotation. However, the sterile stock we checked, such as IV bags or dressings, were found to be poorly rotated, with products with longer expiry dates sitting on top of products with shorter expiry dates.
- Controlled drugs were stored appropriately according to legal requirements. Controlled drug books were reviewed and found to be legible, complete and appropriately recorded. Medication errors were audited internally. We reviewed six medication charts while on site and they were all legible, but were not all completed correctly. For example, weight of patients was not always recorded, antibiotics prescribed did not have stop/review dates, and four of the medication charts had blank entries and no codes were completed for non-administration.
- Fridge temperature audit checks showed a lack of robust implementation of fridge temperature checks. An internal audit for June 2015 showed that for 4 days temperatures were not always recorded within acceptable limits. During the inspection fridge temperatures were recorded although the insulin fridge was found to be unlocked in an unlocked room.
- We observed a medication round during the unannounced part of our inspection and the member of staff complied with good practice.

Records

- The hospital used a paper patient records system for nursing and medical documentation. Records were stored when not in use in a locked office.
- Pre-operative assessment documentation was clear and processes appeared thorough: policies used were based on NICE guidance. Patients were assessed by anaesthetic staff prior to surgery and patients were also offered a cooling down period prior to surgery. We reviewed an audit of records carried out bi-annually and noted that cooling off periods had been offered.
- We reviewed 11 sets of medical records while on-site and noted (where required) all patients were able to

have a cooling-off period and an in-depth discussion with the GP prior to cosmetic surgery. Four patients had been seen on more than one occasion pre-operatively, and all patients received post-operative follow-up.

- Patient records had risk assessments for VTE, pressure care and nutrition although these were not always completed. We also noted that staff were using a generic risk assessment document for assessing the risks of bed rail use. Legibility of notes was an issue on two records and we noted incomplete records for intentional rounding, missed medications and theatre checklists and pre-operative sign in. One fluid balance chart we reviewed had not been added up for three days despite the patient having a fluid intake restriction. VTE charts were often assessed once and not re-assessed. Staff told us that an internal records audit showed 97% compliance with documentation checks. All patients attending the hospital had a full set of medical records stored on-site for a maximum of a four month period, and all clinics were arranged 24- 48 hours in advance which ensures patients should never attend clinic without medical records being available.
- We reviewed four sets of discharge notes and found these to be informative, legible and completed correctly.
- Information governance training rates for the two Spire sites overall showed compliance at 41% for July 2015.This training programme commenced in April 2015 with 95% compliance expected by March 2016.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction followed by yearly safeguarding refresher training. Hospital compliance data showed that 63% of theatre staff and 56% of nursing staff had completed safeguarding refresher training during 2015.The deadline for the remaining staff was the end of December 2015. Specific numbers for medical staff training were not held.
- Data supplied by the hospital showed that no safeguarding concerns were recorded in the last 12 months.
- The nursing and medical staff we spoke to were aware of their responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children, including escalation to the relevant safeguarding team as appropriate.
- Safeguarding flow posters were displayed highlighting key actions and key individuals to contact were displayed in the ward office.
- Hospital policy is for staff to have a DBS review every 10 years. However, during inspection, on review of 10 personnel records, this did not always occur.
- We reviewed five RMO records and found that three had no DBS check, and two RMOs had no evidence that safeguarding training had been completed.

Mandatory training

- As part of induction, staff received appropriate training for their role such as fire, IPC and manual handling. Staff also completed refresher training every year. Mandatory training was delivered as a mixture of face to face and e-learning training. Staff we spoke to all said they had undertaken all mandatory training required for their role.
- Compliance rates were reviewed and we noted variable compliance with training. At the end of month eight it would be expected that approximately 67% of staff would have completed mandatory training, in line with the calendar year training programme. For some aspects of training it was behind trajectory to achieve Spire's expected level of 95% by the end of the year. Examples include level 2 blood transfusion training and resuscitation training was 38%; basic life support was 51%; basic life support level 2, and Immediate Life Support (ILS – a course for first responders) was 30%Following the inspection the hospital informed us that the 2014 full year training results showed above 95% compliance with mandatory training modules.
- For clinicians that were employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with Spire Hull and East Riding hospital, mandatory training was usually undertaken by the substantive employer and monitored by the hospital. However, during review of the personnel documents we had little assurance this monitoring was being undertaken.
- We reviewed 10 sets of medical personnel records: mandatory training records were not always completed or checked with substantive employers; there were only three records with training evidence logged.

Assessing and responding to patient risk

- The hospital had a policy for the inclusion/ exclusion criteria for patients accepted for treatment at the hospital. This helped to risk assess patients prior to agreeing any treatment plan.
- The hospital had recently introduced the national early warning score (NEWS) assessment.
- Staff we spoke to were aware of their responsibilities in relation to escalating the needs of the deteriorating patient. We reviewed the process for escalating and transfer of the deteriorating patient. The hospital had an agreement in place with the local NHS provider to accept emergency patients requiring further treatment. No analysis of the information leading to the transfer was carried out internally which limited learning to prevent any re-occurrence. We reviewed unplanned returns to theatre and found 17 in 2014 and nine in 2015, with six of these patients being cosmetic re-operations.
- The hospital policy was to undertake the nationally recognised five steps to safer surgery procedures and related audit.
- During the inspection we observed a number of patient handovers to theatre. We observed one handover that did not comply with the procedures, with the patient not been consented, marked or being handed over to theatre staff in an appropriate way. We reviewed the policy for transfer of patient from ward to theatres and noted that in practice the pre-operative handovers we witnessed were not in compliance with the policy because the pre-operative checklist was not completed by an RN prior to theatre. Also another pre-operative check by the receiving nurse/ODP was not completed. Despite the policy being in place staff told us that no formal mechanism existed to handover patients to theatre staff. The transfer team did not always report to ward staff and patient notes were left in the patient room awaiting collection by the theatre team. We noted a good recovery to ward staff handover post-operatively. We raised this concern with the provider at the time of the inspection. Following the inspection they provided us with a root cause analysis which identified that guidance had not been followed and additionally that the particular surgeon did not routinely mark their patients. The provider has put an action plan in place to prevent further occurrences.
- Prior to undergoing surgery, there was a pre-operative risk assessment to identify patients at risk of harm. Patients who were identified as high risk were discussed with the consultant in charge of their care and plans put in place to mitigate the risks. Patients were assessed to identify patients with underlying medical conditions or those deemed at risk of complications after surgery.
- Venous thromboembolism (VTE) screening rates were good with 100% of all patients requiring VTE screening being screened in all quarters April 2014 to March 2015. No incidence of hospital acquired VTE or pulmonary embolism PE was noted in the reporting period April 2014 to March 2015.
- The hospital also has a service level agreement for 24 hour cover with the local NHS hospital for the transfer of deteriorating patients.

Nursing staffing

- There was no effective patient acuity tool in use on the ward; instead a projected occupancy ratio was used by the hospital as a basis to plan the staffing levels. It did not take into account acuity and dependency; therefore, the management could not effectively assure themselves that staffing was safe. It was not uncommon for 40 day case and inpatients to be admitted for theatre on the same day.
- The inpatient ward area was split into four corridors, each with 11 beds, with one registered nurse and one healthcare assistant allocated for each corridor. They were supported by a qualified ward co-ordinator and a floating healthcare assistant.
- We reviewed documents supplied by the hospital indicating the ratio was based on one member of staff (including RNs and unqualified) to five patients on a morning; a ratio of 1:6 in the afternoon and 1:7 overnight. The RN was usually allocated to work with 8-10 patients. Staff told us that skill mix ratios were variable on the day depending upon the acuity of the patients.
- We reviewed nursing rotas for the previous three months actual compared to established and found a ratio of RNs to patients was 1:11 (or 1:9 patients if the ward manager was included in the establishment). Night cover had three RNs on duty, with up to 40 patients when full.
- We reviewed current vacancy rates and found 6.8 WTE posts vacant in the inpatient area. Senior staff told us that they were actively recruiting to these posts; however recruitment had been difficult.
- Agency or bank staff were used to cover these vacancies.

- In the theatre department 34.7 WTE staff were employed. We reviewed current vacancy rates and noted that five vacancies were outstanding as of July 2015.
- We reviewed the rate of agency staff usage and noted that there was an increased use of agency staff for inpatient areas in January to March 2015. Agency staff were used on a daily basis June 2015 to August 2015. Senior staff recognised the increased use of agency staff within the hospital and where possible tried to employ agency staff on short term contracts.
- Within the theatre environment the use of agency staff was only occasionally less than 20%, with no use of agency care assistants. An increase in agency usage was noted in December 2014 to March 2015.
- Staff on the inpatient area worked mainly long day shifts, rotating between the impatient ward area, the day case area and the clinic at Hesslewood. Staff told us that they enjoyed the rotational posts.
- Nursing staff handovers occurred twice a day at 7am and 7pm.We observed a handover discussion which covered relevant areas. However, it was interrupted by a member of medical staff. Extra handover huddles with the co-ordinator were held throughout the day.
- Staff within theatres spoke to us about concerns with shift patterns within theatres as staffing rotas were only completed a week in advance. The management team told us it was only possible to allocate shifts a week in advance so they had the ability to respond quickly to patients and the ever changing volume of patients to be booked for theatre procedures.
- We reviewed six sets of nursing staff personnel records and found mixed results regarding confirmation of current professional PIN numbers and DBS checks. In one set of records a staff member had not had a police check for over 15 years.This was not compliant with Spire policy. Following the inspection we were told that Professional PIN numbers are recorded on the Spire HR system.

Surgical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice in hospital). During the inspection we were provided with different numbers of consultants varying from 223 to 248 to 272. Following the inspection we were told these figures varied as in some instances they included support specialists such as nutritionists.
- Prior to the inspection the hospital reported 100% bi-annual review of practising privileges, for doctors at the two sites. Evidence from June and August MAC minutes noted that the figure was 97%. Staff told us that the grace period was 3 months for receiving the correct information to allow practice privileges to continue, and after this time practising privileges were stopped. There was no grace period for GMC registration.
- Medical cover on the wards was provided by the consultants in charge of the patients' care 24 hours a day for their admitted patients. Consultants had to arrange cross-cover when required for their patients from suitably trained colleagues, with practising privileges. A spreadsheet was available with consultant contact details for emergency contacts and staff we spoke to were aware how to access this document.
- The resident medical officer (RMO) was based in the hospital 24 hours a day. We reviewed RMO cover and found it to be sufficient, and staff we spoke to had to have the correct skills.
- The hospital has a '2' on call anaesthetist rota available for when cardiac surgery was carried out which was 24 hours cover and seven days a week if required.

Major incident awareness and training

- The hospital was not a receiving area for major incidents prior to the inspection.
- The hospital business continuity plan was in use, due to a generator problem which occurred during routine testing, but this was resolved during the inspection, and senior staff said the plan had been implemented successfully.
- Five resuscitation scenarios had been carried out throughout the hospital including two specific paediatric scenarios.
- We asked if the hospital had 'tested' their major haemorrhage policy plan. We saw evidence that test runs had been completed in 2014 and 2015. The hospital had a contract in place with a private company to urgently deliver blood should it be required.
- In an emergency any patient can be given O negative blood. Two units of O negative were kept in a blood fridge in the transfer room which was located between the ward and the theatre suite.

Surgery

Are surgery services effective?

Requires improvement

We rated surgical services as requires improvement because:

Concerns were noted about the length of time patients had to fast for pre-operatively. Internal data showed poor compliance with theatre fasting times.

Comparable patient outcomes by consultant were not audited within the hospital, however the senior management team told us these were monitored using complaints and incidents data.

Competence records were used by staff; all records we reviewed had been self-signed. The senior management team post the inspection provided evidence that this process had changed. Appraisal rates were good but there were some discrepancies with the percentage of medical staff appraisal rates.

However, patients were cared for in accordance with evidence based guidelines. Training compliance rates for Mental Capacity Act training were noted to be good for ward and theatre based staff.

Patients we spoke to were happy with the pain relief medication they had been offered post-operatively, and we saw good examples of nursing staff offering pain relief. Patients we spoke to were happy with the food choices being offered and out-of-hours access was available. Patient's records contained an assessment of patient's nutritional requirements. MUST (Malnutrition Universal Screening Tool) assessments were completed during pre-assessments.

Seven day services were available for most of the multidisciplinary teams, and on-call rotas and procedures were detailed and clear to follow.

Evidence-based care and treatment

- Patient care was carried out according to national guidelines such as National Institute for Health and clinical Excellence (NICE) and guidance from Royal colleges.
- The majority of the operational policies were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- When a new organisational policy was received, staff and the MAC reviewed the policy and undertook a gap analysis on the policy, and information relevant to the site was added in; nothing was allowed to be removed from the policies. Policies were available in hard paper format on the unit and in electronic format on the intranet.
- The service used the World Health Organisation surgical checklist and compliance against this was audited monthly by checking 10 sets of notes. The audits of notes we reviewed showed good compliance against the criteria the hospital used. However, this was not corroborated at inspection; we found a set of medical notes where the safer surgery checklist was not complete; we observed a patient who was not marked prior to theatre and were told it was common practice for one of the ophthalmology surgeons not to mark patients. The provider acted on these concerns. Following the inspection we were provided with evidence that this had been raised with staff and additional audits of notes had been completed along with observational audits of the process which showed good compliance.

Pain relief

- Staff we spoke to said that they used a pain assessment score of 0-4 to assess the comfort of patients both as part of their routine observations and at regular intervals following surgery. Staff could detail the correct action to be taken if a patient was in pain.
- Patients' records we looked at recorded that patients that required pain relief were treated in a way that met their needs and reduced discomfort.
- Patients we talked with said that during their stay their pain had been well controlled and extra pain relief offered post-operatively. Patients did speak about stiffening up during the night and not receiving pain relief early in the morning to allow them to have adequate pain relief prior to mobilising.
- A pain infusion service had been developed recently as a result of commissioning decisions.

- Staff we spoke to told us that they routinely asked whether the patient was in pain, had any nausea and checked their wound if present.

Nutrition and hydration

- Patients' records contained an assessment of patients' nutritional requirements. MUST (Malnutrition Universal Screening Tool) assessments were completed during pre-assessments. BMI (Body mass index) scores were assessed on admission and an organisational policy existed where patients were not operated on below a BMI of 18. Staff told us that patients with extra nutritional needs were referred to a dietitian by the RMO.
- Staff told us that they did not admit anyone with swallowing issues, however during inspection a patient told us that they had longstanding issues with swallowing and this had not been discussed with them.
- We reviewed internal fasting performance targets. Data we reviewed supplied by the hospital showed poor compliance with theatre fasting times. Staff we spoke to corroborated this data and were aware that patients were pre-operatively fasting for longer than required. They felt this was due to a mixture of reasons but primarily down to lists overrunning. The senior hospital team had noted this as an area requiring improvement.They had recently developed a pilot project with two consultants to look at reducing fasting times; we reviewed a fasting time action plan supplied by the hospital which detailed the pilot project being carried out. However, this did not detail the overall change required to ensure patients did not fast for too long pre-operatively. We reviewed internal hospital fasting policies and noted it states that patients should be fasted for six hours pre-general anaesthetic. We reviewed five sets of notes and saw that starve times varied from seven hours to 16 hours, with the average starve time of these patients being 10 hours.
- We reviewed patient led assessment of the care environment (PLACE) results and noted that the food was scored at 96% against a national average of 88%.
- Patients were offered a selection of food and diets.
- Patients with difficulties eating and drinking were offered special diets.

Patient outcomes

- Patient outcomes were audited through various means including: pre & post-operative Patient Reported Outcomes Measures (PROMs) data collection, physiotherapy length of stay audits, patient satisfaction surveys and patient complaints.
- Comparable clinician outcomes were not audited within the hospital or against other organisations so outcomes could not be measured or practice benchmarked for each clinician. Surgical staff told us it was difficult to benchmark private practice with colleagues as no formal feedback mechanism existed even when similar types of surgery were carried out. The senior management team told us that outcomes were reviewed on an individual basis if incident or complaints information highlighted trends. We noted on the senior management team minutes that complaints themes were identified by “consultants and outcomes of surgery”.
- Patient outcomes were monitored and compared across the company through the publication of a quarterly clinical scorecard. This document was RAG rated, which allowed the hospital to compare its outcomes with other Spire sites. It included VTE risk assessment, patient falls, surgical site infections, hospital acquired infections, re-admissions, return to theatre, critical care transfers and pressure ulcer incidents.
- The hospital submitted a monthly quality dashboard to the commissioning Contracts Management Board that included patient complaints, re-admissions, returns to theatre, surgical site infections, Patient Safety Thermometer data, and cancellations.
- Performance reported outcomes measures (PROMs) data was reviewed and we noted ‘significantly better' than England average data for two out of three measures for hip replacement surgery between October 2013 to September 2014. Groin hernia surgery and knee replacement outcomes were not significantly different than the England average. Standardised ratio for repair of inguinal hernia was ‘better than expected' between November 2013 to October 2014.
- The national Joint registry (NJR) data showed that hip and knee mortality rates at the hospital were within the national average.
- 30 day emergency re-admission data following hernia procedures was ‘better than expected’ between October

2013 to September 20 14, 'similar to expected' rates were seen in cataract surgery and hip and knee replacement surgery between October 2013 to September 2014.

- There had been nine instances where patients were recorded as returning to theatre. Six of these patients were post cosmetic surgery and were offered further surgery as they were unhappy or had a poor outcome from their surgery. The further surgery was by the same consultant.
- There were 13 unplanned transfers of patients to another hospital between July 2014 to September 2014. This is a consistent rate over the period assessed to be 'similar to expected'.
- Unplanned returns to theatre were reviewed and we noted nine unplanned returns to theatre in the reporting period April 2014 to March 2015. Overall a falling rate of unplanned returns was noted (for each 100 visits to operating theatre) over the same period. For the time period July 2014 to September 2014, three cases of unplanned returns were noted. We assessed this data as 'similar to expected' compared to other independent hospitals. More recent data supplied by the hospital showed us that seven unplanned returns to theatre have occurred since April 2015 to July 2015.
- Staff told us that intentional rounding was used, and we found evidence of intentional rounding charts in patient records. However, intentional rounding charts were not completed and staff we spoke with were unaware what intentional rounding was. Post the inspection we were supplied with a document which indicated that the processes were changing to only include patients with a greater than two day length of stay and a new audit is planned to be carried out to ensure the intentional rounding occurs.
- Patient satisfaction audits for caring, pain control, experience and discharge arrangements we reviewed showed a good level of satisfaction. However, it was a very low response rate, being 11-16% of all admissions.
- Local audits set by the corporate audit plan were carried out in the hospital and local audits could be added onto the plan if required.
- The hospital had developed weekly pre-operative hip and knee classes which had helped to decrease the length of stay from 3.7 days to 2.5 days.
- Prosthesis best practice was only met in 58% of cases (the target was more than 70%). The senior management team were aware of these issues and managing this issue on an individual clinician basis.
- The hospital held meetings where mortality and morbidity were discussed. We saw evidence that patient deaths were discussed at the Clinical Governance Committee (CGC) and the Medical Advisory Committee (MAC) meetings.

Competent staff

- Newly appointed staff underwent an induction process. Staff we spoke to told us that they had a 4 week supernumerary period at the start of employment. During this time staff worked with an induction buddy to complete an induction record book. This detailed competency and skills required for the role. We reviewed five competency books and all five were found to be self-assessed and not signed off by senior staff. We raised this at inspection and following the inspection we were supplied with a document indicating that this process had been reviewed and processes for sign-off changed.
- Staff told us that bank staff had a longer induction, but used the same competency books, and agency staff had an agency staff induction checklist delivered by the senior nurse on duty. Several different agencies were used to fill vacancy rates.
- High staff appraisal rates were noted for inpatient and hospital wide staff groups. Senior management team reported 100% appraisal rate in theatres for both nurses and ODPs. Nursing staff told us that they had all received appraisals on a yearly basis.
- Consultants working at the hospital were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care). Practising privileges were reviewed every year by the senior management team. This review included appraisal. Documents reviewed showed that there were 272 consultants utilised at the hospital under practising

privileges and documents we reviewed showed us 95% of consultants had a recorded appraisal. Of the 5% that had not recorded an appraisal, 1% were inside the grace period and 4% outside the grace period.

- There were 24 consultants whose indemnity cover had not been seen and all were outside the grace period.Post the inspection we were supplied with a document which showed 100% compliance.
- The resident medical officer (RMO) role was delivered by a team of five research fellows who provided on-site medical cover for the hospital on a rolling 24 hour basis.
- The ward admitted many types of surgical patients. We reviewed competency records for five staff. We saw evidence of general nursing competencies but limited evidence of nursing competencies for specific surgical specialities. We were not provided with sufficient documentary evidence to assure us how staff maintained competencies for all surgical specialities. A small number of medical staff expressed concerns about the competency levels of some nursing staff to look after their patients. Ward staff spoke with us about preferring to allocate staff with particular knowledge and competencies to a particular type of surgery. However, staffing levels and bed capacity did not always allow this to happen.
- A policy to support nurse revalidation was launched by the organisation and a working party was to be commenced.
- The breast care nurse had undertaken extended training to enable her to become a cosmetic nurse and had extended her role to cover cosmetic clinics.
- Staff training needs around cosmetic garment fitting had been identified and staff were currently working with the breast care nurse to increase awareness and knowledge over garment fitting.

Multidisciplinary working

- There was good communication between multidisciplinary teams within the ward.
- Staff told us they had a positive working relationship with the consultants and RMO, and the RMO was available 24 hours a day.

Seven-day services

- Routine surgery was performed in the theatres during weekdays, evenings and on weekends.
- Physiotherapy and imaging services were available seven days a week, and occupational therapy was available six days a week.
- The hospital pharmacy was open on-site Monday to Friday 9am until 3pm and 9am until midday on Saturday. Outside normal working hours the pharmacy could be accessed with the RMO providing a second signature for any medications used from the pharmacy.
- On-call rotas and procedures were available for key staff, such as the pharmacist, physiotherapy, radiology, senior nurse and senior management team.
- Access to consultants in charge of care was available 24 hours a day. Should a surgeon be on leave this was locally agreed with another consultant with practising privileges.
- The hospital also has a service level agreement for 24 hour cover with the local NHS hospital for pathology, transfusion, pharmacy and transfer of deteriorating patients.
- Physiotherapy, imaging and pharmacy staff attended the morning handover meeting on the ward daily. We observed a handover to radiological staff and noted this was carried out in an organised and informative manner.

Access to information

- Staff had access to the hospital computer system. This contained booking information and pathology reporting systems.
- Paper based patient records were available on-site for patients seen in the last four months, with access to other patient records using an external storage centre.
- Password access was supplied to staff as required on an individual basis.
- Staff could access information such as policies and procedures on the hospital intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was gained in both verbal and written forms. We saw evidence of this within patient records.

Surgery

- The staff we spoke with were aware of how they sought verbal and written consent before providing care or treatment. Staff we spoke with had the appropriate skills and knowledge to seek consent from patients or their representatives.
- Consultant medical staff sought consent from patients prior to starting surgery/ procedure. A recent memorandum had been sent from the group medical director stating that consent must not be obtained in the anaesthetic room.
- Where patients lacked capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions (for health and welfare) on the patients' behalf.
- Staff we spoke to were able to describe their responsibilities in relation to the legal requirements of the Mental Capacity Act 2005 (MCA). We reviewed MCA training compliance rates and noted 77% compliance for Nursing staff and 90% for theatre staff.

Are surgery services caring?

Good

We rated surgical services as good because:

Patients were cared for in a positive and compassionate way. Patients we spoke to all gave positive examples of a caring approach. We observed positive interaction of staff with patients and staff appeared genuine, supportive and kind.

There were high positive scores (above 85%) for the Friends and Family Test, however the response rate fluctuated from low to high. Internal organisational patient surveys showed positive responses around care received, discharge information, and privacy and dignity. Patient records we reviewed took into account patient preferences and patients felt they were involved with information and decisions taken about them.

Psychological assessment prior to cosmetic surgery was undertaken and evidence of GP involvement pre-surgery was noted.

Compassionate care

- We spoke with 10 patients who all gave positive comments about the care and treatment they received. They gave good examples of caring and compassionate care and told us staff were 'very good' and were 'very kind'. They told us that if they had needed to ring the nurse call system staff answered very promptly.
- When we observed staff going about their work, we saw positive patient/ staff interaction with staff appearing thorough, genuine and knowledgeable.
- Patient dignity was maintained by covering the patient in the corridor by gowns/dressing gowns and bed curtains were used around the bed space to maintain dignity.
- We reviewed patient led assessment of the care environment (PLACE) results and noted that the privacy, dignity and well-being was scored at 88% compared toa national average of 86%.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. There were high (scores above 85) for the Friends and Family Test, however the response rate fluctuated from high levels (above 61%) to low levels (less than 30%). Published data by the NHS shows that the response rate for Spire NHS Inpatients in August 2015 was 22% compared to the national NHS average of 24%.
- An internal organisational patient survey was carried out for April to July 2015, covering care, discharge information, decisions, and privacy and dignity. This showed that approximately 80-90% of patients received excellent care and attention from nursing staff. Approximately 78% of patients had an excellent admissions process and discharge process.
- Confidentiality was maintained on the admission boards displayed in the ward area by the addition of small doors which covered the names of admitted patients.

Understanding and involvement of patients and those close to them

- Patient records we looked at included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us they were fully informed of their plan of care, right from their first visit into the pre-operative clinic and consultant appointments. They also said they felt they were involved in decisions about their care and treatment plans.

- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place. We witnessed an informative patient centred discharge plan discussion with a patient. The member of staff explained to the patient their discharge plans, appointments and medications. This was carried out at an appropriate pace and the member of staff paused at appropriate moments and asked the patient whether they had any questions.

Emotional support

- Clinical nurse specialists were available in oncology and breast care. Patients accessed support during routine clinics and visits, and they were provided with contact numbers for other times.
- Phone calls were made to all breast care/cosmetic patients from the breast care nurse. If patients were not happy with the outcome of cosmetic surgery they were offered corrective surgery within the hospital.
- Psychological assessment prior to cosmetic surgery was undertaken and patients were referred back to GPs if concerns became evident. We saw evidence of involvement with a GP and prior to cosmetic surgery GPs were always contacted.
- A patient support group had been developed by the breast care nurse specialist for breast cancer patients and the breast care nurse specialist shared good examples on how this had made a difference to patients.

Are surgery services responsive?

Good

We rated surgical services as good for responsive because:

The surgical service was busy and had grown in demand over recent years. Senior staff had anticipated the increased demand and had planned to improve the patient experience.

Referral to treatment (RTT) target data for the reporting period April 2014 to March 2015 showed that the provider had exceeded the target of 90% of admitted patients beginning treatment within 18 weeks every month. No patients waited longer than 18 weeks for treatment.

Patients' individual needs were mostly met.

However, a small number of patients were cancelled on the day of surgery due to over booking of theatre lists, list overruns and staff or equipment not being available. Theatre utilisation was low: utilisation was noted as being 51% over a 12 month period for all four theatres.

Due to the design of the theatre suite privacy and dignity was difficult to maintain, particularly for patients in theatre 3 and in one of the post-anaesthetic care units (PACU) next to critical care; patients were moved from theatre 3 along public corridors to PACU and access to critical care for relatives was through a PACU.

An increased number of complaints had been received in 2014 for the hospital and these had been rated as an amber risk on the corporate scorecard. However, for quarters one and two of 2015 the percentage of complaints responded to within the policy timescales was at 93% and none had been escalated to stage two.

Service planning and delivery to meet the needs of local people

- The service had variable demands depending upon the number of patients requiring surgery. The service had grown in demand from when the hospital was first developed with capacity increasing from 8,000 in 2012 to nearly 14,000 patients 2014.
- A further anticipated growth in service was anticipated and plans were in place to build and open further clinics on this site to improve the patient experience.

Access and flow

- Patients were referred to the hospital by their GP, self-referral or NHS referral.
- Referral to treatment (RTT) target data for the reporting period April 2014 to March 2015 showed that the provider had exceeded the target of 90% of admitted patients beginning treatment within 18 weeks every month. The data showed that 100% of patients had begun treatment within the target range for five of the reported months.
- The provider also exceeded the target of 92% of patients with an incomplete pathway beginning treatment within 18 weeks every month in the reporting period April 2014 to March 2015. The data showed that 100% of patients had begun treatment within the target range between July 2014 and March 2015.

Surgery

- The data showed that no patients waited longer than 18 weeks for treatment.
- Data supplied by the hospital indicated that bed occupancy rates were 90%.
- Access was available to theatres from 7am to 8pm Monday to Friday, and 7am to 4pm on Saturdays.
- Documents from the hospital showed an 'on the day' cancellation rate of 36 in the reporting period January 2015 to March 2015; of which 22 were clinical cancellations and 14 non-clinical. The latter were due to over running theatre lists and surgeons not being available on-site. We reviewed urgent cancellation rates logged on the incident reporting system and noted that 12 patients were cancelled on the day of surgery in August, and 11 in July 2015. We discussed this with clinicians and senior staff and they told us that medical staff occasionally booked too many patients for each list.
- Senior staff told us that they did not carry out theatre start time audits to review utilisation and efficiency. We reviewed a document supplied to us showing utilisation with 12 month rates September 2014 toAugust 2015 to be 51% across all four theatres.
- Two post anaesthetic care units (PACU) were available. Senior medical staff told us that one of the PACUs was often closed due to staffing issues and patients transferred to the other PACU. We walked the route of this transfer and noted it to be a difficult route to negotiate through a public corridor. We discussed this with senior staff and they told us that staff always made sure the public corridor doors were closed during transfer to improve privacy and dignity. There was a Spire Healthcare policy in place for risk assessments which included assessing "Moving patients in the corridor". However staff we spoke with were unaware of a risk assessment or standard operating procedure detailing this transfer. We asked the hospital to provide us with data detailing when PACU 2 was not in use and patients had been transferred on review. This document showed that over a three month period June to August 2015 theatre 3 had 75 operating days, and for 13 days the PACU was closed for the whole of the list and for a further 30 days the PACU was closed for all sessions or part of the session.
- Following the inspection the provider sent us confirmation that they were planning to include as part of building works in 2016/17 access to the critical care unit by a separate route to avoid the public entering the PACU.
- Patient records we looked at showed staff completed appropriate discharge summaries and these were communicated to GPs in a timely manner. Internal hospital discharge targets for discharge patients by 10am were not met and the hospital were only meeting the targets 35% of the time in August 2015 against a target of more than 40%.
- We followed a patient journey and noted that patients were met at the reception desk in the main waiting area by one of the clerical staff, prior to being escorted onto the ward. The patient was then admitted to their bed and prepared for theatre.

Meeting people's individual needs

- Written information leaflets including the complaints leaflet could be made available in several different languages if required.
- Patients whose first language was not English could access an interpreter. Staff could describe to us how to access translation services. They spoke about times when they have cared for patients in rooms with an interpreter present.
- Bariatric services were offered at the hospital and specialised beds, chairs and wheelchairs were available. All bariatric patients were referred to a dietitian for aftercare.
- The access criteria for the services meant that staff did not routinely care for patients with confusion, severe dementia and/or complex needs.
- Locally Spire had developed dementia awareness champions.
- Staff we spoke to were not aware of the role and were not aware of any extra provision offered to patients with dementia. Staff were not sure if they had had appropriate training for nursing patients with dementia, learning disability or for patients with complex needs. There was no specific training for staff to raise awareness of dementia and how to care for people with it.
- We were told that if patients required extra support additional staff would be provided. We observed this in practice during the unannounced inspection for a patient who had confusion.

Surgery

- We reviewed patient led assessment of the care environment (PLACE) results and noted that the dementia care was scored at 91% compared toa national average of 74%.
- We did not observe any rooms specifically decorated for patients living with dementia.
- We noted that on every bed a leaflet called 'HELP' was provided. This stood for 'handling and moving, environment, loo and pain'. This was an initiative encouraging patients to tell staff if they were not comfortable or needed assistance.
- Theatre 3 was accessed from a main public corridor and as the door was sliding, patients could be seen waiting in the lobby area and could be observed from the main corridor.
- There was an active group of volunteers working within the hospital who supported patients through their patient journey.
- Patients were offered a selection of food and diets. Staff told us that if patients had changed their minds or did not like the choices they would offer other choices.
- A pantry was available on the ward which offered out-of-hours food access with a choice of soup, cereal and toast. Access to drinks was available in this area, and although patients were not allowed direct access to this area, staff said they were willing to make patients food and drinks.
- Patients we spoke to were happy with their food choices and meals they had had during their stay.
- Cultural needs of patients were taken into consideration with 'halal' or 'kosher' meals provided if required.

Learning from complaints and concerns

- An increase in provider received complaints for 2013 to2014 was noted with 102 complaints received in 2014 in comparison to 77 complaints received 2013. For quarters one and two of 2015 the percentage of complaints responded to within the policy timescales was at 93% and none had been escalated to stage two. Minutes of clinical governance meetings showed complaints as an amber risk due to the numbers received.
- Information on how to raise complaints was documented on the patient satisfaction leaflet provided to all patients.
- Patients we spoke to had no complaints and raised no concerns about their stay.
- Staff we spoke to were clear about the complaints process for receiving, handling and investigating complaints. All complaints were investigated by a senior manager who was supported by the head of department. This information was recorded onto the centralised incident reporting system. Complaint acknowledgement letters were sent within 48 hours of the complaint. The response was sent to the patient within 20 working days of receipt.
- Meeting minutes we reviewed showed that complaints were shared at the team meeting of the ward.
- We reviewed five recent complaints received by the hospital and their responses: apologies were offered. However, lessons learnt and plans to prevent the same complaint from occurringwere variable.
- Staff told us that complaints trends were monitored and one consistent theme was delays in treatment. They felt that this was especially in relation to NHS orthopaedic patients but they felt that this was due to unrealistic expectations of the patient. None of the complaints we reviewed corroborated this view.

Are surgery services well-led?

Requires improvement

We have rated surgical services as requires improvement for well-led because:

Risks were identified on the risk registers; however risks remained on the risk register for many months without being closed. There was a lack of effective oversight and action to ensure that incident investigations were of a high standard and root causes identified. Senior managers told us that clinical recruitment was one of the top risks for the hospital; however recruitment of staff was not documented on the registers. Systems to ensure compliance with IPC standards required improvement.

While there were governance structures in place for the provider and locally within the hospital these were not effectively implemented; there was a high element of trust and a low assurance culture.

The monitoring system to ensure the doctors' safety to practice within the hospital was not effective at the time of the inspection. For a varying number of the doctors, especially the RMOs, information regarding: mandatory

training; DBS checks; appraisal information from the employing organisation and; professional indemnity insurance arrangements, was out of date or had not been provided to the hospital and therefore the doctors' safety to practice within the hospital was not assured.

Systems to ensure compliance with IPC standards required improvement.

However, the hospital had a vision and strategy and staff were aware of this and the values of the organisation. The organisation had a governance structure with reasonable attendance at meetings. Staff described leadership and culture of the hospital in a positive manner.

Vision, strategy, innovation and sustainability for this core service

- The Spire vision was 'to be a world class healthcare provider'. Staff appraisals were linked to the vision and values.
- The vision and values were displayed and had been shared with staff. Staff we spoke to showed understanding of the vision and values. Staff performance objectives were linked to vision and values.
- Staff were proud of implementation of the nursing 6Cs and of the "hello my name is" strategy.
- The hospital had recently received Macmillan accreditation for cancer services.

Governance, risk management and quality measurement for this core service

- While there were governance structures in place for the provider and locally within with the hospital these were not effectively implemented; there was a high element of trust and a low assurance culture. The hospital had a governance structure, with a clinical governance committee in place. This committee took reports from the clinical, audit and effectiveness committee and the infection prevention and control committee. This committee fed directly into the medical advisory committee (MAC). It also had direct links into the senior management team and hospital and group governance arrangements.
- Senior staff told us that they had 100% attendance at the MAC. However, during review of the minutes we noted that attendance was lower, about 50%, with apologies being noted from medical staff at all three of the meetings reviewed.
- Medical staff we spoke with said the MAC worked well and provided assurance in the system. They spoke about specific changes they had seen as a result of discussion at the MAC, for example, changes in pain relief for inpatients.
- We reviewed four sets of clinical governance minutes and noted attendance was good. Detailed documentation of the discussions held were clear and included complaints, incidents and performance.
- There was a clinical scorecard in place across Spire Healthcare which enabled comparisons between locations. These were on display in staff areas and discussed with governance meetings.
- We reviewed minutes from the cosmetic group meetings. Attendance was good from nursing staff and appropriate issues were discussed. There were no cosmetic surgeons present at these meetings. After the inspection we were told that these were nurse-led meetings and minutes were shared with cosmetic surgeons.
- The senior management team of the hospital met weekly with the heads of department and discussed risk, finance, incidents and current operational issues.
- We reviewed three team meetings minutes from the ward and pre-assessment team and noted average attendance. These were well documented meetings with complaints and incident themes discussed. Theatre team meetings had variable attendance; one meeting had good attendance while another the meeting was cancelled as no one attended. Key issues to the department were discussed however, incident or complaints themes were not documented as discussed.
- There was a lack of effective oversight and action to ensure that incident investigations were of a high standard and root causes identified. We reviewed five RCAs pre- inspection and found that these did not evidence that an effective investigation had been completed in order to identify the root causes and lessons learned.
- The hospital had performance dashboards, which showed performance against key organisational performance targets and were used during contract monitoring with the local commissioner.
- We reviewed the hospital business risk register and the hospital risk analysis register. Open risks were noted with the oldest of the risks being documented in 2010. Multiple risks existed including bariatric patient management and equipment and cross-infection due to

manual cleaning of endoscopes. There was mitigation of risks identified within the risk analysis register however risks did not appear to be removed from the register and not all risks were identified, such as staffing, the critical care environment and mandatory training for doctors.

- During the inspection the senior management team told us that the main clinical risks were for wrong site surgery, fire risks and clinical recruitment however recruitment of staff was not documented on either risk register.
- A post had recently been created for full time risk manager; however they were not in post at the time of the inspection.
- The monitoring system to ensure the doctors' safety to practice within the hospital, especially the RMOs, was not effective at the time of the inspection. We reviewed 10 sets of medical personnel records and noted variable levels of compliance with the HR policies. DBS checks were not performed regularly; four were recorded as out of date as set out in Spire's policy. Mandatory training records were not always completed or checked with substantive employers; there were only three records with training evidence logged. Two references were not available in four of the 10 sets of records.
- Systems to ensure compliance with IPC standards required improvement. There were minimal IPC audits carried out, policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were not performed.

Leadership/culture of service related to this core service

- The overall lead for the hospital was led by the senior management team. The ward was led by a senior member of nursing staff on the ward and a theatre manager for the surgical department. This role was supported by a team of four sisters on the inpatient area. Staff we spoke to told us they understood the reporting structure clearly. All staff we spoke to, spoke positively about immediate senior leadership on the inpatient environment.
- Staff we spoke to all described the culture within the hospital as friendly with a cohesive group of colleagues, and spoke positively about their colleagues being "fantastic and supportive", and they gave positive examples of support after illness and bereavement.
- Staff we spoke to said they felt able to raise concerns in the hospital. We also saw evidence of a "speak out" campaign, encouraging staff to speak out if they had any concerns. The senior manager had developed an "ask Maria" initiative which allowed staff to speak to her directly with specific concerns or questions.
- Staff turnover was fairly static; several staff we spoke with had been in their role for many years.
- Staff we spoke to expressed that their biggest worry was staffing levels and recruitment. Senior hospital staff recognised that improving staff and consultant feedback was an area requiring improvement.

Public and staff engagement

- The response rate to the staff survey for Spire Hull and East Riding and Spire Hesslewood was 80% for 2014.
- The results from the survey indicated that staff were likely to recommend the hospital to their friends and family for treatment.
- The local Spire management team used regular team briefs, which included recognition and thanks to individuals from their colleagues.
- Public engagement activities included asking patients for feedback as to how services could be improved on the patient satisfaction survey.

Critical care

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

Information about the service

Spire Hull and East Riding Hospital was described prior to inspection as having a two bedded unit delivering level 2 critical care. Information received from the hospital indicated that the bed occupancy within the unit was approximately 50%. On our inspection we were told that the unit could accommodate three patients and we saw the vacant bed space for this bed.

The majority of patients admitted to the unit were elective patients with a planned admission. Some unplanned patients were admitted following surgery. Some patients were transferred to the unit after deteriorating on the ward. The unit did not undertake emergency care except in those circumstances.

There had been 282 admissions to the unit between March to August 2015. The majority of these (175) were cardiology patients, forty nine were cardiac surgery, fifteen were emergency transfers in, ten were bariatric patients, three were vascular, three urology, two thoracic and twenty five were logged as 'other'.

Other than emergency transfers in to the unit patients requiring admission were identified at their pre-operative assessment. The hospital had exclusion criteria.

During our inspection we visited the unit. There were no patients being cared for on the unit at the time of our announced or unannounced inspection. We spoke to the unit manager, a physiotherapist, four registered nurses, the unit sister, the lead anaesthetist and the registered medical officer. We looked at the case notes of ten patients who had previously been cared for on the unit.

Summary of findings

We rated the Critical Care unit as requires improvement overall because:

The unit was not meeting all the level two critical care standards. The unit did not meet the recommended guidelines in terms of the built environment. Bed spaces were smaller than recommended and there was a lack of hand washing facilities and specialist equipment. Following the inspection the provider confirmed that one bed space had been removed from the facility to increase the space for eachbed and confirmed that following a risk assessment this has been added to the hospital risk register and plans were being developed to extend the unit for the provision of two fully compliant bed spaces. Patient risks were identified but there was limited evidence that actions were taken to mitigate risks.

Local pathways and guidelines did not evidence that they had been reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were not implemented. Staff were not aware of key quality performance indicators. The unit did not have a lead intensivist or nursing staff with appropriate post graduate training.Again following our inspection we were given assurance that actions to address this in 2016 were in place. Staff were aware of their responsibilities regarding the mental capacity act but they were not fully aware of their responsibilities in

Critical care

relation to the duty of candour. There had been no complaints about the unit for more than eighteen months. The number of emergency transfers to the local NHS trust for intensive care were low.

The unit staff were reporting incidents and while there was some evidence of some verbal feedback, these processes needed to be formalised. There was limited evidence of monitoring of infection control procedures such as hand washing.

Medical and nurse staffing numbers were appropriate. Staff were not aware of any vision or strategy for the unit. There was a lead anaesthetist and nurse manager who oversaw the clinical management of the critical care unit. There was little evidence of quality monitoring processes or monitoring of actions taken on identified risks. There was a lack of clarity about the purpose of the unit which was described by some staff as a higher observation unit rather than a high dependency unit. Information gathered indicated that predominantly short term level two care was provided in the unit however the unit also admitted patients who did not require HDU care for example post-angiogram patients.

Are critical care services safe?

Requires improvement

We rated safe as requires improvement because:

There was limited evidence that staff followed infection prevention and control practices or that the hospital monitored these. Additionally there was a lack of hand washing facilities in the unit. Access to the unit was through another clinical area.While staff used good practices to maintain the privacy and dignity of patients there may be times when this could have been compromised. Bed spaces in the unit were much smaller than national guidelines but this had not affected patient outcomes. There was a single patient record that all professionals used. However, documentation was not always fully completed. Patient clinical risks were assessed but there was sometimes limited evidence that staff had implemented actions to mitigate risk. There was a flexible approach to nurse staffing levels which meant there were appropriate numbers of staff on duty to meet the needs of patients. There were no suitably trained nursing staff employed on the unit, however some staff had recent critical care experience from NHS employment. Medical staffing was co-ordinated to provide adequate cover for patients and mitigate risks, however there was not a lead intensivist.

The environment was clean. Equipment was available and this was serviced and maintained.

Staff were reporting incidents and there was verbal evidence of some feedback and learning as a result.

Incidents

- Seven clinical incidents were reported in 2014. All of these incidents related to an unplanned or unexpected transfer of a patient to the local NHS acute trust. Some of these patients were transferred to the unit from the ward area before being transferred to the local trust
- We were told that on average one level 3 patient was cared for on the unit each month. This was usually a patient who needed to be stabilised prior to transfer, however evidence provided demonstrated these are not classed as level 3 patients.

- The patient's anaesthetist or the on-call anaesthetist would attend when these patients were identified.
- Three clinical incidents had been reported between January and August 2015; these were a respiratory arrest, an equipment malfunction and a staffing shortage.
- The hospital reported that there had been no serious incidents or never events on the unit between April 2014 and August 2015. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There had not been any deaths on the unit during 2014 or 2015.
- Staff we spoke with were aware of how to report incidents using the hospitals electronic reporting system. An automatic email was sent to the person completing the submission to confirm receipt. Information provided by the hospital indicated that 79% of incidents were closed fully within their target of 45 calendar days.
- Staff told us they were informed about incidents on the unit at the team meetings and that they also received emails and information froma newsletter about incidents in other areas of the hospital.
- Four staff were able to tell us about incidents including a never event that had happened in another area of the hospital relating to wrong site surgery. The staff told us of the learning and changes to practice that had occurred as a result of this incident.
- We reviewed the minutes from the unit's last three team meetings (dated January, May and June 2015). There was no evidence that local or hospital wide incidents were discussed. There was also no evidence, from the meeting minutes, that any learning from incidents on the unit were shared with all staff.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents'and provide reasonable support to that person.
- Staff we spoke with including senior staff were not able to articulate the duty of candour however some staff told us about being open and honest.

Safety thermometer

- The NHS Safety Thermometer is an audit tool that allows organisations to measure and report patient harm in four key areas (pressure ulcers, urine infection in patients with catheters, falls and venous thromboembolism (VTE)) and the proportion of patients who are "harm free". The 2014/2015 CQUIN scheme rewarded submission of data generated from use of the NHS Safety Thermometer.
- The hospitals 2014 Annual Governance Report dated January 2015 indicated that the patients audited for the thermometer were all NHS patients undergoing inpatient treatment within the hospital on a predetermined date.
- We were told by the hospital governance manager that safety thermometer data collection was conducted by the unit managers and this was submitted by the Governance Manager monthly.
- Spire Hull & East Riding commenced submitting data in July 2012 and had submitted data on a monthly basis. All patients (100%) audited had all been rated as harm free. This is better than the England average of 93%.
- We were informed that the hospital did not have a separate corporate clinical scorecard for the unit but that the corporate clinical scorecard covered all departments across hospital.
- The corporate clinical scorecard for quarter two - 2015 indicated that:
  - VTE risk assessment compliance was 100%. The hospital had not reported any incidences of VTE
  - There had been no pressure ulcers of category 2 or above.
  - The percentage of patients who had any slip, trip or fall (per 1000 bed days) was 2.2% which was slightly worse than the hospital target of 1.9%.

- Information pertaining to UTI's (Urinary infections) in catheterised patients was not included on the scorecard however this information was evidenced on the Spire Quality Dashboard which showed that between April and July 2105 there had been no reported cases of patients developing a UTI following catheterisation.

Cleanliness, infection control and hygiene

- The unit was visibly clean and looked well maintained.
- We looked at the daily cleaning schedules for equipment on the unit and found that there were seven gaps in the 21 days viewed. Cleaning did not take place on days when the unit was not occupied although staff were on duty.
- No cases of Methicillin-resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C.difficile) were reported by the hospital in 2014. There had been no cases reported in 2015 up to the time of our inspection.
- Personal protective equipment (PPE) such as gloves and aprons and alcohol hand gels were available in the unit. There were no patients in the unit at the time of our inspection therefore it was not possible to monitor the staff use of PPE when delivering care.
- Staff told us that PPE was used and that they used sanitising gel prior to and following patient contact. Staff did not refer to hand washing.
- Information we reviewed indicated that hand hygiene audits were conducted quarterly; however, the measure for this was the amount of hand hygiene sanitizer used. The clinical scorecard for 2015 quarter one and quarter two indicated that the hospitals target of greater than18 had been exceeded in both quarters: being 21 in quarter one and 19 in quarter two.
- In addition, we also saw one hand hygiene environmental audit which was undated. It included asking staff about hand hygiene technique but no observations of practice.
- The National Institute for Clinical Excellence (NICE clinical guideline 139) recommends that regular local hand hygiene observation audits are undertaken. Monitoring the use of hand sanitizer does not evidence that staff have been observed decontaminating their hands effectively before and after patient contact.
- The World Health Organisation (WHO) state that unobtrusive direct observation of hand hygiene practices by a trained observer is considered the gold standard for evaluating compliance. A senior member of nursing staff was not able to tell us when the last observational hand hygiene audits were completed.
- We were told that the unit had been refurbished within the last 12 months however the unit did not meet the recommendations of Health Building Note 00-09: Infection control in the built environment (March 2013) which states that intensive care and high dependency units should have a clinical hand wash sink available by each bedside. This was not evident in the unit. Hand sanitizer was available at both bed spaces.
- The hospital undertook environmental spot check cleanliness audits. A sample audit for the unit showed that actions to address any concerns had been completed in a timely manner. This included replacing a toilet seat and that cleaning to address dusty areas was been discussed with the housekeeper.
- Equipment in the unit was visibly clean and was labelled with green tape to indicate that they had been cleaned.
- Staff told us that they did not routinely have patients who needed isolating and there were no single rooms available on the unit. Staff were able to give an example of when a patient had developed loose stools. The patient was moved to a single room on the general ward and barrier nursed. The bed area was cleaned and the curtains were changed.
- The unit did not meet the recommendations of the Health Building Note 04-02 for Critical care units section 6.4 which states that single bed rooms with lobbies are required to control the spread of infection or for the protection of immunosuppressed patients.

Environment and equipment

- The unit was adjacent to the Post Anaesthesia Care Unit (PACU). Access to the unit was via the PACU. This meant that staff, visitors and relatives had to pass through an area where patients may be recovering following anaesthetic. This was not in line with Health Building Note 04-02 for Critical care units (2013) which

recommend that patients and visitors should not share the same entrance, to ensure that visitors do not observe patients coming in and out of the critical care unit.

- Staff told us that they hoped that a separate entrance to the unit was to be created via the fire doors. We noted that opposite the nurse's station was a double doored fire exit. There was a bin placed in front of the exit; this was unsafe as fire exits should not have obstacles in the way.
- We were told that the unit had been refurbished within the last 12 months. We asked for minutes of any meetings that had taken place in relation to the refurbishment but were told that these were not available.
- Information we reviewed about the service indicated that it had two beds. Staff told us that when necessary they could accommodate three patients. There were three bed spaces in the unit but only two beds were in place during our inspection.
- The unit consisted of a main room and a separate sluice and patient's toilet. Information received from the hospital indicated that the main room was 6.75 x 6.75 metres. Therefore the total area of the main room was 45.5 metres this included the bed spaces, the storage areas and the nurses station.
- Bed spaces and facilities did not fully comply with current Department of Health building note 04-02 for Critical Care Units published in March 2013. Bed spaces did not have individual hand-wash basins, there were no ceiling hoists and bed spaces did not meet the recommended minimum space of 25.5 metres squared.
- Staff did not report any concerns about the bed spaces but due to the limited space around patient's beds and the amount of equipment, easy access to the patient might have been difficult in an emergency situation i.e. cardiac arrest.
- Information we reviewed about the unit showed that between June 2015 and August 2015 the unit had accommodated three patients on 38 out of a possible 92 days meaning that the unit cared for three patients at a time 41% of the time. Due to the lack of compliance with bed spacing this could have put patients at risk due to limited space availability if an emergency had occurred.
- Following the inspection the provider confirmed that one bed space had been removed from the facility to increase the space per bed. However, the unit still remained non-compliant with the HBN 04-02 Building Guidance; the provider confirmed that following a risk assessment this has been added to the hospital risk register and plans were been developed to extend the unit for the provision of two fully compliant bed spaces.
- The unit shared a resuscitation trolley and medication fridge with the PACU. Daily checks of the equipment had been completed and equipment available was in line with recommendations for emergency resuscitation procedures.
- Daily room temperature checks were recorded in the unit.
- Staff were aware of how to report equipment faults. We were told that equipment servicing and maintenance was completed by an external company. Two members of staff stated that the use of an external company created delays; this resulted in the unit being unable to care for patients who required specialised equipment during their recovery and gave an example of repair to a continuous positive airway pressure (CPAP) machine which took 10-14 days.
- Each bed space in the unit had a wall mounted monitor. Other equipment available in the unit included
  - A CPAP machine. CPAP is a treatment that uses mild air pressure to keep the airways open. CPAP typically is used by people who have breathing problems, such as sleep apnoea.
  - Two ventilators.
  - A blood gas analysis machine.
  - An ACT machine which is used to monitor blood clotting times.
- The RMO (Resident medical officer), staff on the unit and some ward staff were able to use these machines.

Medicines

- The pharmacy manager told us that medication charts were checked each day and that pharmacy staff had close working relationships with unit staff and consultants.
- There were no independent non-medical prescribers within the hospital. All medications were prescribed by the patient's consultant and/or anaesthetist. The Registered Medical Officer (RMO) was also available to prescribe medications.
- Staff in the unit told us that they were responsible for checking quantities of medications and reordering required stock medications.
- Because there were no patients on the unit at the time of our inspections we were unable to observe any medications being administered.
- Medicines including controlled drugs were stored securely. Controlled drug checks had been completed appropriately other than on days when the unit was closed.
- We looked at ten sets of records for patients who had been cared for on the unit and found that all sections of the medication charts had been fully completed on eight charts (80%). On two charts (20%) there were gaps in the administration of a medication.
- There had been no reported medication errors on the unit in the four months prior to our inspection.
- Guidelines and resources were available for medications including the British National Formulary (BNF), intravenous drug compatibilities and glucose monitoring guidelines.

Records

- There were no patients on the unit during our announced or unannounced inspection.
- The unit used two care pathways, one for patients undergoing cardiac surgery and one for general patients. In addition we saw pre-assessment / ward / theatre / PACU handover sheets. These sheets were used as patients transferred through the hospital during their surgery.
- We reviewed the medical and nursing records for ten patients who had recently been cared for on the unit and found the above documents held within the records
- We found that compliance varied in relation to the completion of the records including
  - The decision to admit to the unit was documented in the pre-assessment documentation in all of the records
  - Visual infusion phlebitis (VIP) scores were completed in 90% of the notes. VIP scores are used to assess indicators of infection in intravenous cannulation sites to enable early detection of risk.
  - Pressure area assessment had only been completed in five of the ten sets of notes indicating that only 50% of patients had been assessed for risk of pressure ulcer development. The hospital used the Waterlow risk assessment tool. The records did not show any evidence of skin integrity inspection or turning regimes for any patients who had been assessed as being at increased risk of pressure damage.
  - VTE assessment and evidence that prophylactic medication was administered as prescribed was completed in all records.
  - Patient's nutritional status had been recorded and reassessed daily in 100% of the notes reviewed.
  - 60% of the records showed evidence of MDT involvement.
  - Staff told us that the physiotherapist visited the unit twice a day but this was not evident from the records.
  - Pain assessment was completed and evidence of administration of appropriate pain relief was seen on the medication charts in the records reviewed.
- The WHO Surgical Safety Checklist was developed to decrease errors and adverse events, and increase teamwork and communication in surgery. We saw that a safer surgery checklist had been completed in all records reviewed.
- All entries within the notes were dated and signed in line with NMC and GMC guidance.
- Within one set of records we noted that a patient had suffered a respiratory arrest. The documentation relating to the incident was comprehensive and there was a clear post-arrest plan in place.

Safeguarding

- There were no reported safeguarding cases to the Local Authority Safeguarding Board in 2014. Senior staff from the hospital attended quarterly meetings with the local authority to ensure that the hospital had correct policies and procedures in place
- The hospital had policies available for staff for the safeguarding of children and vulnerable adults.

Mandatory training

- Staff completed mandatory training via e-learning and face to face sessions. Staff told us that some training was delivered at Spire Hospital and some was delivered at the local NHS Trust.
- Records provided by the hospital showed that compliance with yearly mandatory training for staff employed in the unit was 100% for Fire Safety, Health and Safety and Infection Control.
- Compassion in practice and bi-annual training in manual handling compliance were both 88%.
- Staff attended 'once only' sessions in child protection and equality & diversity.
- Role dependent training consisted of Managing Violence and Aggression, Controlled Drugs, Mental Capacity Act, Safe Transfusion n1 and n2. Compliance was 100% in all except for Safe Transfusion n2 which was 75%.
- This evidence showed that unit staff were predominantly compliant with mandatory training. There was a risk that some new staff were not up to date with manual handling and blood transfusion n2 which could result in unsafe skill mix if patients needed assistance with repositioning or required blood transfusion when these staff were on duty.
- We were told that staff on the unit also completed intermediate or advanced life support training (ILS / ALS)
- Staff told us that they had completed this training. Information provided by the hospital indicated that that all staff except one newly appointed member of staff were up to date with this training.
- 100% of staff in the unit had attended Protection of Vulnerable Adults training as a once only course. 100% of staff had attended adult and children's safeguarding refresher training in 2015.

Assessing and responding to patient risk

- National Early Warning Scores (NEWS) is a tool used to standardise the assessment of acute illness severity. Staff told us that the observation charts that were used on the unit were the same as the ward. The charts we looked at were not recognised NEWS charts. There was a scoring system in place but no reference to 'trigger' scores or an escalation procedure.
- When staff were asked about 'triggers' for deteriorating patients we were told that these were not used but they looked for trends.
- We saw a policy which related to staff training in acute illness management (AIMs) for qualified staff and healthcare assistants (HCAs). The unit sister told us that she facilitated the AIMs course.
- The unit had pre-prepared emergency equipment trays; these included a chest opening set, tracheostomy set, arterial and central line sets, catheterisation and chest drain sets.This meant that emergency equipment was immediately available when needed.
- The unit did not have emergency admissions, but would admit patients who had unexpected complications following planned surgery. We were told that the RMO would arrange transfer to the unit if a patient deteriorated on the ward. In addition the RMO would attend the unit and liaise with senior medical staff if a patient needed to be transferred out of the hospital to another hospital.
- The hospital had a policy for the emergency transfer of patients. Within this there was guidance on the procedures to be undertaken when it was recognised that a patient needed to be transferred out to one of the acute trust hospitals.
- Patient risk assessment tools for pressure area care, cannulation sites and nutrition were used on the unit. Staff told us that patients were initially assessed at their pre-operative appointment and reassessed on admission to the unit. We saw some evidence of this in the records we looked at however we noted that only 50% of pressure risk assessments were completed.
- All bariatric patients were routinely admitted to the unit following surgery because of the higher risk factors.

Critical care

- There was not a dedicated outreach team in the hospital. This role was provided by staff in the unit. The purpose of a Critical Care Outreach Team is to support the care of critically ill patients elsewhere in the hospital. In the event of additional support being required, for example if a patient deteriorated but there were no beds available on the unit on call staff were available and could be contacted if required.
- The RMO was available to assess patients in the unit for pain relief or to insert cannulas. It was reported that the RMO had good working relationships with the consultants and anaesthetists.
- Patients in the unit were cared for by their own consultants and anaesthetists. However the RMO provided first line support if a patient deteriorated. We were told that the RMO's was ALS trained and one was a clinical research fellow in cardiology. Nursing staff we spoke to told us that they routinely reviewed all cardiac patients after they had been transferred to the ward.
- The hospitals resuscitation policy identified the hospital resuscitation team as being RMO, a senior ward nurse, an Operating Department Practitioner (ODP) and a porter. We were told by a member of nursing staff that the hospital undertook simulation scenarios as outlined in the Resuscitation protocols hospital policy no: 72.

Nursing staffing

- The unit had eight registered nurses. Staff were rostered to work four shifts per week. We were told that these shifts often changed depending on activity in the unit and patient dependency.
- Staff told us that they worked flexibly between the unit and the PACU**.**
- Staff told us that there were always two registered nurses on duty for day and night shifts this meets the Core Standards for Intensive Care Units guidance (2013) which states that level 2 patients require a registered nurse to patient ratio of a minimum 1:2 to deliver direct care.
- Staff from the unit told us that they were able to assist in the pain clinic if patients there were administered sedation.
- During our inspection there were no patients in the unit. Staff told us that staffing was flexed to meet the needs of the service and that two staff were always on call. More staff were rostered depending on the number of elective admissions and if there was a planned cardiac surgery patient.
- Staff told us that they worked flexibly and were able to 'bank' hours which enabled them to take time off when they needed to.
- Staff told us that bank and agency staff covered shifts but these staff had worked regular shifts on the unit. An agency nurse was on duty at the time of inspection. They had worked shifts in the hospital for four years. We reviewed the rosters for the unit for June, July and August and found that bank or agency staff were on duty every week except one in the fourteen week period. The number of shifts covered by bank or agency workers varied between one and eight shifts per week.
- We saw an induction checklist for bank and agency staff. This document contained pertinent information in relation to the location of cardiac arrest equipment and fire procedures. This meant that staff who were unfamiliar with the environment received relevant information. The document also gave general information relating to the hospital such as the location of changing rooms, the use of mobile phones and the location of the hospital policies.

Medical staffing

- Information we reviewed confirmed that patients in the unit were cared for by their admitting consultant and anaesthetist. There was not a lead intensivist.
- The hospital was covered by RMO's who were trained in advanced life support. They provided 24 hour medical cover and were available to attend the unit in an emergency situation to provide patient care until the consultant surgeon and/or anaesthetist arrived.

Major incident awareness and training

- The hospital was not a major incident-receiving centre.
- We found the hospital's business continuity plan had been activated over the weekend prior to our visit. This was due to an electrical problem when completing some routine checking. The hospital had cancelled forty cases of elective surgery on the first day of our visit because of this.

Critical care

- We asked if the hospital had 'tested' their major haemorrhage policy plan. We saw evidence that test runs had been completed in 2014 and 2015. The hospital had a contract in place with a private company to urgently deliver blood should it be required.
- Following our inspection we received data from the hospital indicating that a test run had taken place in June 2015. The time taken from the call to receipt of the emergency blood products was 35 minutes. The test runs took place at 10:00am in 2014 and 11:30am in 2015.
- In an emergency any patient can be given O negative blood. Two units of O negative are kept in a blood fridge in the transfer room which is located between the ward and the theatre suite.
- Staff said that they would evacuate via the fire doors in the unit (ground floor).
- The RMO was on call 24 hours per day. They did not routinely provide cover for patients within the unit however they received a handover for the patients so that they were aware of the patients in the unit in the event of first line response being needed for a deteriorating patient.
- Staff told us that there was a cardiac registrar who remained on site for 24 hours post cardiac surgery and consultant anaesthetists were available 24 hours per day.

Are critical care services effective?

Requires improvement

We rated effective as requires improvement because:

Local pathways and guidelines did not have evidence that they had been reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were not implemented. Staff were not aware of key quality performance indicators. From records reviewed patients appeared to receive appropriate pain relief but there was no evidence of adequate assessment of their pain relief. Patients also appeared to have received appropriate nutrition and hydration. National standards recommend that a minimum of 50% of registered nursing staff should have a post registration award in critical care nursing. None of the staff employed in the unit, including the sister, had completed a post registration award in critical care nursing. The hospital was taking action to address this in 2016.

Staff obtained consent prior to treatment and had an understanding of the Mental Capacity Act and the deprivation of liberty safeguards. Multi-disciplinary working with all disciplines was not evident within the care records but staff communication was effective.

Evidence-based care and treatment

- Clinical guidelines recommend how healthcare professionals should care for people with specific conditions. The unit specific care pathways and clinical guidelines, which we reviewed, did not reference any evidence based best practice, NICE or Royal College guidelines. However the hospital's policies and staff competency assessment documents did contain references to appropriate guidelines.
- The National Institute for Cardiovascular Outcomes Research (NICOR) was established in 2006 to use national clinical audit data to improve the quality of care and outcomes of patients with cardiovascular disease. We were told that NICOR data was collected and submitted nationally for cardiology patients who had been treated in the hospital.
- Senior staff told us that quarterly bed utilisation, environment and equipment and health and safety audits were performed. We saw one environmental audit with actions, which had been completed.
- Monthly audits included extended length of stay and case mix of admissions to the unit.
- Other operational policies which were not specific to critical care were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.

Pain relief

- Staff reported that they used an analgesic ladder to assess patients' pain. A pain score of 0-4 was used. They were able to contact the RMO or the pain clinic if they needed assistance with pain control for a patient.
- There were no patients on the unit at the time of our inspection so we were unable to get feedback from patients in relation to their pain relief.

- We reviewed ten medication charts and found that appropriate pain relief had been prescribed and administered.
- A survey of patients who had attended the hospital in July 2015 indicated that 91% of patients surveyed felt their pain relief had been managed 'a great deal' and the remaining 9% 'a fair amount' by the hospital.

Nutrition and hydration

- Patients were assessed for malnutrition risk at their pre-operative assessment. We found that these were complete in 100% of the notes we reviewed.
- The hospital had Guidelines for Pre-operative Fasting (Hospital Policy No 53) as extended pre-operative fasting can increase the risk of hypoglycaemia (low blood sugar) and dehydration.
- Internal fasting audit data had identified that patients cared for in the hospital had experienced extended fasting times.
- The hospital had produced an action plan as part of their review of fasting times following the introduction of this measure as part of the corporate clinical scorecard.
- A fasting protocol was being piloted with two orthopaedic surgeons with a plan to roll out to all specialities in Q4 of 2015. There were six actions on the plan, five of which were completed.
- Staff we spoke to were aware of the pilot.

Patient outcomes

- Staff we spoke to said that they cared for post operatively ventilated patients but that patients were usually extubated within three hours after arriving on the unit. These patients were single organ support patients and did not therefore need to be classed as level 3 patients.
- The unit pathways incorporated guidelines for staff to follow in relation to the extubation of patients. The patients' anaesthetist set the parameters for extubation.
- There was a competency assessment document for a number of clinical procedures including extubation.
- Patients having cardiology procedures such as stent insertion were admitted directly to the unit without being cared for in the PACU.
- Staff told us that patient step down to the ward was nurse led if the patient met the criteria set by the consultant.
- Staff told us that they did not submit data to the Intensive Care National Audit and Research Centre (ICNARC) because the dataset that ICNARC collate is not applicable to the patients who were cared for on the unit. ICNARC collate data from critical care units nationally in order to help critically ill patients by providing information/feedback about the quality of care to those who work in critical care. They also make information about the quality of care available to the public through the Annual Quality Report.
- Staff said that the hospital data was not appropriate for ICNARC in the past but that plans were being developed to revisit this because of the development of the unit.
- Information provided by the hospital showed that only three patients had an extended length of stay of 1 day each on the unit between January and December 2014.

Competent staff

- All patients were cared for by their admitting consultant surgeon and consultant anaesthetist throughout their in-patient stay on the unit.
- It was part of the Consultants' Practising Privilege that they reviewed their patients on a daily basis.
- Consultant practising privileges, indemnity and appraisals were monitored through the MAC committee. The meeting minutes from August 2015 showed evidence of some non-compliance, in that 97% were completed but 3% were outstanding due to lack of documentation for current appraisal or indemnity.
- We were told by senior staff that the hospital monitored and had procedures in place to manage non-compliance, for example, in cases where evidence of annual appraisal was not submitted to the Hospital Director. Consultants would receive two written reminders from the hospital; the first reminder would be sent six weeks after a year had passed since the last appraisal, with a second reminder four weeks later if required. Failure to submit evidence of appraisal within

15 months of the date of the last appraisal may lead to suspension of practising privileges which would only be lifted once satisfactory evidence of annual whole practice appraisal (including documented consideration of private activity) had been received.

- The Core Standards for Intensive Care Units (2013) state that each designated critical care unit will have an identified lead nurse who is formally recognised with overall responsibility for the nursing elements of the service. The unit had a dedicated lead nurse.
- The standards also recommend that a minimum of 50% of registered nursing staff will be in possession of a post registration award in critical care nursing. None of the staff employed in the unit, including the sister, had completed a post registration award in critical care nursing. We were told that all staff had previous employment within a critical care area.
- Following our inspection, we discussed the staff competency concerns with the matron and the registered manager. We were advised that three staff are enrolled on BSc (Hons) Critical Care FT 470103 / PT 470051 commencing in February 2016 and a further two staff were due to enrol in October 2016 which would make the unit 56% compliant.
- We were told by the unit sister that new staff had a preceptorship and induction checklist. We looked at personal files of two staff (25%) and saw evidence of an induction checklist for both staff. We were also told that a buddying system was used to support new staff.
- Staff said that they had training in blood transfusion competency and mandatory training records confirmed this.
- Information received by the hospital indicated that each clinical staff member had been issued with a personal folder to collate all competencies relevant to their role. These folders were kept within their normal working environment and were seen as 'live' documents. Compliance for progress & completion is discussed at Enabling Excellence (EE) interviews. Staff members' personal development plans are kept with their EE paperwork.
- We were told that competency assessments were signed off by the sisters or a mentor. Senior staff told us that six members of staff were signed off on the competencies that were in place. Two newly appointed members of staff had commenced the new recently introduced Spire national Competency Framework for Adult Critical Care Nurses. All eight members of HDU staff would use the new competencies in 2016. The provider confirmed to us after the inspection that all staff were fully up to date with operational training in this area and that the intensivists had agreed to sign off these staff competencies in December 2015.
- Information provided by the trust indicated that 100% of the unit staff had an up to date appraisal. Staff we spoke to told us that they had an annual appraisal.
- We were told that a number of the bank and agency staff used by the unit had substantive posts on critical care units within the NHS and that these staff shared their knowledge and information relating to changes in practice.
- We were told by the unit sister that when the hospital began treating cardiac patients all staff rotated to the local acute hospital to gain experience.
- There was 75% of the staff in the unit who had completed advanced life support training (ALS). The remaining 25% were new starters The RMO had the lead responsibility for cardiac arrest scenarios and was ALS trained.
- There was a resuscitation link nurse at the hospital who ran resuscitation scenarios with staff approximately six times a year.

Multidisciplinary working

- The unit sister and staff nurses told us that the hospital had close working relationships with the local acute hospital. The unit sister told us that she attended an intensive care network meeting. Staff told us that they attended training and could contact the critical care units from the local trust for advice and they were able to borrow equipment when required.
- Staff said that they had good working relationships with both the consultants and anaesthetists and they were able to ask consultants if they needed advice. Each consultant had a preference sheet which gave staff information on the procedures they performed and their preferred post-operative care.

Critical care

- The hospital held an MDT meeting when cardiac surgery was planned.
- We were told that the physiotherapist visited the unit twice a day. However, they could be asked to attend outside of their routine visits if required.
- Support from other allied health professionals was also available including dietitians for nutritional support.

Seven-day services

- The hospital pharmacy was open on site Monday to Friday 9am until 3pm and 9am until midday on Saturday. Outside normal working hours the pharmacy could be accessed with the RMO providing a second signature for any medications used from the pharmacy.
- The RMO was on call 24 hours each day 7 days a week.
- The patients'consultant was responsible for their care.
- There was a consultant anaesthetist on-call 7 days a week.
- The unit was open seven days each week. Initially the service provision had been limited to two and a half days.

Access to information

- We were told that emergency blood tests were sent to the local NHS trust for analysis. A service level agreement was in place for this and staff reported that this was appropriate. Staff told us that they can access the results on line within 15 minutes of them being processed.
- In addition to this the hospital had a blood gas analysis machine and a machine that monitors blood tests in relation to blood clotting levels.

Consent and Mental Capacity Act

- There was 100% of the staff in the unit who had completed mental capacity act training as part of their role specific mandatory training in 2015.
- The hospital had a policy relating to the deprivation of liberty safeguards (Clinical Policy 44) which was available electronically.
- The hospital had consent to investigation or treatment policy (Fin 07).
- As there were no patients on the unit at the time of our inspection we did not observe staff asking for consent prior to providing treatment.
- The hospital undertook audits of compliance in the completion of pre-surgical consent forms. The audit results showed that 100% of the records audited contained a consent form. 100% of the forms evidenced that the risks and benefits had been explained to the patients and that written information had been provided and that the consultant had dated, signed and printed their name. 96% of the forms were completed on the day of the procedure and 4% were completed at the time of the consultation. Only 88% of the forms had been fully completed by the patient. In 12% of records, either the printed name or date were not included, usually the date.Audit results were shared through the MAC Meeting.

Are critical care services caring?

Not sufficient evidence to rate

We were unable to rate this domain as the hospital was unable to provide any separate evidence for this service about patient care and feedback.There were no patients in the unit during our inspection so we did not observe staff from the unit providing direct care. Staff spoke about providing emotional support to patients and their families.

Compassionate care

- There were no patients in the unit during our announced and unannounced inspection therefore we were unable to observe staff interacting with patients.
- The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. We were told that specific friends and family data and patient satisfaction survey results were not available for the unit as this was produced corporately for all areas of the hospital (see surgery section).
- The annual Spire Hull and East Riding hospital patient survey for 2014 received a 39% response. The hospital's excellent/very good score was 89%.

Understanding and involvement of patients and those close to them

Critical care

- Nursing staff told us that whenever possible they go to the ward to pre-operatively meet the patients who will be nursed in the unit following their surgery or procedure. They also told us that they would show patients around the unit if possible.
- There was no dedicated family room for the unit. There was a room on the ward which was shared between the two departments. This might result in a room not being available for the family of a patient on the unit.

Are critical care services responsive?

Good

We rated responsive as good because:

The service was responsive to the needs of their patients. Critical care patients were appropriately admitted and discharged from the unit and the number of transfers to the local NHS trust for critical care was low. The support required for patients living with dementia and with a learning disability was assessed during pre-operative assessment. Staff told us that they would use family members for translation which could compromise patient confidentiality. Patients had received information prior to admission but limited information was available on the unit. Staff understood how to manage complaints but there had been none on the unit in the last eighteen months.

Service planning and delivery to meet the needs of local people

- The unit provided care and treatment for patients undergoing elective surgery. The majority of this work was cardiology but also included cardio thoracic surgery, bariatric and general surgery.
- The hospital held a weekly bed management meeting.This was not minuted therefore we were unable to see evidence of this. However, we were told that discussion about the following two weeks theatre lists took place at this meeting and that patients identified as needing post-operative care in the unit were highlighted.
- We were told that the patients who had deteriorated on the ward were transferred to the unit when required.
- Bed occupancy on the unit was around 50%. This is well below the national recommendation that units do not go above 85% bed occupancy to ensure adequate beds are available at all times.

Meeting people's individual needs

- We saw an information leaflet for the provision of translation services available for patients who first language was not English. Staff told us that they do not get many patients who do not speak English and that usually the need for translators would be determined prior to referral to the hospital by the doctor of the patient however staff had access to a service if required.
- Staff told us that they used family members to translate and would be more flexible with visiting if translation was needed. This is not considered best practice due to the possibility that patient confidentiality could be compromised by using family members.
- Information leaflets were available on the unit for patients with heart conditions.
- Staff told us that they rarely care for patients with dementia or learning disability on the unit. If any patients were identified as needing additional support this would have been identified and arranged at their pre-operative assessment. This could include additional staffing for closer observation.
- A patient led assessments of the care environment (PLACE) audit undertaken by NHS England in 2015 rated the hospital as better than the national average for patients with dementia with a score of 91% in comparison to the England average of 74%.
- Patients were seen in a pre-assessment clinic prior to surgery and were given verbal and written information and were given the opportunity to ask questions. The information was written in a format that was easily understood.
- Staff we spoke to said that they followed processes which ensured that patients in the PACU had their privacy and dignity maintained while staff, visitors and patients walked through PACU to access the unit. We saw this in practice during our unannounced inspection. Staff closed the curtains around a patient in the PACU before we entered the unit and on leaving the unit the staff on the unit checked with the PACU staff that it was appropriate for us to pass through.

Critical care

Access and flow

- Information provided by the hospital indicated that no elective surgical cases, for patients who would require level two post-operative care, had been cancelled in the last year due to there being no beds available within the unit.
- Staff told us that patients admitted to unit are identified at pre-assessment.
- All bariatric patients were routinely admitted to the unit.
- Any patients who deteriorate would be transferred to the unit.
- Most patients were admitted from the operating theatre following an elective procedure.
- Patients were managed in a planned way and were not discharged from the unit at night.
- Seven patients had been transferred out of the hospital to the local acute trust during 2014. Some of these patients were transferred to the unit from the ward area before being transferred out.
- We noted that although the unit is referred to locally as an Intensive care unit (usually for level 3 patients) it was actually a level 2 critical care facility which also cared for patients who required higher observation but not necessary a critical care level 2 unit, such as following an angiogram.
- Information provided by the hospital indicated that between April 2014 and September 2015 there were 77 patients who would usually have been admitted to the unit which were cared for on the ward. Staff told us that when this happened the patients were nursed 1:1 and in rooms within close proximity to each other. This meant that the patients continued to receive level 2 care. Sixty of these patients had undergone angiograms the remainder included one cosmetic surgery case, one coronary artery bypass graft patient, one gastric bypass, one patient requiring CPAP, two pressure wires study patients, three percutaneous coronary interventions and three pulmonary vein isolation procedures.
- This was discussed with the provider who agreed to review the admission criteria to the unit to ensure patients received the appropriate level of care and those requiring level 2 care were clearly recorded.

Learning from complaints and concerns

- There had been no complaints raised about the unit between April 2014 to September 2015.
- There was a complaints procedure in place and all patients received a copy of it as part of their admission.

Are critical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

Staff were unable to provide specific information around any vision or strategy other than to expand the service. They identified with values and the need to provide excellent care. Quality and patient experience were seen as priorities and everyone's responsibility. However the unit did not collect quality indicators, nor did they submit any data nationally in order to benchmark the service. Staff we spoke with appeared to work well together. The local leadership of the unit was considered to be visible and supportive, but there was no evidence that they were aware of the quality monitoring processes. In addition to this the unit sister did not have the appropriate qualifications to lead the service. We did not see any evidence of a unit specific risk register. We saw a risk analysis register for 2015 which had in excess of one hundred identified risks some of which dated from 2010. There were actions to mitigate the risks. The hospital used a red, amber or green (RAG) rating after mitigation. All risks had been RAG rated as green (acceptable). Multiple risks existed including bariatric patient management and equipment and cross-infection due to manual cleaning of endoscopes. There was mitigation of risks identified within the risk analysis register however, risks did not appear to be removed from the register and not all risks were identified, such as staffing, the critical care environment and mandatory training for doctors. The unit had a lead consultant in place but not a lead intensivist. Unit specific patient feedback was not collated.

Vision, strategy, innovation and sustainability for this core service

- Staff were unable to describe a specific vision or strategy for this service.

Critical care

- Staff told us that they were aware that the hospital was to expand but they were unaware if there were any plans for the unit.
- We were told that the unit had expanded the service from initially opening the unit for two and a half days a week to being available 24 hours a day, seven days a week.
- The unit sister described how she used to 'chase' patients but now consultants were aware of the service and requesting the use of beds.
- When speaking to staff at times they referred to the unit as a high observation bay (HOB) rather than a high dependency (HDU) or intensive care unit (ICU). There appeared to be a lack of clarity about the use of the unit. All signage called the service an Intensive Therapy Unit (ITU). The information received from the hospital referred to the unit being a high dependency unit. Documentation we saw, such as care pathways and policies, were titled ICU (intensive care unit) or ITU (intensive therapy unit).The unit was described by the hospital as a high dependency unit caring for level 2 patients and occasionally short term level 3 patients. From discussions with staff and data collected the unit appeared to provide occasional level 3 care when dealing with patients who have deteriorated. However, it appeared that the majority of patients were short term level 2 patients or required higher observation due to the type of post-operative and post procedure care that was provided in the unit.
- At a meeting with the hospital following the inspection managers confirmed that it was a level 2 Critical Care facility and that this had been stated in the data that was provided ahead of the inspection. We were told that all documentation has been updated to ensure this is reflected consistently and new signage has been ordered and would be in place by mid-December 2015.

Governance, risk management and quality measurement for this core service

- The hospital had a governance structure, with a clinical governance committee in place. This committee took reports from the clinical, audit and effectiveness committee and the infection prevention and control committee. This committee fed directly into the medical advisory committee (MAC). It also had direct links into the senior management team and hospital and group governance arrangements.
- The unit manager attended the hospital MAC meeting and the manager and the unit sister attended the governance meetings.
- A senior nurse told us that staff have raised risks which she then transferred to a risk template to be sent to management for inclusion on the hospital risk register.
- Senior staff told us that the risk register was reviewed four times a year by the hospital Health and Safety committee.
- We did not see any evidence of a unit specific risk register. We saw a risk analysis register for 2015 which had in excess of one hundred identified risks some of which dated from 2010.The hospital used a red, amber or green (RAG) rating after mitigation. All risks had been RAG rated as green (acceptable). Multiple risks existed including bariatric patient management and equipment and cross-infection due to manual cleaning of endoscopes. There was mitigation of risks identified within the risk analysis register however risks did not appear to be removed from the register and not all risks were identified, such as staffing, the critical care environment and mandatory training for doctors.
- All risks and incidents at this location were monitored nationally by the parent company Classic Hospitals Limited.
- There was little evidence that staff were aware of the data collated to evidence quality.

Leadership/culture of service

- There was a lead anaesthetist and nurse manager who oversaw the clinical management of the critical care unit. The leads represented the consultant and nursing staff on the hospital's Medical Advisory Committee
- Staff from the unit told us that the unit manager was always available if staff had any concerns.
- All levels of staff we spoke to told us that the senior management team were visible and approachable. Staff also said that the hospital was not hierarchical.
- The sister of the unit had been in post for 15 years.

Critical care

- We were told that staff development was encouraged.
- Staff in the unit told us that the hospital had a pleasant working atmosphere, there was camaraderie and close team working and that it was less stressful than the NHS.
- Staff said that they are able to voice opinion in relation to the patients accepted for surgery and aftercare in the unit. If staff feel that the patients are not appropriate they feel supported to raise concerns.
- Senior staff told us that they do link with other hospitals in the same group but that 'this was not done particularly well' and needed to improve. The unit sister told us that she benchmarks with other units and had sought advice from units who were 'green' in order to improve her unit.
- The hospital annual governance report stated that celebrating success and rewarding excellence was key within the hospital to ensure that all staff were rewarded and recognised for their contributions. The hospital rewarded five staff over the course of 2014 for demonstrating outstanding behaviour and going the extra mile for patients and colleagues. Any member of staff was able to nominate a colleague for this award.
- Information is shared with staff from other Spire organisations. An example of a warning about bogus visitors on another Spire site was given by staff.

Staff engagement

- The response rate to the staff survey at the hospital was 80% for 2014.
- The positives indicated that staff were likely to recommend the hospital to their friends and family for treatment; they got personal satisfaction from their work and believed that what they did made a positive difference to the hospital. Staff also felt that they were proud to work for the hospital and felt that they fitted in with the rest of the team.
- However, the survey also indicated that some staff felt that other departments did not understand the impact their actions have on their team and how different teams within the hospital did not work effectively together. Some staff felt that they did not have enough staff in their team to look after the patients or have the required equipment or information to be able to do their job. An action plan was created to review and address these concerns.

Services for children and young people

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

Information about the service

Spire Hull and East Riding hospital provided paediatric services for children and young people from the age of three upwards for outpatient services, elective day case or overnight surgery. Day case and inpatient overnight facilities were provided on the general ward, which had 46 beds, 34 of which were in single rooms. Outpatient appointments for children and young people were in the hospital's outpatients department (OPD); the hospital did not have separate outpatient facilities for children and young people.

Information provided prior to the inspection stated that services offered to children and young people at the Spire Hull and East Riding hospital included diagnostic imaging, endoscopy, podiatry and orthotics, pharmacy and physiotherapy. Minor elective surgery procedures carried out at the hospital included tonsillectomies, dental work, grommets, circumcisions, hernias and skin lesions.

We visited all of the clinical areas where children and young people were admitted or which they attended on an outpatient basis. This comprised of the general ward, the OPD and the theatres.

We were unable to obtain verbal feedback from children, young people or their families about their experiences of using the service during the on-site visit as no patients attended the service during the inspection. After the visit, we contacted parents by telephone to ask them about their experiences of using services at the hospital. We spoke with five relatives and eight staff, including the matron, the ward manager and two children's nurses. We reviewed four sets of medical/nursing records and management and quality documents related to the service.

Two part time children's nurses and two bank children's nurses provided care and treatment for children and young people undergoing elective surgery. The ward manager of the general ward managed the two part time children's nurses.

Activity in the period from April 2014 to March 2015 for children and young people:-

- 17 inpatient overnight aged 3 to 15 years
- 14 inpatient overnight aged 16 to 17 years
- 80 day case aged 3 to 15 years
- 44 day case aged 16 to 17 years
- 12 outpatient first attendances aged 0 to 2 years
- 250 outpatient attendances aged 3 to 15 years
- 136 outpatient attendances aged 16 to 17 years.
- 358 outpatient follow ups aged 3 to 15 years
- 163 outpatient follow up aged 16 to 17 years

Services for children and young people

Summary of findings

The environment was visibly clean and personal protective equipment was available. However, the service was not carrying out observational hand hygiene audits or general environmental audits. No incidents had been reported which involved children and young people.

Nurse staffing for children and young people was predominantly two part time contracted children's nursesand bank children's nurses. The service planning elective surgical cases according to availability of appropriately trained staff. Senior staff told us they planned to recruit more children's nurses. Children attending routine outpatient appointments were not routinely cared for by qualified children's nurses.

The environment and equipment were well maintained and mandatory training was up to date, and this enabled staff to carry out their roles effectively and safely.Training included awareness of safeguarding procedures and child protection. Procedures were in place for assessing and responding to patient risk, including risk assessment of rooms where child assessments took place. However, However,patient identification sheets, which were located in the front of each patient's' care records, all had missing entries which meant patients may not always be kept safe.

Children and young people had access to appropriate pain relief as and when required. Employed staff caring for children and young people had their competencies checked and received professional development, including an annual appraisal. Parents told us the care their children received was supportive and the staff were kind, caring and friendly. Both staff and parents told us they would recommend the service to their families and friends. The service had not received any complaints.

Senior nursing staff were unable to tell us about the vision and strategy for the children's service. Governance, risk management and quality measurement within the service were not well developed and there was no evidence of continuous quality improvement. The hospital did not carry out any audits relating to services specifically for children and young people. Feedback from staff about the culture within the service, teamwork, staff support and morale was positive.

Services for children and young people

Are services for children and young people safe?

Good

We rated safe as good because:

The environment was visibly clean and personal protective equipment was available.

No incidents had been reported which involved children and young people.

Nurse staffing for children and young people was predominantly two part time contracted children's nurses, one of whom was leaving for another position, and bank children's nurses. The service planned elective surgical cases according to availability of appropriately trained staff. Senior staff told us they planned to recruit more children's nurses. However, for routine outpatient appointments there was no separate clinic.

Procedures were in place for assessing and responding to patient risk, however we found some omissions in patient records, which meant patientsmay not always be kept safe.

The environment and equipment were well maintained and mandatory training was up to date for employed staff, and this enabled staff to carry out their roles effectively and safely.Training included awareness of safeguarding procedures and child protection. Some consultants may have been treating children without having received the appropriate level 3 safeguarding training.

Incidents

- We looked at the hospital's incident reports and found there were no incidents reported which involved children and young people.
- Staff confirmed there had been no recent incidents at the hospital involving children or young people. They explained children and young people treated at the hospital were generally low-risk, healthy and without any co-morbidities. The children's nurses told us they knew how to report incidents.
- The lack of incidents reported involving children and young people meant we were unable to judge whether there was learning from incidents for this core service.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly clean, including the communal areas, toilets and bathrooms. We saw personal protective equipment (PPE) was readily available for staff to use.
- We observed appropriate infection prevention and control notices on display in clinical areas, such as notices reminding staff that they should be bare below the elbows.
- The provider had reported no cases of methicillin resistant Staphylococcus aureus (MRSA), Clostridium difficile (C.difficile) or methicillin sensitive Staphylococcus aureus (MSSA) infections in the reporting period April 2014 to March 2015 at Spire Hull and East Riding hospital. There had been no cases of MRSA, MSSA or C.difficile in the children's service.
- Records showed that 75% of staff had completed infection control training at the time of the inspection which was in line with the hospital's calendar year training programme.
- Paediatric nurses we spoke with told us families were encouraged to bring in bedding and toys from home for children and young people undergoing surgery. We were concerned that this could present an infection control risk.
- We spoke with five parents who all told us there was no problem with cleanliness at the hospital; one said the rooms were "Spotlessly clean".

Environment and equipment

- There were no separate waiting areas for children in the outpatient department. Staff we spoke with told us this was not a problem as low numbers of children and young people were seen in outpatients.
- Children and young people had individual single rooms on the general ward when they came in for day case or inpatient surgery. Senior nursing staff told us that, on the rare occasions when they had more than one child on the ward, children may be cared for together in one of the bays on the general ward. Most of the patients on the hospital ward were adults.
- We spoke with five parents after the inspection; they all told us the rooms were comfortable and the facilities good.
- Staff told us the service carried out a risk assessment on all rooms where children and young people were

cared for. When we reviewed this document, we saw it did not include an assessment of ligature risks. When we discussed this with the matron, she said she would address this finding immediately.

- Staff told us there were no issues with the equipment available and new equipment could be obtained as and when required. For example, the matron told us the hospital had recently purchased a paediatric ultrasound probe.
- We saw resuscitation equipment for adults and children was readily available and regularly checked. Paediatric resuscitation packs were available; the equipment was designed to accommodate children of different weights and heights.
- The hospital's annual governance report stated that: 'paediatric scenarios had been designed and added to the resuscitation scenario training'. The ward manager confirmed this and told us the paediatric lead for the hospital ran resuscitation scenario training.

Medicines

- Staff had completed the drug prescription and record charts and medication administration records correctly in the five sets of patient records we reviewed. However, we found the parental consent form for when the 'as and when' pain relief was required had not been signed for in two out of five patient care records we reviewed.
- See surgical/OPD parts of this report for further detail on the management of medicines.

Records

- Children and young people's medical records were accurate, fit for purpose and stored securely. We did not see any unattended notes during our inspection.
- We reviewed five paper based treatment records during the inspection for children and young people that had undergone elective surgery recently. Patient identification sheets, which were located in the front of patients' care records, all had missing entries. One patient, who had latex allergies identified in the patient record, did not have this on the patient identification sheet. A second patient, who had allergies to morphine and certain antibiotics, did not have this recorded on the patient identification sheet. This meant there was a risk of unsafe treatment being given.
- Risk assessments and observations were well documented.
- However, we found one or more signatures and associated entries were missing on the theatre handover sheets in all five of the patient records we reviewed. This meant it was not possible to see which staff had been involved at each stage of these procedures.

Safeguarding

- Spire Hull and East Riding Hospital had not reported any safeguarding concerns to CQC in the previous 12 months. The matron confirmed there had been no incidents involving children and young people that had required reporting.
- The safeguarding lead was the hospital director, and the responsible person was the matron / head of clinical services.
- The matron told us that in the event of a safeguarding incident, this would be managed locally, and discussed and overseen by the group medical director. They said the hospital actively participated in the local safeguarding board and would escalate any concerns to the relevant council's safeguarding lead.
- Records showed that between 1 April and 31 August 2015, 282 staff (68%) had completed safeguarding refresher training and 372 staff (91%) working at the hospital had undertaken child protection training.
- We were told that all the consultants on the paediatric register had been written to by Spire, asking them for evidence of their recent training and that they had to be up to date with safeguarding and paediatric resuscitation. Senior staff told us that Spire locally was planning to "put on training" in level 3 safeguarding and paediatric basic life support (BLS), to help ensure they were up to date with current requirements.
- The matron, ward manager and children's nurses had been trained to safeguarding level 3. One of the substantive children's nurses had safeguarding level 4 and was a train the trainer in safeguarding. The ward manager told us the majority of staff on the general ward and working in the hospital had safeguarding level 2 training. Staff told us the bank children's nurses used by the service had been trained to safeguarding level 3.

Mandatory training

- Senior nursing staff explained that staff training records started every January, apart from information governance, which started again from April each year. They said Spire Healthcare set targets to track

completion of training through the year; for example, the matron told us training completion rates should be at approximately 60% at the time of the inspection visit. The ward manager told us mandatory training figures was one of the performance indicators for the hospital.

- Staff and managers told us mandatory training was all up to date and records submitted by the hospital confirmed this. For example, 80% of staff had completed fire safety training, and 90% of staff had completed equality and diversity training.
- The ward manager told us there were no problems getting funding and time off for training. Staff we spoke with all told us the hospital was supportive of staff training and development.
- We were told that the resident medical officers (RMOs) and registered children's nurses (RCNs) had all undertaken the European paediatric life support (EPLS) qualification. Staff also had EPLS: we were told, "There are enough staff on site with EPLS."
- The ward manager told us all nurses and healthcare assistants were basic life support (BLS) trained and some nursing staff had undertaken paediatric basic life support (PBLS) training or paediatric intermediate life support (PILS) training. We asked the hospital to submit these competency records following the inspection. Training records showed 17 staff were PILS trained, 69 staff were PBLS trained and six staff had EPLS, including four RMOs and one RCN.
- Consultants and anaesthetists caring for children and young people at the hospital had undertaken paediatric care as part of their substantive role within their NHS practice. Staff told us an EPLS trained member of staff was always present during a paediatric admission.

Assessing and responding to patient risk

- The paediatric leads in each area had carried out risk assessments for all of the areas where children and young people were seen. When we reviewed these risk assessments, we found they did not include identification of ligature risks. When we asked the matron about this, they said they would address this issue immediately.
- We observed that the cords on the window blinds throughout the hospital were not 'quick release.' We pointed this out to the ward manager and matron who said they would take action to address this concern.
- We saw there were emergency buzzers in every room on the ward and the ward manager told us staff would ring 2222 in the event of an emergency; the members of the emergency team for each shift were identified and were available 24 hours a day.
- We reviewed the hospital's intensive care transfer policy and saw it stated that patients who require critical care treatment should be referred and transferred as early as possible. The policy also stated that paediatric stabilisation beds were located at the local trust. Staff we spoke with confirmed this was the procedure to follow if a child or young person required critical care.
- We asked the children's nurses and ward manager about the procedures to follow in the event of a deteriorating patient being identified. They said there had been no incidents of this kind for several years; the ward manager told us they had been in post for 20 years and could only recall one incident. Staff said the paediatric nurse would go with the child in the ambulance. They said the hospital did not carry out any high-risk procedures, including blood transfusions, for children and young people.
- We saw correctly completed safer surgical safety checklists in all five of the patient records reviewed. The five patient records were for children undergoing elective surgery at the hospital.

Nursing staffing

- The hospital used two part time qualified children's nurses and two bank children's nurses to care for children and young people. However, one of the contracted part-time nurses was leaving at the end of the inspection week. We were told they were going to join the Spire bank when they left.
- There was a plan to advertise for a substantive children's nurse, as one of the contracted staff children's nurses was leaving and a full-time children's nurse had retired in April.
- There were low numbers of children and young people receiving care and treatment at the hospital; this meant staffing for each elective procedure was considered on an individual basis.
- Staff told us a qualified children's nurse assessed all children and young people prior to admission and children's nurses cared for children and young people throughout their stay.

Services for children and young people

- Patients were booked in for elective surgery according to the availability of qualified children's nurses and theatre staff with appropriate paediatric training and skills.
- The ward manager told us the children's nurse to patient ratio would be either 1 to 1 or 1 to 2. They said if there were four children on the ward then a second children's nurse would be on duty.
- Children's nurses were requested / booked to accompany children and young people in other departments, for example in radiology or if an interventional procedure was to be performed in outpatients.
- However, for routine outpatient appointments there was no separate clinic and children were not routinely cared for by qualified children's nurses.
- We spoke with five parents about their experiences at the hospital. They all told us they felt there were enough staff on duty to meet their needs. One said, "There are plenty of staff."

Medical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice in hospital). 223 doctors and dentists were working under practice privileges with Spire Hull and East Riding.
- A paediatrician represented children on the hospital's medical advisory committee (MAC). Paediatric trained medical staff cared for children and young people who were patients at the hospital.
- The hospital's resident medical officer or the consultant provided medical cover overnight and at weekends. Consultants were responsible for their admitted patients on a 24-hour basis.
- One parent told us their child's operation had been cancelled due to lack of appropriately skilled staff being available. When we asked staff about this, staff told us there had been no anaesthetist available with the required paediatric training. However, this cancelled operation had not been reported as an incident.

Major incident awareness and training

- The hospital was not a major incidentreceiving centre.
- We found the hospital's business continuity plan had been activated over the weekend prior to our visit. This was due to an electrical problem when completing some routine checking. The hospital had cancelled forty cases of elective surgery on the first day of our visit because of this.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because:

The hospital did not carry out any specific audits relating to services for children and young people and there was no evidence to show how they monitored patient outcomes for children. There were gaps in assessing and auditing of infection prevention and control procedures, specifically observational hand hygiene audits. There was very little evidence provided by the hospital to indicate whether they used NICE or other specific national guidance for children's services.

We found children and young people had access to appropriate pain relief as and when required. Care records reviewed contained completed pain assessments and feedback from parents confirmed children and young people received pain relief when they needed it. Staff caring for children and young people had their competencies checked and received professional development, including an annual appraisal.

Evidence-based care and treatment

- There was very little evidence provided by the hospital to indicate whether they used NICE or other specific national guidance for children's services.
- The hospital was BUPA accredited for paediatric services.
- We saw other general operational policies, such as the resuscitation policy, which were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- When a new organisational policy was received, staff and the MAC reviewed the policy and undertook a gap analysis on the policy, and information relevant to the

site was added in; nothing was allowed to be removed from the policies. Policies were available in hard paper format on the unit and in electronic format on the intranet.

- We asked the ward manager about specific audits within children's and young people's services. They told us they were unsure whether staff carried out specific care records audits for children's and young people's care records. They said previously the children's nurse who had retired in April 2015 had audited children and young people's care records.
- Staff we spoke with confirmed no audits were currently carried out in children and young people's services. This meant omissions in care documentation would not be identified and/or reported as near miss incidents.
- There were gaps in assessing and auditing of infection prevention and control procedures such as observational hand hygiene audits.

Pain relief

- We did not identify any problems with pain relief in the patient records we reviewed.
- We also asked five parents of children and young people who had undergone surgical procedures at the hospital about pain relief and none of them identified any concerns.
- We saw correctly completed pain score records in the five patient records we reviewed.

Nutrition and hydration

- In all five of the patient records we reviewed, we saw all food and fluid charts were incomplete. For example, four out of five had no output entries and in all five, staff had not totalled up the input figures. This meant there was a risk of inadequate hydration as it was not possible to confirm what the childs' fluid intake and output had been.
- Parents told us the food was good and their child and any accompanying family members had been offered food and drink on a regular basis throughout their stay.

Patient outcomes

- Staff told us patient outcomes were good; however, we did not see any evidence to show that patient outcomes for children and young people's services at the hospital were routinely monitored.
- There was no evidence to show that the service participated in national audits. When we asked about this staff told us this was due to the low number of low risk patients treated at the service.
- The proportion of unplanned re-admissions for the hospital was 'similar to expected' compared to the other independent acute hospitals. These figures did not show re-admission rates for children and young people separately.

Competent staff

- The children and young people's service cared for low numbers of patients and had low numbers of nursing staff; these staff maintained competencies in their roles within other organisations, usually within the NHS, which also employed them.
- When we asked about phlebotomy for children and young people the matron told us, the number of children and young people needing blood tests on-site was low. The matron told us three or four phlebotomy staff were booked to attend a paediatric phlebotomy course.
- The ward manager told us all staff received an end of year 'enabling excellence' appraisal and there was a review meeting half way through the year.
- Consultants were subject to a biennial review of their practising privileges, which included feedback from other Spire hospitals and the NHS Trust, which employed them.
- Spire Hull and East Riding hospital provided consultants with an annual appraisal report when requested to support their NHS annual appraisal. This detailed information such as their practice profile, clinical indicators, serious adverse events and complaints.
- Spire Hull and East Riding hospital ensured all consultants submitted their NHS annual appraisal each year along with current indemnity, GMC registration and confirmation of revalidation where applicable.
- The hospital carried out regular checks to ensure all documentation was submitted in a timely fashion; this documentation contributed to the consultant's biennial review. The Medical Advisory Committee meetings discussed any serious issues.

Multidisciplinary working (in relation to this core service)

Services for children and young people

- Staff, teams and services worked together well to deliver effective care and treatment for children and young people using the service.
- Staff we spoke with gave examples of multidisciplinary working, both within children's services, with other hospital departments and with outside agencies. The matron told us there were no problems with sharing information such as patient notes and X-rays, between the Spire hospital and the local trust.

Seven-day services

- The resident medical officer (RMO) or the consultant provided medical cover overnight. The RMO was on duty within the hospital at all times and the consultants were generally off-site.
- The hospital pharmacy was open on-site Monday to Friday 9am until 3pm and 9am until midday on Saturday. Outside normal working hours, the pharmacy could be accessed with the RMO providing a second signature for any medications used from the pharmacy.
- The hospital had a service level agreement for 24-hour cover with Hull and East Yorkshire Hospitals NHS Trust for pathology, transfusion, pharmacy and the transfer of patients who were unwell.

Access to information

- We were told patient notes were available as required.
- Systems were in place to obtain clinical results in a timely manner. Some tests could be performed on-site while other samples were sent to external laboratories. We had one negative comment about getting results back from an external source.

Consent

- We saw correctly completed and signed consent forms in all five of the patient records reviewed. All five parents we spoke with confirmed that, prior to a procedure, they had signed consent forms for their child.They also told us the consultant had explained the risks and benefits to them as part of the consent procedure.
- We reviewed the hospital's 'Consent for children' policy, which described the process to follow for gaining consent from children and young adults for examination or treatment.
- We saw the policy described how to obtain consent and how to test whether the child had sufficient understanding and intelligence to enable them to understand fully what was proposed. This is known as 'Gillick' competence and is a legal requirement.

Are services for children and young people caring?

Good

We rated caring as good because:

There were no children receiving care at the time of the inspection. We spoke with five parents of children who had recently received care; they all told us the care their children received was supportive and the staff were kind, caring and friendly. Parents also told us they were happy with their involvement in their child's care and treatment.

Staff gave families feedback forms to complete on discharge from the general ward; the feedback was all positive. Both staff and parents told us they would recommend the service to their families and friends.

Compassionate care

- Staff were caring and friendly. All five parents we spoke with after the inspection gave positive feedback about all of the staff they had met during their contacts with the hospital before, during and after their procedures. Comments included:
  - "Very helpful."
  - "We were treated like royalty, it was lovely."
  - "Very impressed with the whole experience."
  - "Happy with how it all went, X (Children's nurse's name) was really attentive and caring. We got her a thank you card."
  - "All of the staff were lovely, including the hostesses and physios."
  - "Even the porter that took him to theatre was friendly."
  - "They really looked after us."
  - "We were just really welllooked-after."
- When we spoke with the ward manager, they told us, "The feedback is amazing."

Services for children and young people

- Staff gave families feedback forms to complete on discharge from the general ward. We reviewed 12 feedback forms completed by parents of children who had been inpatients between May to September 2015. Comments included:
  - "Excellent care and support."
  - "X (consultant's name) was immensely reassuring, obviously respected in his field."
  - "Y (nurse's name) is very kind and caring."
  - "Y (nurse's name) was amazing, her care and attention to detail was fantastic."

Understanding and involvement of patients and those close to them

- All five parents we spoke with told us they were happy with their involvement in their child's care and treatment. Comments included:
  - "They explained everything."
  - "We were kept informed all the time, for example how long they would be in theatre."
  - "We were well-informed about what was going to happen."
  - "We felt fully informed."
- Two parents we spoke with told us they had been in for 'a look round,' prior to their stay, and another told us this had been offered but they had declined as their child had been in for a procedure previously.
- Staff told us children and young people were cared for during their stay by the paediatric nurses. The five parents we spoke with confirmed this.
- When we asked five parents whether anything could have improved their experience at the hospital they all said there was "Nothing that could have been improved." One parent said, "I couldn't fault anything" and another said, "The staff were very motherly."
- In two of the five patient records we reviewed, we saw that the child or young person had made a list of questions to ask the consultant, with the help of their children's nurse.

Emotional support

- Verbal feedback from parents and comments on the feedback forms showed families felt reassured and supported by staff during their hospital stay.
- Staff told us they provided distraction for children and young people when they went to theatre for their operation; parents we spoke with confirmed this. They told us all of the staff involved in the procedures were good at distracting their child, prior to their operation. One parent said, "They were very good at distracting him when he was going to theatre."
- Staff told us parents could phone the ward after their child had been discharged home; they said the service had an 'open door' policy for help and advice.
- Parents we spoke with after the inspection confirmed this. They told us the children's nurses kept in touch with them regularly before and after their child's operation. One said, "The nurse rang and has been very good, keeping in touch and following up with us." Another said, "We had a really good experience and my son is really fearful of needles."
- Other feedback from parents about emotional support included:
  - "They were so good with her, making her laugh. Really very good."
  - "We felt reassured."

Are services for children and young people responsive?

Good

We rated responsive as good because:

Qualified children's nurses nursed children and young people throughout their stay and the service was responsive to the individual needs of the children and young people who used it. The service had not received any complaints.

We found there were no separate areas for children and young people to wait and/or be seen in the outpatients department. One child's operation was cancelled during the inspection due to a lack of paediatric staff to support the procedure.

Service planning and delivery to meet the needs of local people

- The service was meeting the needs of children and young people. Senior nursing staff told us the service dealt with a mixture of NHS choose and book and private patients.
- Orthopaedic and ear nose and throat surgery were the main surgical specialities provided for children and young people.

Services for children and young people

Access and flow

- The low numbers of children and young people cared for at the hospital meant there were generally no problems with access and flow management. However, one child's operation was cancelled during the inspection due to a lack of paediatric staff to support the procedure.
- Staff told us a children's nurse assessed all children and young people prior to admission for elective surgery.
- Feedback from parents was mixed about the timeliness of their child's procedures.
- For example, we spoke with one parent whose child's operation had been cancelled. They told us, "It was a bit awkward; I had booked the day off and had to re-arrange everything at short notice."
- One parent told us, "We were waiting around on the morning of the operation. We were told to arrive at 8am and expected to be straight in. They were not operated on until 11am." However, another parent said, "Our operation was within five minutes of the expected time."
- The operations director told us that if surgery had to be cancelled then it would be re-booked within a month. They said free slots were always kept available for this.
- Following the inspection, we requested figures for the numbers of cancelled surgical procedures for children and young people. The submission received, for the six-month period March to August 2015, did not list cancelled surgery for children and young people separately and did not give the reasons for the cancellation. Numbers of cancellations were categorised as clinical or non-clinical but there was no explanation of these terms.
- The ward manager told us bookings staff liaised directly with the children's nurses about their availability for elective procedures on the ward. They said children and young people were normally taken to theatre at the beginning or the end of the list. They said staff discussed theatre lists every Thursday at a meeting.
- The ward manager said that if there was an unexpected overnight stay for a patient post-operatively then the team of children's nurses "would manage it." They said they had never had to transfer a child or young person because the hospital could not provide appropriate cover. They told us there was always a trained children's nurse available.
- Staff told us the anaesthetist and surgeon always saw their surgical patients before they were discharged from the hospital.

Meeting people's individual needs

- Children from the age of three were treated at Spire Hull and East Riding Hospital and qualified children's nurses nursed children and young people throughout their stay.
- Parents we spoke with told us the staff were very responsive to their needs; one parent told us, "Every time we wanted anything it was there," another said, "They got me a bed to stay overnight; they looked after me too."
- Staff told us there were facilities for parents to stay overnight, either in the Wilberforce bay on the general ward or on camp beds in their child's room.
- Staff told us none of the phlebotomy staff at the hospital were trained to take blood from children and young people. They said there used to be a children's centre with phlebotomy staff, which patients could use. This meant the service was not meeting children's needs for phlebotomy. Several staff told us phlebotomy staff were due to undertake training for taking blood from children and young people; however, we did not see any evidence to confirm this.
- There were no separate areas for children and young people to wait and/or be seen in the outpatients department. There were no toys available; when we asked about this, we were told colouring books and crayons were available on request. We saw notices on display in the waiting areas which stated, 'Colouring books and crayons are available for children, please ask.'
- We saw the bedroom for a child who was to have surgery.We saw an age appropriate duvet set on the bed and children's nurses wearing child-friendly uniforms.
- One parent we spoke with after the inspection told us their child was pleased with the child-friendly bedding on the bed when they arrived and they had been given a teddy bear.
- Staff on the general ward explained that children's nurses from the ward would collect children and young people from the reception area, after they had been booked in.

- Leaflets were available about interpretation and translation services. These services were available for patients visiting the OPD, day care or inpatient admissions. The text contained in these leaflets was in nine different languages.
- British sign language interpreters were also available on request.

Learning from complaints and concerns

- Senior nursing staff told there had been no complaints or concerns raised about services for children and young people at the hospital. When we asked staff about responding to concerns, they did not tell us they would record any issues raised. They told us the staff were always responsive and sorted any issues out straight away.

Are services for children and young people well-led?

Requires improvement

We rated well-led as requires improvement because:

Senior nursing staff were unable to tell us about the vision and strategy for the children's service. Governance, risk management and quality measurement within the service were not well developed and there was no evidence of continuous quality improvement.

Feedback from staff about the culture within the service, teamwork, staff support and morale was positive. Feedback from parents about the care and treatment received was also positive.

Vision, strategy, innovation and sustainability and strategy for this this core service

- We were told Spire Healthcare had recently updated its clinical policy 'Guidelines for the care of children in Spire Healthcare. This was a recent development, which the hospital would be following / adopting. Following our inspection we requested a copy of this document, however this was not received.
- Staff were unable to describe a vision or strategy for children's services within the hospital.

Governance, risk management and quality measurement for this core service

- We did not find any evidence of audits, risk management or quality assurance for children and young people's services at the hospital.
- When we asked about medication audits and audits of patient records, senior nursing staff and the children's nurses told us these were not done. They said the service was "Going to audit patient records."
- The matron told us paediatric services were discussed at the quarterly clinical governance meetings and there were links to the MAC, hospital and group governance arrangements. When we reviewed the June 2015 MAC minutes we saw that a Paediatric Policy was due to be released 'in the next few months' and the recommendations following the report "Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile" were also being reviewed. The August 2015 MAC minutes documented that the Paediatric Policy had been released and that consultants would have to undergo training in order to operate on children in the independent sector. The hospital would keep a paediatric register of consultants with appropriate paediatric training and the matron would organise PBLS training for consultant staff. This confirmed what the matron had told us.
- We were told that there would be a local governance review for paediatric services in December 2015.
- The matron explained that there was a national Spire paediatric steering group and the paediatrician who worked at the hospital would be contributing to this. We were not shown any documentary evidence about this paediatric steering group.
- Spire services had an internal annual clinical review; five people from Spire nationally had reviewed the Spire Hull and East Riding hospital. As required action plans were developed following the review and monitored nationally.
- We looked at the hospital's 'annual governance report for 2014' and saw that paediatric services were mentioned in relation to services provided (medicine and surgery) and the number of paediatric consultants employed (one). There was one action related to paediatric services, which was to do a gap analysis on the 2015 national report "Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile".
- There was limited evidence of monitoring of infection control procedures such as hand washing. The Health and Social Care Act 2008: Code of Practice on the

prevention and control of infections and related guidance July 2015 states that an audit programme must be available to ensure policies are implemented, it also states that policies must be audited. In addition WHO 2009 states that IPCT must measure compliance with policy through audit and EPIC 3 guidance recommends that hand hygiene guidance be audited.
- While there were audits of patient care records, none of those we reviewed were specific to children.

Leadership/culture of service

- Staff told us there was no specific leadership structure in place for paediatric services The ward manager on the general ward managed the children's nurses, for HR issues and work schedules.
- The paediatrician told us they had taken on the lead for children and young people's services recently, after the previous post-holder left. As a result, they had started attending the MAC in the summer of 2015 and had only been to one meeting so far. They explained that the service had been without a consultant paediatrician for five months before that.

Culture within the service

- The ward manager told us the children's nurses working with children and young people were, "very committed and want the best for the service".
- Staff we spoke with loved working at the hospital, they told us it was a welcoming, supportive culture and morale was good. They said the hospital had a 'learning culture' with good investment in training and education.
- The lead paediatrician told us staff working at the service were, "flexible and accommodating".

Public and staff engagement

- Information regarding hospital developments was shared and cascaded down; additionally staff could find information on the intranet, from emails and in the staff newsletter. One person told us they felt there was a, "proactive approach".
- Staff told us they gave out feedback forms to children, young people and their families on discharge. Feedback all referred to one of the children's nurses and was universally positive. However, staff we spoke with confirmed there was no analysis of feedback results, or any action plan or follow-up.
- We reviewed the feedback received from 12 parents, between May to September 2015 and saw six of these twelve comments had been placed in the hospital's monthly newsletter.

Innovation, improvement and sustainability

- When we asked the children's nurses, ward manager and paediatrician about innovation, improvement and sustainability no one gave any examples. The matron told us about an updated corporate policy which would improve services. To sustain the service senior staff told us they planned to recruit more children's nurses

Outpatients and diagnostic imaging

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

Information about the service

Spire Hull and East Riding Hospital had an outpatient department providing access to a wide range of services to NHS and privately funded patients. Consultations were provided regarding breast care, ear, nose and throat, cosmetic surgery, orthopaedic surgery, general surgery (including weight loss surgery) ophthalmology, audiology and health and wellbeing for men and women. Medical services were also available for a wide range of conditions such as heart conditions, dermatology, pain and migraine. The department had thirteen consulting rooms, radiological imaging facilities and a physiotherapy department. The hospital provided diagnostic testing including blood testing and diagnostic imaging.

The physiotherapy department offered a wide range of services, including assessment and treatment of patients attending the hospital for surgery, a variety of therapies including pain management and a sports injury service. Physiotherapy services were provided from four dedicated treatment rooms, one cubicle and a gymnasium. Self-paying patients could also refer themselves for physiotherapy assessment and treatment. The physiotherapy department was open from 8am – 6pm for outpatients and on-call services were provided 24 hours, seven days a week for inpatients. The department offered flexible appointments for outpatients outside of these times and at weekends if requested.

The diagnostic imaging service provided an extensive range of tests, including plain film x-ray, ultrasound, Computerised Tomography (CT) scanning, Magnetic Resonance Imaging (MRI), fluoroscopy, angiography and mammography. A mobile unit visited the hospital three days a week and provided MRI scanning. A mobile unit visited the hospital one day a week and provided CT scanning.

Other diagnostic tests offered included: blood tests, cardiology tests, ophthalmology and audiology services. Pathology and laboratory services were, in the main, provided by a local NHS trust through a service level agreement.

Between 1 September 2014 and 31 August 2015, the Spire Hull and East Riding and Hesslewood outpatient services saw 73,361 patients.

During the inspection of Spire Hull and East Riding Hospital, we visited the outpatient, physiotherapy and radiology services. As part of the inspection process, we spoke with 10 patients and 21 members of staff, including volunteers. We also received feedback from 111 patients through comments cards. Staff we spoke with included managers, nurses, doctors, radiographers, healthcare assistants and administrative staff. We observed the radiology and outpatient environments, checked equipment and looked at patient information and records. We also reviewed performance information from, and about, the hospital. We received comments from patients and members of the public who completed comment cards and from other people who contacted us directly to tell us about their experiences.

Outpatients and diagnostic imaging

Summary of findings

Incidents were reported, investigated and lessons were learned and shared across the hospital. Risk assessments were up to date and protective measures were put in place where necessary. Staff adhered to policies and procedures and there was sufficient well-trained and competent nursing, allied health professional (AHP) and medical staff within the departments to deliver care safely.

The outpatient and diagnostic imaging departments offered appointments weekdays, evenings and Saturday mornings. Support services such as physiotherapy and radiology were in place 24 hours a day, seven days a week. The department participated in a number of local and national audits; however, information submitted for the inspection did not always include interpretation, benchmarking or actions for either improving or sustaining performance.

Patients told us they were treated with kindness and compassion and that staff were courteous and respectful. Receptionists were reported as excellent and chaperones were offered. Patients felt that confidentiality was excellent. Patients spoke very highly of the service provided by the pain clinic.

Patients could be seen quickly for urgent appointments if required and departments offered flexibility around clinic times. Clinics were rarely cancelled at short notice and waiting times for appointments were well within target timescales.

Staff and managers had a vision for the future of their services and staff felt empowered to express their opinions or concerns. Staff were engaged with the organisation's mission to deliver the highest quality patient care and patients were given opportunities to provide feedback about their experiences of the services provided.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

We found that patients received safe care. Incidents were reported, investigated and the lessons learned were shared across the hospital. The cleanliness and hygiene in the department was of a good standard and sufficient personal protective equipment was available to protect patients and staff from cross-infection and contamination. Clean and well-maintained equipment ensured that the interventions patients received were safely carried out.

Risk assessments were up to date and protective measures were put in place where necessary. Medical records were always available for outpatient clinics.Staff were aware of policies and procedures to protect vulnerable adults or those with additional support needs and there was sufficient well-trained and competent nursing, allied health professional (AHP) and medical staff within the department.

Incidents

- Between the 1 April 2015 and 22 September 2015 there were 36 incidents logged relating to outpatient areas and diagnostic imaging services. Themes identified in these incidents included: a number of patients' procedures cancelled due to no longer requiring them, and cancellations and delays due to equipment failure. Three incidents were information security breaches, two incidents related to late clinic starts, there were two falls and two incidents were related to pathology specimens being missing or not labelled. A small number of post-operative surgical site infections were also logged, as these were discovered in outpatient clinics when patients returned for follow-up appointments. All incidents were low or no harm.
- Staff were able to explain how to report incidents using the electronic incident reporting system and when to escalate incidents to their line manager, or Radiological Protection Supervisor (RPS).
- Radiology staff were aware of the need to report radiation incidents under Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R.

Outpatients and diagnostic imaging

- In the case of equipment related incidents staff were aware of the need to also report to the Health and Safety Executive (HSE).
- Staff used a decision tree to determine whether an incident met Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) criteria for reporting to the HSE.
- Radiology staff had access to a Radiological Protection Advisor (RPA) external to the hospital as and when needed. This resource was available through Integrated Radiological Services Ltd (IRS) as part of a contract agreement with the Spire group.
- There were no IR(ME)R reportable incidents for Radiology during the 12 months prior to the inspection.
- There were no never events or serious incidents relating to this service in the 12 months preceding the inspection.
- Outpatient and radiology staff, including medical staff, reported that any incidents were discussed at departmental meetings and they described an open and honest culture.
- Learning from incidents was demonstrated by a change in practice in radiology, regarding the positioning of patients undergoing sedation. All patients must now be in a flat position before any sedation is administered.
- Radiology staff were also aware of an incident relating to a patient being recalled after discharge when an unreported complication was picked up during the reporting process. They were aware that the ward had implemented actions to prevent patients being discharged before films were reported.
- Incident reports were reviewed by the Medical Advisory Committee, who were responsible for identifying any over-arching patterns and learning points.

Duty of Candour

- Staff had knowledge of duty of candour and described how they had informed patients if an incident or mistake had occurred. They were clear of the requirement to be open and honest with patients when incidents occurred.
- We observed that information was available in the staff room regarding duty of candour and that this had been one of the topics in a recent staff briefing.
- There had been no incidents in the last 12 months that had triggered a formal duty of candour response.

Cleanliness, infection control and hygiene

- The departments we visited were visibly clean and we saw evidence that waiting areas, clinic rooms, and equipment were cleaned regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use and imaging equipment was cleaned and checked regularly.
- Patients felt the departments were clean, tidy and safe.
- We observed staff complying with "bare below the elbow" policy in clinical areas and hand hygiene policy. Soap dispensers and hand gel were readily available for staff, patients, visitors and the public to use. Dispensers were clean and well stocked. We observed staff using good infection control practices and they told us there were sufficient supplies of personal protective equipment (PPE).
- We observed staff using the correct handwashing technique.
- An undated hand hygiene environmental audit of outpatients and the angiography laboratory showed 100% compliance. The audit included questioning five members of staff regarding hand hygiene, using a list of standard questions. There was no observation of hand washing noted.
- Equipment in outpatients, radiology and physiotherapy was visibly clean and stickers were in place to show that cleaning had been carried out and that the equipment was ready for use.
- There was a system in place to decontaminate instruments after use and to ensure traceability. Traceability stickers were entered into patients' notes following procedures.
- Appropriate containers for segregating and disposing of clinical waste were available and in use across the departments and we saw that PPE, used linen and waste was disposed of correctly.
- Outpatients were discouraged from attending appointments if they were suffering from infectious diseases, such as diarrhoea and vomiting or had flu like symptoms.
- If inpatients needed urgent imaging procedures within the department then they were seen at the end of lists and the radiologists operated a dirty and clean system with two staff present. One radiographer would be in contact with the patient while the other operated the machinery. We were told that cleaning staff were very responsive to requests for decontaminating equipment if needed in between routine cleaning.

Outpatients and diagnostic imaging

- If inpatients were known to be infectious then images would be taken on the ward if possible using portable equipment, which would be decontaminated following use.
- Patients told us they had observed staff washing their hands and using hand gel before their treatment.
- Sharps audits showed compliance at 95% for imaging in the private patient suite, 99% for the outpatient department and pharmacy, and 100% for physiotherapy and phlebotomy. The issue picked up as being non-compliant in the audit was in regard to their being no temporary closure of the boxes containing sharp items.
- MRSA screening rate reports showed non-compliance with screening targets due to patients not collecting treatments and booking not allowing sufficient time to screen and treat patients.
- There was a link nurse network in operation across the hospital and environmental spot checks had been introduced in June 2015.

Environment and equipment

- A patient-led assessment of the care environment (PLACE) audit for the hospital showed scores above the national averages. Scores for cleanliness, food, privacy, dignity and wellbeing, and condition appearance and maintenance were 100%, 96% 88% and 97% respectively. These scores were better than national averages of 97%, 88%, 86% and 90%.
- There was sufficient seating available in waiting areas.
- There was an emergency resuscitation trolley shared between the outpatient and radiology areas. The trolley was checked every day to ensure it was in good working order. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis. Drawer locks were in place. The trolleys were clean and tidy and all consumables were within the use by date. The oxygen cylinder was also checked and within date.
- Curtain changes were recorded and consumable items were in date.
- Not all equipment was labelled to show when it was last serviced or maintained. However, there were contracts and a centralised system in place to ensure regular service and maintenance of all equipment across the hospital. We saw records that indicated that services and maintenance were up to date and there was an IT system in place to track and schedule routine maintenance and servicing as it became due. There were contracts in place with specialist companies to undertake emergency repairs of equipment and maintenance people could be contacted and brought in 24 hours seven days a week if needed.
- The departments were well signposted and volunteers were available to help patients who needed directing further.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protected patients against unnecessary exposure to harmful radiation.
- Staff wore dosimeters (an instrument for measuring the amount of radiation absorbed by somebody) to ensure that they were not exposed to high levels of radiation.
- There was clear and appropriate signage regarding hazards in the imaging department.
- Waiting and clinical areas were clean and there were radiation warning signs in areas used for diagnostic imaging.

Medicines

- We were told that drug stocks was audited and rotated on a regular basis. We checked drug cupboards and found that all drugs were in date.
- Prescription pads were locked in the drug cupboard and nursing staff provided these to Consultants on an individual patient basis.
- The onsite pharmacy dispensed the prescribed medications for outpatients. Prescription charges were covered as part of the packages of care commissioned for NHS outpatients.
- Prescription charges for private outpatients were added to, or included in, consultation fees depending on the treatment plan purchased.
- We checked records of drug fridge temperatures and found these were monitored daily. Records were up to date with no gaps and noted that fridges had been maintained within the recommended temperature range.
- Flu vaccines were available to patients and staff and were administered under a patient group directive (PGD). The nurses administering flu vaccines had received training from the occupational health nurse.

Records

Outpatients and diagnostic imaging

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images. Medical notes and referral letters were not held electronically.
- All patients attending the hospital have a full set of medical records stored on-site for a maximum of a fourmonth period. After this, they were transferred to an off-site storage facility.
- All clinic notes were arranged 24 to 48 hours in advance, which meant patients should never attend clinic without medical records being available.
- Staff reported that records were usually available in a timely manner for clinic appointments and the department estimated that records were unavailable less than 1% of the time. However, this was not routinely monitored.
- In the event of a late booking, and records being unavailable for a patient appointment, a temporary set of records was created. Records were requested from the archive at the time of booking and temporary records were amalgamated as soon as the original was received.
- Medical records were transported securely around the hospital and stored securely when not in use.
- Any loss of medical records was reported to the matron. However, patients were not routinely notified by the medical records team if this occurred. It was not clear whether the loss was reported to the patient by another department.
- The hospital policy was that consultants did not take medical records out of the hospital. However, the hospital required that all consultants were registered with the Office of Information Commissioner and were personally accountable for the protection of information.
- All electronic patient records, including images held on discs, were encrypted and password protected.
- All patients booked for interventional radiology had a full set of medical notes ready prior to admission. Imaging requests were made on a paper referral form but were electronically scanned on to the system. Diagnostic images were stored electronically and were available to clinicians through PACS (Picture Archiving and Communications System).
- Radiologists dictated reports for typing which they verified and signed before they were sent to the patient's GP. A copy was then placed in the medical record.
- None of the patients we spoke with had experienced any problems with availability of their care records.
- Records were stored securely away from waiting patients.
- We looked at six sets of records in the outpatient department and found them to be complete with both NHS and Spire records attached, all had a referral letter present and all had consultant letters following initial consultation. Records and letters were all signed.
- Record audits showed 100% compliance in quarter one and two regarding the standard of completion, including elements such as clear dating and signing of entries.
- A world health organisation (WHO) safer steps to surgery checklist was used in imaging for interventional procedures where sedation was used. There was no evidence that use or completeness of this record was audited. The checklist was not used for non-sedated patients at the time of inspection; however, the Radiology manger was in the process of introducing the use of a checklist for all interventional procedures.
- Use of the checklist was not audited at the time of the inspection but this was to be added to the annual programme.

Safeguarding

- Staff we spoke with were aware of their responsibilities to safeguard adults and children and knew whom to contact in the event of any concerns.
- We saw evidence of children and adult safeguarding policies and procedures.
- Adult and children safeguarding was a part of mandatory training. Staff told us they were up to date with mandatory training. We were told that children safeguarding training for all staff was at level 2.
- Staff confirmed they had completed safeguarding training and that they were expected to undertake an annual refresher.
- Data provided by the hospital showed 90% and 91% compliance with adult and children safeguarding training among outpatient staff.
- There was a range of information available in the staff room relating to: anti-terrorism "PREVENT", domestic abuse, female genital mutilation and mental capacity act and deprivation of liberty standards.

- Whistleblowing posters were visible in staff areas and staff expressed confidence that they could speak to managers regarding any concerns they had about services or other staff.
- All staff felt well supported by senior staff who were readily available if they needed to escalate any safeguarding concerns.

Mandatory training

- Data provided by the hospital showed good overall compliance with mandatory training between 70% and 91% for all modules year to date January to August 2015. The remaining staff would be monitored to ensure completion before the end 2015.
- The trust mandatory training programme was composed of 12 modules covering all appropriate topics including: general health and safety, adult and children safeguarding, moving and handling, information governance and infection control.
- Training provided was a combination of e-learning and face to face training.
- Staff in the outpatient, imaging and physiotherapy areas told us they were up to date with mandatory training.
- Mandatory training and induction was given to all hospital staff including bank staff.
- For clinicians that were employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with Spire Hull and East Riding hospital, mandatory training was usually undertaken by the substantive employer and monitored by the hospital. However, during review of the personnel documents we had little assurance this monitoring was being undertaken.
- We reviewed 10 sets of medical personnel records: mandatory training records were not always completed or checked with substantive employers; there were only three records with training evidence logged.

Assessing and responding to patient risk

- There were policies and procedures in the diagnostic imaging departments to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- There was a named certified radiation protection supervisor (RPS) to give advice when needed and to ensure patient safety at all times. It was acknowledged that there was a need to train a second radiographer to fulfil the requirements of this role and provide adequate cover and it was planned that the new department manager would undertake this training as soon as possible.
- There was a contract with an independent company (IRS) to provide RPA support and advice. The RPA undertook a schedule of planned visits and inspections and was available for additional one off support. The RPA support was easily accessible by telephone and site visits could be arranged if needed.
- The hospital director had overall responsibility for radiological safety in line with IR(ME)R requirements.
- The hospital did not provide any interventions requiring nuclear medicine.
- There were local policies, procedures and processes in place to protect patients and staff.
- Risk assessments had been undertaken in relation to patient safety, the environment and staff safety. Identified risks had mitigations in place to reduce potential risks to a minimum and new assessments were undertaken when new risks were identified. On-going risks were reviewed annually.
- In accordance with radiation protection requirements and the identified risks to an unborn foetus, female patients were asked if they might be pregnant before exposing them to X-ray.
- The 2015 Radiation Survey Report and the 2014 Patient Dose Audit reports demonstrated compliance with patient and staff radiation exposure levels.
- Early warning scores were used to monitor and manage patient risk when they were undergoing interventional procedures and a safer surgery checklist was used for patients undergoing procedures under sedation. The new radiology manager was in the process of extending use of this safety tool to all patients undergoing interventional radiology.
- No radiation incidents had been reported to CQC in relation to IR(ME)R in the last two years.
- There had been a recent cardiac arrest simulation within the outpatient and diagnostic area. Staff told us they had no warning this was going to take place and that the exercise went well. One member of staff told us the exercise had given her confidence and skill regarding what to do in such an emergency. The

member of staff had subsequently needed to deal with a real life emergency in a public place and had been commended in the local paper by the ambulance driver for her action.

- Resuscitation equipment was at hand in the angiography room and patients' vital signs were closely monitored while undergoing procedures.
- Nursing staff working in the angiography room were Advanced Life Support (ALS) trained. Other staff in outpatients were all trained to basic life support level with most staff trained to intermediate level.
- The majority of nurses and healthcare assistants working in the outpatient department had undertaken Paediatric Immediate Life Support (PILS) training in addition to adult ILS.
- There was a recommended two-week cooling off period for cosmetic surgery patients, however, we were told that if patients wish to proceed to surgery within two weeks they could sign a disclaimer. Most cosmetic surgery patients were referred to Spire by their GP. There was no formal process to check back with GPs when patients self-referred for cosmetic surgery to ensure cosmetic surgery was appropriate. Contact with the GP for self-referring patients was at the discretion of the Consultant.
- Medical staff were focussed on patient risk and safety. They assessed patients to see if they were suitable for interventions at the Spire Hull and East Riding Hospital. Higher risk, complex cases were referred to the local NHS trust.

Nursing and allied health professional staffing

- The outpatient departments were staffed by 10 whole time equivalent ` (WTE) registered nurses, 6 WTE care assistants and 11 WTE allied health professionals which included physiotherapists and radiologists who provided both inpatient and outpatient services.
- Sickness rates were low (less than 10%) for staff working in outpatient departments, there were no vacancies for nurses or healthcare assistants and there were low turnover rates; 7% registered nurses and 11% healthcare assistants. All staff had worked for the hospital for longer than one year. Most staff had worked at Spire Hull and East Riding Hospital for many years.
- The vacancy rate for allied health professionals was moderate (11%) hospital wide.
- There was no reported use of agency staff in outpatient areas in the last 12 months.
- Within outpatients, staffing levels were based upon a number of factors including the number of patients expected to attend and the number, type and complexity of clinics to be held. However, there was no specific acuity tool used to determine staffing levels.
- Staff and patients we spoke with, as well as our observations confirmed that there was enough staff available to meet patients' needs.
- The hospital had its own bank of staff to call on when needed to cover unexpected absence.

Medical staffing

- Medical staff were employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice in this hospital). At the time of our inspection, over 230 doctors and dentists were working under practicing privileges with Spire Hull and East Riding.
- The hospital reported that consultant contact details are available on a spreadsheet and they must arrange cross-cover when required for their outpatient clinics from a suitably trained colleagues, with practising privileges.

Major incident awareness and training

- There was a hospital major incident policy and staff were aware of contingency plans should major incidents occur. All staff were required to have read the policy and sign to say they had done so.
- As an independent provider, the Spire Hull and East Riding Hospital did not routinely become involved in major incidents external to the organisation.
- Business continuity plans were in place and senior managers operated an on-call rota to ensure availability out of hours.
- Staff were clear how to escalate both clinical and non-clinical incidents of a serious nature.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment was evidence based and staff in the department were competent. There was evidence of multidisciplinary working both internal and external to the hospital.

Outpatients and diagnostic imaging

The outpatient department was open 9am to 9pm Monday to Friday and occasional Saturday mornings. Although the service did not operate a full seven day service, support services such as physiotherapy and radiology were in place 24 hours a day, seven days a week.

The department participated in a number of local and national audits. However, information submitted for the inspection did not always include interpretation, benchmarking or actions for either improving or sustaining performance.

Staff and patients had good access to information and staff gained patient consent before care and treatment was given.

Evidence-based care and treatment

- The majority of the operational policies were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- When a new organisational policy was received, staff and the MAC reviewed the policy and undertook a gap analysis on the policy, and information relevant to the site was added in; nothing was allowed to be removed from the policies. Policies were available in hard paper format on the unit and in electronic format on the intranet.
- We saw staff in the departments were adhering to national guidance and local policies and procedures. Staff were aware of how policies and procedures had an impact on patient care and they had easy access to policies, protocols and other clinical guidance online. Hard copies of documents in regular use were available for staff to refer to.
- Radiology staff had access to local policies and protocols written in accordance with Ionising Radiation (Medical Exposure) Regulations IR(ME)R guidance and requirements. All departmental policies were found to be within review date.
- Outpatients and imaging departments used communication files and signing sheets to cascade new information regarding policies, procedures, and guidance to all staff.
- Findings of audits and inspections were discussed at team meetings so all staff were aware when any changes to practice were required.
- The 2014 national IR(ME)R report was available for radiology staff to refer to and relevant sections and findings of the report had been discussed at the local team meeting.
- Protocols were in place to ensure only authorised, competent staff could order radiological tests.

Pain relief

- Pain relieving medications and local anaesthetics were prescribed for and administered to patients undergoing interventional radiological procedures.
- Patient feedback regarding the pain clinic was very positive.

Patient outcomes

- Physiotherapists measured patient outcomes using the Patient Specific Functional Scale (national tool) to evaluate patient progress and the effectiveness of interventions.
- Physiotherapy had introduced a pre-operative group, which was felt to be beneficial to patients and aid recovery.
- Physiotherapy also undertook documentation audits in relation to outcome information, pain scores, discharge, and whether they were dated, timed and had patient goals set.
- If incidences of post-operative wound infection were detected during follow-up appointments, these were reported to the infection control lead who collated hospital surveillance data.
- The cardiology service was fully compliant with the National Institute for Cardiovascular Outcomes Research audit.
- Patient outcomes relevant to outpatients were monitored through complaints and cancellations, which were included on a clinical scorecard with other quality measurements for other areas. This was submitted to the local commissioners on a quarterly basis and was used to benchmark against other Spire hospitals.
- The radiology manager described the audit systems in place and recognised that there were gaps in the local audit programme. For example, there was no audit of the adapted safer surgery checklist in the department. The new radiology manager had plans to add this to the regular audit programme.
- We saw that outpatient and imaging departments participated in a number of Bupa audits such as the health assessment, compliance audit, MRI audit and

radiology safety audit and we were able to see data that was submitted. Data submitted showed good compliance with the audit indicators. However, there was little analysis and no benchmarking data available.
- It was not always evident that data collected from audits in outpatient areas was analysed for trends or cause and effect or led to improvement action. For example, length of stay was audited by physiotherapy but it was not clear whether the data demonstrated acceptable or improving length of stay or whether initiatives such as the pre-operative therapy group had made any positive impact on length of stay. Audit of sharps containers, although showing good overall compliance with infection control and safe practice, showed no temporary closure in some areas but there were no documented actions to improve practice. We found similar issues in some of the radiology audits such as mammography and quality of discharge x-rays and chest x-rays where interpretation and actions for either improving or sustaining performance was not documented. The new manager was aware of these limitations and was planning to improve how audit results were used and how progress against recommendations was monitored.

Competent staff

- All staff groups working within the outpatient areas had received an appraisal in the last 12 months.
- Managers encouraged staff to undertake professional development.
- Staff told us that induction was thorough and structured. A learning diary was in place for the first four weeks, then monthly e-learning which directed staff to what they needed to know.
- New starters, which included bank staff, were allocated a "buddy" and given time to be orientated to other departments in the hospital. Staff felt this was beneficial and aided understanding of where patients would be referred to for different parts of their care and treatment. This helped staff to know where to refer patients to in a timely manner.
- Staff were expected to read any new policies that were issued and there was a record sheet for staff to sign when this had been actioned. We saw that this policy record sheet was up to date with staff signatures.
- Staff working in the angiography laboratory had received additional training through networking arrangements with a local NHS hospital. Identified training needs were discussed with network colleagues and arrangements were made to access appropriate training when needed.
- HCAs had received further training in suture removal and wound care.
- Staff were booked onto training regarding paediatric phlebotomy during October and November 2015.
- Staff moving and handling competence was assessed by members of the physiotherapy team.
- Consultants working at the hospital were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital). Practising privileges were reviewed every two years.
- The hospital liaised with the Consultants' NHS employers regarding annual appraisal and fitness to practice. The hospital also provided each consultant with a report, which included practice profile information, clinical indicators, serious adverse events and complaints to support their NHS appraisal.
- The hospital had a process in place to assure itself that consultants held current indemnity, GMC registration, had an annual appraisal and to confirm revalidation where necessary.
- There were 21 consultant radiologists working at Spire Hull and East Riding Hospital and of these two appraisals were overdue. One consultant had this booked for September 2015 and the other consultant had informed the hospital managers that IT issues at their NHS trust had resulted in their appraisal being delayed.
- Appraisal rates from Medical Advisory Committee (MAC) minutes March 2015 indicated that 95% of consultants had been appraised with a further 1% being inside the grace period.
- Indemnity results from these minutes showed 87% compliance with providing indemnity documentation to the hospital.
- The medical director for the Spire group was the responsible officer for overseeing medical appraisals and could undertake appraisals for consultants who no longer worked in the NHS.

Multidisciplinary working

- There were good examples of internal and external multidisciplinary team working (MDT). For example,

physiotherapists worked closely with consultants and GPs as well as with other AHPs and nursing staff to ensure patients were provided with individualised treatment plans.
- Radiology staff worked closely with consultants from different specialities to optimise imaging and had good working relationships with staff at the local NHS trust. This ensured staff were kept abreast of changing practices and developments within the local trust and could provide consistency of available investigations and interventions.
- There were good MDT working arrangements with the local trust regarding provision of cardiology, cardiothoracic and oncology services to ensure patients received a streamlined service during their pathway of care, which could cross both providers.
- Internal to the hospital, there was an improvement plan to improve interdepartmental working as a result of the 2014 staff survey. Actions regarding this had included changes to the Heads of Department meeting structure and active involvement of staff from all areas. One focus for the action plan was to improve communications regarding handover and transfer of patient care between departments.

Seven-day services

- General x-ray services were available Monday - Friday 8:30am to 9pm and on a Saturday 8:30am to 1pm to run alongside booked outpatient clinics. On-call services were provided 24 hours, seven days a week for inpatients.
- CT scanning was provided every Tuesday, 8am to 8pm, by a mobile unit and MRI was provided Wednesday-Friday, 8am to 8pm, by a mobile unit.
- Outpatient clinics were accessible at varying times of day and evening up until 9pm and Saturday mornings.
- Physiotherapy services were available 8am to 6pm for outpatients and on-call services were provided 24 hours, seven days a week for inpatients. The department offered flexible appointments for outpatients outside of these times and at weekends if requested.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as x-rays, medical records and physiotherapy records appropriately through electronic and paper records.
- Patients were not routinely copied into correspondence between Spire Consultants and the patient's GP. This was done at the request of the Consultant. Patients were told how they would receive their test results during their consultation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated knowledge and understanding of safeguarding vulnerable adults. They had received adult safeguarding training that had included Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) with some awareness of dementia and people with a learning disability.
- Staff demonstrated a good understanding of informed consent.
- Staff reported if consent could not be safely obtained and/or the patient lacked capacity to consent, they would contact the hospital safeguarding lead for advice. There was a process in place for staff to follow when patients were not able to give consent because of fluctuating capacity.
- We observed that verbal or implied consent was obtained from patients before care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and other physiological signs.
- Seventy five percent of staff had accessed mental capacity act training between January to August 2015.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

We found that outpatient and diagnostic staff were caring. Patients told us they were treated with kindness and compassion and that staff were courteous and respectful. Receptionists were described as excellent and chaperones were made available when needed. Patients felt that confidentiality was excellent.

Outpatients and diagnostic imaging

Services were in place to emotionally support patients. Patients were kept up to date with and involved in discussing and planning their treatment. They were able to make informed decisions about the treatment they received. Patients spoke very highly of the service provided by the pain clinic.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions or treatment.

Compassionate care

- During our inspection we saw patients being treated respectfully by all staff. Staff were wearing name badges and were observed to introduce themselves to patients, politely and professionally.
- Reception staff were observed to provide a warm welcome to patients as they entered the hospital and gave clear instructions and advice in a helpful, caring and compassionate manner.
- We saw patients' privacy was respected and the environment in the outpatient department allowed for confidential conversations.
- Notices offering chaperoning were displayed and staff told us this was provided whenever requested.
- Patients reported that they were treated with respect, that staff on the front desk were very confidential and they were impressed with the manner in which they were treated and that confidentiality was generally maintained.
- All patients we spoke with were satisfied with their care and treatment and told us that the majority of staff were excellent in caring, compassion and maintaining dignity.
- Where patients had experienced problems with treatment or if a mistake had occurred staff had apologised and explained what had happened.
- There were two comment cards received during the inspection regarding poor attitude of consultants and a further two similar comments posted on NHS choices in January and March 2015. It was not possible to determine which site they applied to.
- Feedback relating to the pain clinic in particular was extremely positive both on NHS choices and in comment cards received from patients during the inspection, stating: "Without question the two nurses who run the clinic are worth their weight in gold and manage the clinic in the most professional way and always put the patients first. They are a credit to the Spire and not only run the clinic but also co-ordinate the background staff for the support services and ongoing appointments."
- There were two patients who completed CQCs comment cards who were unhappy about waiting times in the outpatients department.
- Other patients left positive comments regarding the care and efficiency of outpatient and radiology staff and the quality of care and efficiency of oncology staff.

Understanding and involvement of patients and those close to them

- We observed staff spending time explaining procedures to patients using both verbal and written information. Patients were given time to ask questions and these were answered in a way they could understand.
- Patients and their representatives told us they were involved in decision making where appropriate.
- Patients were satisfied with the information they received about their appointment, what to expect and requirements regarding tests and procedures.

Emotional support

- All but one patient we spoke with felt they had been given appropriate emotional and psychological support.
- A member of the nursing team was made available to accompany a consultant when breaking bad news to patients and was then also available to provide support and answer questions from the patient and relatives until the patient left the hospital.
- A specialist nurse offered support to patients undergoing cosmetic surgery.
- Chaperones were available for patients when required and notes were stamped and signed with the chaperone's details.
- We spoke to two staff involved in booking appointments and one secretary. Two of these staff told us that they had not received any training on supporting distressed patients/managing difficult telephone contacts. One staff member told us they had this type of training but a long time ago.
- We were unable to locate any policies for staff on how to support distressed patients or manage difficult telephone contacts. None of the three staff we spoke to were aware of any guidance on signposting patients to other organisations, such as the Samaritans.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

We found that outpatient services were responsive to the needs of patients. Patients were able to be seen quickly for urgent appointments if required and departments offered flexibility around clinic times. Clinics were only rarely cancelled at short notice and patients were given new appointments quickly if this happened. Waiting times for appointments were well within target timescales.

Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those whose first language was not English. Although the hospital did not treat many patients with complex needs such as those living with dementia ora learning disability or physical disability, there were mechanisms for obtaining specialist advice and support when needed and reasonable adjustments could be made.

Systems were in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- Service planning was observed to be responsive to the needs of local people and supported delivery of services offered by the local NHS trust.
- For example, the hospital had expanded service provision in pain management, dermatology and pathology where the local trust was struggling to meet local demand for services and meet acceptable reporting times.
- CT and MRI services were able to offer additional weekend or evening lists if demand increased and if waits were likely to exceed six weeks.
- There were business plans in place to extend outpatient and radiology services through development of a nearby site, which would allow for provision of static MRI and CT services and enable better use of space within the hospital outpatient department. Business plans also included an increase of car parking spaces, which was often an issue for patients.

Access and flow

- The hospital accepted referrals for children and adults from a large catchment area. Private and NHS patients were referred to the Spire consultants by GPs.
- Systems of electronic referrals using “choose and book” and paper faxed referrals were in place.
- Referrals were screened and triaged by the outpatient manager and department sister as to suitability for treatment at the Spire Hull and East Riding Hospital. There were a number of exclusion criteria used to assess the suitability of patients. The relevant consultants made the final decision regarding whether it was appropriate to see and treat a patient at the Spire Hull and East Riding Hospital.
- If a patient was deemed too high risk to have surgery at the Spire Hull and East Riding, the hospital would arrange an “inter-provider transfer” to the consultant in an NHS hospital to avoid the patient needing to go through the referral system again.
- Most of the patients attending outpatients departments were NHS funded. Between April 2014 to March 2015, around 10,000 NHS patients were seen for first attendance. There was a further 20,000 follow up appointments during this time attended by NHS patients.
- Activity for other funded patients was around 7,000 first appointments and 8,000 follow up appointments.
- A total of 44,714 appointments were attended between April 2014 to March 2015.
- Referral to treatment (RTT) target data for the reporting period April 2014 to March 2015 showed that the provider had exceeded the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral. The data showed that 100% of patients had begun treatment within the target range between July 2014 to March 2015.
- One patient we spoke to had only waited 1 week for an appointment, another reported they had waited 5-6 weeks and was happy with this.
- Although diagnostic imaging waiting times varied between modalities, the Spire Hull and East Riding was 100% compliant with the six week wait target and all patients between January 2015 to March 2015 had received their test within three weeks.
- Patients waiting for an MRI scan may have to wait for 2-6 weeks. Patients waiting for CT usually waited for up to two weeks.

Outpatients and diagnostic imaging

- On average, from referral to scan, MRI patients waited seven days and the average reporting time was 96 hours.
- The radiology clinics were planned to include capacity to see urgent patients. Appointments were reviewed on a daily basis and vacant slots and cancellations were proactively managed to ensure these were filled wherever possible. This included contacting waiting patients to offer short notice appointments or to bring appointments forward, if necessary to fill capacity.
- Patients wanting cosmetic surgery could self-refer and there was a system in place to contact the patient's GP to determine whether there were any contraindications for the treatment requested, prior to treatment commencement.
- Physiotherapy mainly received referrals from GPs, however patients could self-refer.
- Patients who did not attend (DNA) the hospital for an outpatient appointment were sent a consultant letter offering a second appointment. If NHS patients did not attend on a second occasion, they were removed from the consultants' list and the patient and their GP were informed of this by letter. Private patients were offered a third appointment before being removed from the consultants' list.
- The hospital did not collect information regarding DNA rates.
- We were told that the hospital rarely cancelled clinics and if this did occur it was usually due to unavailability of consultant. Patients were contacted by telephone to tell them of the cancellation and their appointment was rescheduled as soon as possible.
- Consultants were flexible and available to hold extra clinics when required.
- Four patients we spoke to had appointments cancelled / rearranged at one time or another but could not recall being given an explanation of why the appointment had been rearranged. One patient's appointments had been rearranged three times. The patients we spoke to were not given a choice of appointments: they had been informed by letter or telephone when their new appointment would be.
- Numbers of cancelled clinics, reasons why and timing of rescheduled appointments was not systematically monitored. If it was noted that a particular consultant was regularly cancelling clinics this would be brought to the attention of the outpatient department manager who would discuss this with the consultant concerned and escalate if further action was required.
- Waiting times within departments was not routinely collected or audited, however we were told that in radiology all patients were seen within 15 minutes of their arrival at the imaging desk. In outpatients, the average waiting time for patients was reported to be 15-30 minutes.
- There were notices in the reception area to inform patients that if they had been waiting 15 minutes or more for their appointment, they should speak to reception and enquire about the delay.
- Most patients felt they were seen in a timely manner once they had arrived at the hospital even when they had to attend different areas for investigations and tests.
- If patients needed to see more than one consultant or health professional this was arranged to all take place at the same visit.

Meeting people's individual needs

- There was a clear process to identify patients who needed an interpreter. Patients requiring an interpreter were identified at booking and translation services were arranged in advance to ensure interpreters were present for outpatient appointments and diagnostic imaging tests.
- Written information leaflets including the complaints leaflet could be made available in several different languages if required.
- The hospital accommodated patients with a learning disability and mild dementia. The need for reasonable adjustments was determined at first outpatient appointment.
- There was a hospital lead for safeguarding and dementia to provide support to patients and staff when needed.
- When patients required follow-up appointments or investigations they were informed during their consultation. Appointments were made at reception before leaving the hospital. When patients were awaiting test results, the consultant would advise how these results could be accessed.
- NHS patients needed to arrange their own transport to and from appointments, or through their GP if they required the assistance of a patient transfer service or ambulance service. It was noted by a member of the

clinical appointments team that they did not provide NHS patients with any information about accessing patient transport services with their appointment confirmation letter.
- Patients told us that local parking was difficult and caused some anxiety regarding attending appointments and potentially receiving a parking ticket. Some patients had travelled a long distance to attend and were unfamiliar with any alternative parking. Information on car parking was not provided to patients with the appointment confirmation letter.
- For cosmetic surgery, free mini consultations were offered and all patients were given a cooling-off period.
- There was a specialist nurse available to support patients undergoing cosmetic surgery.
- X-ray staff had identified a need for a dedicated toilet to improve the privacy and dignity of patients undergoing abdominal ultrasound examinations and had put this into place.
- Patients had access to tea and coffee and water while waiting in the outpatient and diagnostic areas.

Learning from complaints and concerns

- The hospital aimed to respond to patients complaints within 20 working days of receipt. Over the previous 18 months, 70% of complaints had been responded to within this period. Complexity of the complaint and investigation was the primary reason for responses exceeding this period. Patients were informed by letter if the time scale was likely to be longer than 20 days. For quarters one and two of 2015 the percentage of complaints responded to within the policy timescales was at 93% and none had been escalated to stage two.
- Complaints were investigated by the Matron who involved and collated information from the other members of the team involved in the patient's treatment.
- Patients we spoke to did not know how to raise a complaint or concern, but felt able to talk to staff about any issues if they arose.
- Multi-language complaints information posters were displayed in the reception areas. The poster provided information about how to make a complaint.
- There were "Please Talk to Us" leaflets available for patients to take away which informed patients how to complain if needed.
- Physiotherapy comment cards were available in reception for patients to leave feedback for that service.
- Complaints were discussed at the customer care committee, which included staff from all areas to facilitate shared learning. The committee identified themes and trends, developed and implemented actions and cascaded information and learning to the clinical areas.
- Two of the themes identified were length of appointments and staff attitude. Complaints regarding staff attitude resulted in staff undergoing reflective exercises to improve displayed behaviours and communication skills. Complaints regarding short appointment times had resulted in longer appointments being offered in some specialities.
- The hospital had introduced a quarterly customer feedback update to further raise awareness among staff regarding complaints received and remedial actions undertaken.
- The outpatient manager told us that learning in the department is shared with the team in a number of ways. There was a communication folder in the department that staff could review and memos were displayed on a notice board. In addition, there were monthly team meetings, which were minuted.
- One to one discussions with staff took place to share learning, where appropriate.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

We found that the outpatient and diagnostic services at Hull and East Riding Hospital were well-led. Staff and managers had a vision for the future of their services and were aware of the risks and challenges faced by the departments. There were clear governance arrangements in place and staff felt empowered to express their opinions or concerns and felt they were listened to. Risk registers were in place and risk assessments were regularly reviewed.

There was an open, supportive culture and managers encouraged learning and development. Staff were engaged

with the organisation's mission to deliver the highest quality patient care and patients were given opportunities to provide feedback about their experiences of the services provided.

Managers made good use of opportunities to develop innovative and sustainable services.

Vision, strategy, innovation and sustainability and strategy for this this core service

- Staff were aware of the Spire vision and clearly wanted to be part of "…delivering the highest quality patient care".
- Organisational expected behaviours and competence were integral to staff performance, development and appraisal.
- Managers received information and training regarding business plans and had the support of a financial officer.
- Staff were aware of the vision and business plans to extend and improve outpatient and diagnostic services and told us they felt positive and engaged with these developments.
- Staff told us they were encouraged to propose innovative ideas for service developments and or to improve patient experience. Radiology gave us an example of how they had improved patient experience and dignity by re-allocating use of toilets in their clinical area.

Governance, risk management and quality measurement for this core service

- Staff were aware of governance arrangements and feedback from governance and management meetings was given at team meetings. All staff had access to the minutes of meetings.
- Incidents, complaints and potential items for the risk register were discussed at Heads of Departments and operational team meetings.
- Incident and complaint data was also reported to the clinical governance committee.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints at team meetings where audits and quality improvement were also discussed.
- Spire Hull and East Riding Hospital had systems in place to escalate issues to its parent company when necessary.
- The hospital had risk registers in place for business and clinical risks and managers updated these when necessary. Managers were aware of the risks within their departments and were managing them appropriately.
- Not all local risks for radiology were on the central risk register, however there was documentation demonstrating risk assessments had taken place in the department and mitigating actions were implemented.
- Spire Hull & East Riding hospital have a scheduled radiation protection committee meeting annually which last met in March 2015. There were some actions outstanding from this meeting, but it was not clear when actions were due by or how these would be followed up in the interim before the next meeting.
- There were policies and processes in place to ensure the competence of clinical staff and we were given examples of when these had been used to address concerns regarding consultants' practice.
- There were processes in place to both monitor and provide consultants with statistical quality information regarding their practice. This enabled any trends, concerns or areas for improvement to be identified and acted on.
- There were examples of actions taken to improve services when quality issues had arisen. For example, increasing turnaround times for pathology results from the local trust had led to moving some diagnostic tests to a second provider to ensure results were received in a timely manner. However, there were no formal performance targets regarding turnaround times and it was unclear how quality and timeliness of pathology results was assured.
- There were no formal reporting target expectations in diagnostic imaging. However, radiologists tried to ensure that diagnostic images were reported before the patient's next appointment. Reporting could be delayed as the responsible radiologist was not always on-site. If needed a radiographer or another consultant could request the radiologist on-site to assess the images. We were told that there was always a radiologist on-site during normal working hours.
- Registration status had been verified for 100% of staff in outpatients and diagnostic imaging.

Leadership

Outpatients and diagnostic imaging

- We found there were clear lines of management responsibility and accountability within the outpatients and diagnostic imaging services. Staff had clear roles and responsibilities and knew what their duties would entail on each shift.
- Staff in all areas stated they were well supported by their managers who were visible and accessible. The matron and hospital director did weekly rounds of the hospital.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes.
- Staff told us they would be confident to raise a concern with their managers and that this would be investigated appropriately.
- Staff told us that they felt they were listened to and engaged in the organisation.
- Staff felt managers were interested in their work and encouraged them to express ideas for service development.
- Service leaders had access to leadership courses and the physiotherapy manager was undertaking this training.
- There was a hospital leadership team, which included heads of outpatients, radiology and physiotherapy.
- We saw evidence that the hospital management team and department leads were undertaking a number of improvement actions following the results of the staff's "Patient Safety Survey" 2014. Some of the actions included: increasing radiographer bank numbers to help with weekend workload, creating an administration bank of staff, and introducing communications books. Staff were being encouraged to work with other departments to improve communications and improve transfers of care. Staff told us that they were encouraged to challenge others regarding any concerns about practice or decisions. They told us managers were supportive of this and had an open door policy.
- We saw the minutes of meetings that documented discussions and updates given to staff regarding progress against this action plan.

Culture within the service

- Staff and managers told us the outpatient and diagnostic imaging departments had an open culture.
- Staff felt they could report concerns and incidents and felt that these would be investigated fairly.
- Posters in the staffroom advised how members of staff could raise any concerns they may have regarding the care and treatment provided at the hospital. There was access to a whistleblowing hotline outlining confidentiality and support available should a staff member have concerns.
- They told us managers were open to comments and suggestions for improvements from staff and staff were encouraged to seek feedback from patients and take immediate action when issues or concerns arose.
- Managers and staff told us that they felt well supported by the organisation.
- A positive culture was evident within outpatients and diagnostic imaging as shown by low sickness levels, low staff turnover and length of staff service.
- The appraisal system "Enabling Excellence" was underpinned by Spire's behaviours and helped ensure that patient experience and customer service were top priorities for all staff. There was evidence of performance improvement plans being used where behavioural issues were identified.
- Criteria used during the recruitment process included expected behaviours as well as competence to help ensure staff were recruited who supported the organisations cultural values.
- All of the staff we spoke with were proud to work for Spire Hull and East Riding Hospital.

Public and staff engagement

- During the inspection we saw good examples of public and staff engagement. For example, when the pain management service was taken over from the local trust the hospital staff had met with a group of patients who were concerned that the service did not meet the standard they had previously experienced. The forum allowed the public to express their concerns and the hospital staff were able to find ways to overcome the problems experienced. The running of the clinic was improved and feedback from patients was extremely positive.
- 'You said we did' boards were visible to patients to demonstrate what actions the hospital and its staff had taken in response to their feedback.
- Other public engagement activities had included a fundraising golf tournament and support for national men's health awareness week, when a consultant provided online question and answer information.

- Staff felt confident that they would be involved in planning activities for service developments and managers welcomed the diversity of ideas from staff across the different disciplines.
- A HCA in the diagnostic imaging department told us that they had suggested that a recent full time HCA vacancy be filled as a job share and management adopted this suggestion. The same HCA reported that their team supported each other "no questions asked".
- Other staff told us that work life balance was respected and that the investment in their training made them feel valued.
- We saw an example of talent management and initiatives to retain staff in the provision of training and development of a member of staff who had changed her role from an administrative position to that of a HCA.
- The hospital management used regular team briefs, which included special thanks from patients to staff and recognition from other staff of individual good work.Staff reported that team briefings were informative and worthwhile.
- Spire HealthCare undertook an annual staff and consultant survey and also surveyed patients from all services annually. Results were given back to the Spire hospitals and clinics to act upon the findings for their site. An action plan had been developed from the 2014 survey and progress was discussed at management and staff meetings.

Innovation, improvement and sustainability

- Staff were encouraged to suggest ways to make departments run more effectively and efficiently and we saw examples of where staff had made small changes, which made a big difference to patients.
- We saw that the management team actively engaged in talent management, proactive recruitment and promoted retention of staff. Some staff incentives included an annual wellness check-up, subsidised meals and drinks, free parking and birthday vouchers.
- It was evident in the acquisition of a number of outpatient services form the local trust and commissioning agreements that the management team actively sought opportunities to improve and sustain the services provided at Hull and East Riding Spire hospital.
- The development of a new site had been identified as necessary to address increasing space constraints and also to improve and extend services in response to increased demand. Business and project plans were in place regarding this and demonstrated good use of opportunity.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

1. The hospital must ensure compliance with the 'five steps to safer surgery' procedures and World health organisation audit, specifically for interventional radiology.
2. The hospital must ensure that infection prevention and control policies and procedures are in place and audited specifically in relation to observational audits for hand hygiene, and theatre dress codes.
3. The hospital must ensure that there is robust and effective root cause analysis following a serious incident and to share any learning across all services.
4. The hospital must take action to ensure that the appropriate checks and records as per HR policies are in place and recorded for the doctors working at the hospital including Disclosure and Barring Service (DBS) checks, mandatory training and appraisals.
5. The hospital must ensure that the bed spaces and facilities in the critical care unit fully comply with current Department of Health building note 04-02 for Critical Care Units published in March 2013 and Health Building Note 00-09: Infection control in the built environment (March 2013).
6. The hospital must ensure that care pathway documentation in critical care is updated to reflect current evidence research based best practice.
7. The hospital must ensure that Midazolam and oxygen are correctly prescribed on a medication chart and signed post administration and that that all CD entries into the CD medicine book are dated within the endoscopy unit.

Action the hospital SHOULD take to improve

1. The hospital should take action to monitor cancellation of clinics.
2. The hospital should action to monitor reporting in radiology and pathology to ensure acceptable and consistent reporting times are achieved.
3. The hospital should review how patient outcome and audit systems are implemented, interpreted and used to improve, sustain good practice and support innovation.
4. The hospital should ensure all disciplines fully complete and sign the patient record.
5. The hospital should ensure there is a vision, strategy and leadership structures in place for each service and that all staff are aware it.
6. The hospital should ensure that risks are addressed in a timely manner and the risk register and the register reflects the closure of risk and any communicated policy or procedure to mitigate the risk.
7. The hospital should ensure that the timings of theatre lists were agreed to avoid patients unnecessarily fasting for an excessive number of hours.
8. The hospital should ensure there continues to be sufficient numbers of suitably qualified paediatric-trained staff available to meet the needs of children and young people using the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met: care was not always provided in a safe way as policies and guidelines were not all compliant with national guidance within critical care; and the management of medicines required improvement.** **The hospital must:** • ensure that care pathway documentation in critical care is updated to reflect current evidence research based best practice. Reg 12(1) • ensure that Midazolam and oxygen are correctly prescribed on a medication chart and signed post administration and that that all CD entries into the CD medicine book are dated within the endoscopy unit. Reg 12(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not met: the critical care unit was not suitable for the purpose for which it was used and did not comply with national building standards including infection control.** **The hospital must:** • ensure that the bed spaces and facilities in the critical care unit fully comply with Department of Health

This section is primarily information for the provider

Requirement notices

building note 04-02 for Critical Care Units published in March 2013 and Health Building Note 00-09: Infection control in the built environment (March 2013). Reg 15(1)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met: The providers' systems were not operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.** **The hospital must take action to:** • ensure that the appropriate checks and records, as per HR policies, are in place and recorded primarily for the doctors working at the clinic including Disclosure and Barring Service (DBS) checks, mandatory training and appraisals. Reg 17 (2)(b) • ensure that there is robust and effective root cause analysis following a serious incident and to share any learning across all services. Reg 17(2)(b) • ensure compliance with the five steps for safer surgery is consistently applied within interventional radiology and this practice is audited. Reg 17(2)(a) • ensure that hand hygiene is audited and monitored along with theatre dress code. Reg 17(2)(a)