Spire Cheshire Hospital

Quality Report

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Date of inspection visit: 18, 19, 28 October 2016.
Date of publication: 17/05/2017

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Cheshire Hospital is operated by Spire Healthcare plc. The hospital has 50 beds which could be occupied by inpatients or day-case patients. Facilities on site included three operating theatres, a five bedded recovery unit, a two bedded Extended Recovery Unit (ERU), an Endoscopy unit and X-ray, computerised tomography (CT) scanner, a magnetic resonance imaging (MRI) scanner, outpatient and diagnostic facilities. The hospital provides surgery, and outpatients and diagnostic imaging for adults, children and young people from birth to aged 17 years. We inspected surgery and outpatients and diagnostic imaging but looked at the care provided to children and young people within each core service.

We inspected this service as part of our national programme to inspect and rate all independent hospitals, using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18th and 19th October 2016, along with an unannounced visit to the hospital on 28th October 2016. We rated both core services and the hospital overall as 'Outstanding'.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated this hospital as 'Outstanding' overall because:

- There were effective and comprehensive systems in place to monitor, highlight and learn from incidents, to help to keep patients safe and to minimise the risk to patients. All staff were knowledgeable and engaged with the process to learn from incidents, the process was robust, effective and integrated into working practices.
- The environment across the hospital was visibly clean and well maintained, there were efficient infection control and prevention measures in place and the hospital had low levels of healthcare related infections.
- Effective systems and monitoring were in place for the administration, usage and storage of medicines, controlled drugs and pharmacy items.
- There were appropriate numbers of skilled, experienced and qualified staff (including doctors, nurses and allied health professionals) to meet patients' need. Arrangements were in place to ensure staff undertook annual mandatory training and had annual performance appraisal and reviews.
- The service actively ensured the nutritional and hydration needs of the patients were met. The hospitality services provided an extensive choice of quality nutritional options tailor made to meet patients' needs and preferences. The services went the extra mile to ensure patients' needs were met and patients were exceptionally pleased with the service and the way this was delivered.
- Care and treatment was aligned to national evidence based guidance and best practice. The hospital continually reviewed their service delivery against national policies and ensured they were consistent with the required standards.
- Patient outcomes were positive and exceeded benchmarks for similar services. The hospital measured their performance against a number of measures and used this information to identify how they could improve.
- Staff were aware of and adhered to legal requirements for obtaining consent.
- The individual needs of patients were recognised and accommodated including those in vulnerable circumstances such as those living with dementia, mental health concerns and learning disabilities. The needs of carers were also considered and planned for within the holistic assessment process.
- Care and treatment was accessible and flexible and patient choice was respected.
- The patients were cared for with kindness and compassion, their privacy and dignity were maintained at all times and staff were attentive and responsive to their holistic needs.

Summary of findings

- The hospital championed a proactive approach to raising standards and seeking improvements, they engaged with the public, community groups and staff to solicit ideas and canvass opinion, responding to feedback and individual needs by acting upon areas highlighted and implementing initiatives to promote satisfaction and increase their responsiveness.
- The hospital was managed by a visible, competent and enthusiastic team who placed patient care as central to their success. The team inspired and motivated staff and promoted a collective ethos of patient care and improving standards. Staff were committed and motivated and demonstrated ambition to achieve high standards, which led to a professional, efficient and caring service.
- Quality measurement and improvement was assisted by effective and well organised management and governance structures at a local level. Managers were not only aware of the risks and challenges they needed to address, but were dynamic in identifying areas for improvement and actively implementing quality advances.

In surgery, we found the service 'outstanding' overall. This was because;

- Staff had adopted a flexible approach to working during times of high demand, with staff working together with a strong team ethos.
- There was a tangible and positive person centred ethos, staff respected the holistic needs of the patients and were extremely motivated and proud to deliver care that was of high quality and effective. There were positive and respectful rapport between those using the service and those providing it. Staff did all in their power to deliver a caring and responsive service to all patients.
- The hospital had built a new endoscopy suite in response to the needs of patients, this improved both the availability of services and the environment in which they were delivered.
- Patients were offered flexibility in their access to treatment, in response to local demand, operating theatres provided surgery services to patients seven days a week. Patients could choose an appointment to suit their personal circumstances.
- Theatre lists were planned around patient's needs, for example, patients with dementia or a learning disability could be placed on the beginning of the theatre list to reduce the amount of time they needed to spend at the hospital thus reducing any anxiety.
- The hospital had consistently good referral to treatment times for NHS patients, on average from July 2015 to June 2016, 95% of patients were treated within 18 weeks of being referred for treatment.
- Anticipatory discharge planning took place at the pre-operative assessment stage to ensure there were no impediments in meeting the needs of patients with complex needs.

In outpatients and diagnostics we found the service 'outstanding' overall. This was because;

- The hospital consistently exceeded performance targets around referral to treatment times for National Health Service (NHS) patients. Appointments were flexible and the needs of NHS patients were accommodated.
- Private patients and self-paying patients could often secure appointments within a few days and were provided with flexibility and options to suit their individual needs.
- No patients waited longer than six weeks for Magnetic Resonance imaging (MRI), Computerised Tomography (CT) or ultrasound scanning. The average time it took to report the result of diagnostic imaging was 1.7days.
- All patients received comprehensive instructions and information with their appointment letters and we observed information packs containing additional useful information.
- The environment was pleasant, suitable and appropriate, waiting areas had sufficient seating available with access to toilets, baby changing facilities and refreshments. Newspapers and free car parking were available.
- The individual needs of patients were accommodated and staff went out of their way to ensure that they understood and accommodated patients' differing requirements.
- Staff were aware of the hospitals' values of delivering high quality clinical care supported by a customer focused service model and felt connected to the wider Spire network through management feedback and the sharing of information and good practice.

Summary of findings

- Managers, clinical leads, matron and the hospital director were visible and approachable. They inspired a cohesive, collaborative and focused workforce with a shared sense of purpose. Staff felt motivated, happy and proud of their work and their achievements. Staff received positive feedback and recognition for their work.
- There was a systematic, logical and comprehensive approach to departmental, clinical and hospital governance. There were joined up committee meetings which worked together to monitor, identify and respond to risks, incidents and key issues. Quality and performance were monitored through the Clinical Scorecard and Key Performance Indicators.
- Radiation Safety Committee meetings were held annually to ensure that clinical radiation procedures and supporting activities in the hospital were undertaken in compliance with ionising and non-ionising radiation legislation.
- The views of patients were actively sought within outpatients and diagnostic imaging using the NHS Friends and Family Test, patient satisfaction surveys and patient feedback initiatives. A child friendly feedback form was also available. A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future service users.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached. Details are 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	Summary of each main service
Surgery	**Outstanding** ☆	Improvements and learning took place through the review of reported incidents. We saw improvements made to the decontamination of endoscopy equipment and longer oxygen tubing was attached to all oxygen points following reported incidents. Infection control procedures kept patients safe from healthcare acquired infection, we observed equipment cleaned after use by patients, and good hand hygiene throughout the theatre and inpatient areas. There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile, for the period July 2015 to June 2016. Emergency equipment was readily available and safety checks were completed. Mandatory training was well attended by theatre and inpatient staff and consistently met the hospital target for compliance. Care and treatment was planned and delivered in line with current evidence-based guidance, standards, and best practise legislation. Adherence to evidence-based practice was monitored as part of the annual audit plan to ensure a consistent approach to care using clinical scorecard and key performance indicators. Patients were monitored to detect any deterioration in their condition and systems were in place to escalate any concerns in a timely manner. We saw action had been taken when a patient had deteriorated the day before our inspection. The Registered Medical Officer reviewed the patient and called the consultant who was on site within 30 minutes and the patient review had been documented within 45 minutes of the consultant being initially contacted. There were service level agreements in place should a patient require transfer to a NHS acute hospital. Appropriate staffing levels were reviewed at the weekly planning meeting and patients with additional requirements such as children, vulnerable adults or those with complex care needs were highlighted and included in the planning. There had been no unfilled shifts from April 2016 to June 2016.

Summary of findings

There was a strong visible person-centred culture within the theatre and inpatient departments. Staff were motivated to offer care that was kind and compassionate. We observed this at the time of our inspection in the way that staff spoke with patients and their carers and feedback that patients gave us at the time of our inspection.
The hospital had introduced the role of a Patient Services Manager who visited patients daily to ensure they were satisfied with services they were receiving. Nine patients we asked told us they had been visited by the Patient Services Manager.
Friends and Family test results for the period August 2015 to August 2016 identified that for 11 months 98-100% (with one month recorded as 96%) of patients would recommend the services they received at the hospital to friends and family if they required the same service. A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future service users.
Theatre lists were planned around patient's needs, for example, patients with dementia or a learning disability could be placed on the beginning of the theatre list to reduce the amount of time they needed to spend at the hospital thus reducing any anxiety.
The hospital had consistently achieved 91-100% for patients being seen within 18 weeks of referral for the 12 month period from July 2015 to July 2016.
Staff felt supported by their local managers, clinical leads, the matron and the hospital director and were comfortable to raise any concerns
Governance was well managed through a variety of meetings held at senior manager and team level. Managers and staff were aware of risks and actions were in place to mitigate risks. Quality and performance were monitored through the clinical scorecard and key performance Indicators.

Outpatients and diagnostic imaging

Outstanding ☆

All of the clinical areas we visited were visibly clean and tidy and completed cleaning checklists were observed.
Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Hand gel was readily available in all clinical areas and we observed staff using it.

Summary of findings

Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
Outpatients and diagnostic imaging staff met the hospital target for compliance with mandatory training.
Care and treatment was delivered in line with evidence-based practice and patient pathways were in place for a wide range of treatments.
An audit programme was in progress assessing compliance in relation to a number of activities including the World Health Organisation (WHO) checklist, patient care pathways and hand hygiene.
A planning meeting was held weekly and attended by senior representatives from each hospital department. This ensured appropriate staffing levels and allowed identification and forward planning for patients with additional requirements such as children, vulnerable adults or those with complex care needs.
Staff valued the ability to give patients time in all interactions and patients we spoke with confirmed how much they appreciated this.
The NHS Friends and Family Test, which assesses whether patients would recommend a service to their friends and family showed that between April 2016 and June 2016 over 99% of NHS patients would recommend the hospital.
Patients had a choice of appointment date and time and clinics were held in the evenings and at weekends for the convenience of patients.
Between July 2015 and June 2016 the hospital consistently exceeded the target of 92% of National Health Service (NHS) patients on incomplete pathways waiting 18 weeks or less from time of referral.
Staff told us they felt supported by their local managers and that managers, clinical leads, matron and the hospital director were visible and approachable.
Clinical governance committee meetings took place quarterly to discuss risks, incidents and key issues and quality and performance were monitored through the Clinical Scorecard and Key Performance Indicators.
A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future service users.

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Outstanding ☆

Spire Cheshire Hospital

Services we looked at: Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Spire Cheshire Hospital

Spire Cheshire Hospital is a private hospital located in Warrington, Cheshire. It is operated by Spire Healthcare Ltd., which is the second largest provider of private healthcare in the United Kingdom. The hospital opened in 1988 and primarily serves the communities of the Cheshire, Merseyside and Manchester but also accepts patient referrals from outside this area.

The registered manager designate is Verlie Brazel who had been in post since 5 November 2013. The provider's nominated individual for this service is Jean Jacques De Gorter. The controlled Drug Accountable Officer was Verlie Brazel.

The hospital has one ward and is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder, or injury

We previously inspected this service in 2013 under the previous methodology and found the service to be compliant.

We carried out the announced part of the inspection on 18th and 19th October 2016, along with an unannounced visit to the hospital on 28th October 2016.

Our inspection team

Our inspection team was led by Amanda Lear, lead inspector with the Care Quality Commission (CQC). The team included CQC inspectors and specialist advisors with expertise in radiography, operating theatres management, general nursing and healthcare governance.

Why we carried out this inspection

We inspected this service as part of our national programme to inspect and rate all independent hospitals, using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18th and 19th October 2016, along with an unannounced visit to the hospital on 28th October 2016. We rated both core services and the hospital overall as 'Outstanding'.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We inspected two core services at the hospital, which were outpatient and diagnostic services and surgery services. The hospital provided care and treatment for children and young people and this was examined within each of the core services. We inspected the ward areas, which comprised of 37 inpatient beds, comprising of 33 single rooms, one two bedded bay, two 'extended recovery' beds in a two bedded bay and 9 day-case beds. These rooms were predominantly used for post-operative surgical patients and could accommodate either sex of patient. We inspected the theatres suite which included three operating theatres, two with laminar flow and the patient recovery area. The endoscopy suite and the

Summary of this inspection

physiotherapy suite, which comprised of three treatment rooms and a gym. The outpatients department, which comprised of 16 consultation rooms, the radiology and diagnostics department, which housed a 64 slice computerised tomography (CT) scanner, Magnetic resonance imaging (MRI) scanner, digital mammography, ultrasound and a general X-Ray machine. We also inspected the reception and patient waiting areas.

We reviewed a wide range of data and documents provided by the hospital and analysed data we had collected. This included policies, minutes of meetings, staff records and results of surveys and audits. We requested information from the local clinical commissioning group and other stakeholders. We placed comment boxes at the hospital before our inspection, which enabled staff and patients to provide us with their views.

We carried out an announced inspection between 18 and 19 October 2016 and an unannounced visit on 28 October 2016. We spoke to staff and asked then for their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee. We spoke with a wide range of staff, including nurses, doctors, radiographers and administrative and support staff, totalling 64 personnel. We also spoke with 36 patients and relatives who were using the hospital. We observed care in the outpatient and imaging departments, in operating theatres and on the wards, and we reviewed 46 patient records. We visited all the clinical areas at the hospital.

Information about Spire Cheshire Hospital

In the reporting period, which covered July 2015 to June 2016, there were 7,566 inpatient and day-case episodes of care recorded at Spire Cheshire Hospital; of these 43% were NHS-funded and 57% were insurance and self-pay funded. 25% of all NHS funded patients and 30% of all other funded patients stayed overnight at the hospital during the same reporting period. There were 57,761 outpatient total attendances between July 2015 to June 2016; of these 32% were NHS funded and 68% insurance and self-pay funded. The hospital recorded 2,046 episodes of care between July 2015 and June 2016. For the age group birth to two years, there were no inpatients or day cases, there were 122 episodes in outpatients and diagnostics. For the age group 3 to 15 years there were seven inpatients, 112 day cases and 1,311 episodes in outpatient and diagnostics. For the age group 16 to 17 years, there were 10 inpatients, 32 day cases and 452 episodes in outpatient and diagnostics.

From July 2015 to June 2016, the most common surgical procedures performed were knee surgery (1120), upper and lower gastroscopy (1151), spinal surgery (564), urological surgery (536), ear, nose and throat surgery (454), general surgery (453), cosmetic surgery (332), gynaecological surgery (292), ophthalmology surgery (287) and dermatological surgery (241).

There were 180 doctors with practising privileges at the hospital, 51 doctors (28%) carried out over 100 procedures between July 2015 and Jun 2016. 54 doctors (30%) did not carry out any procedures during the same period. At 1 July 2016, there were 52 registered nurses employed, 33 operating department practitioners and health care assistants and 144 support staff, including administrative staff.

Staff turnover in theatres was 0%, on the wards was around 13% overall and in outpatients was 25% for registered nurses but zero for health care assistants, this was sometimes better and sometimes worse than similar providers we hold data for. Sickness rates were variable but on the whole were lower than other similar providers we hold data for. There were low staff vacancy levels for most staff, zero vacancies for all grades in theatres and outpatients and 4% to 9% in the inpatient wards. These were lower than rates seen in similar organisations we have data for.

During the reporting period, we did not receive any direct complaints or whistle-blowing contacts. The hospital received 79 complaints, which is similar to the previous year. During the reporting period, there were no never events at the hospital. Never events are serious incidents requiring investigation, (serious incidents that are wholly

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preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers).

There were 181 clinical incidents during the reporting period. 110 of these resulted in no harm, 30 in low harm, 38 in moderate harm, five in severe harm and two in death. The overall rate of clinical incidents (per 100 inpatient discharges) was lower than other similar providers we hold data for.

No safeguarding concerns had been reported since during the period July 2015 to June 2015. An incident was reported in August 2016 and this was referred to the relevant organisation and dealt with appropriately.

During the reporting period July 2015 to June 2015, there were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA). There were no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA). The were no incidences of hospital acquired Clostridium difficile (c.diff) and there were no incidences of hospital acquired E-Coli.

79 complaints were received by the hospital during the period July 2015 to June 2016. We reviewed a sample and found them to have been dealt with in the appropriate manner and timescales.

Spire Cheshire had on site sterile services which had received SGS accreditation for the sterile services department on 13 April 2016. The hospital was awaiting confirmation of Joint Advisory Group on GI endoscopy (JAGS) accreditation for their endoscopy service. The hospital had various service level agreements in place including those for transfer of patients to acute and emergency care, resident medical officer (RMO) provision, and interpreting services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:·

- There was a positive culture of openness in the reporting of incidents. They were investigated robustly, trends and contributing factors were examined and learning opportunities were highlighted. Positive and practical improvements were implemented to prevent similar occurrences. Staff were given information about outcomes and learning in order to improve safety and quality going forward.
- Patients were protected against healthcare acquired infection. We saw evidence that equipment was cleaned when used on each patient to prevent the risk of cross infection and staff adhered to good hand hygiene procedures. There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile or Escherichia coli, for the period July 2015 to June 2016.
- Medicines and prescription items were stored securely and there were processes in place to ensure they remained suitable for use. The procedures for checking, storing and administering of controlled drugs were followed appropriately. Pharmacy, medicines and controlled drug audits were completed regularly, issues were rectified with action plans if required.
- Accurate, complete and contemporaneous records were kept in respect of each patient and these were accessible to all members of the multidisciplinary team to review and maintain. These records contained all relevant documentation, risk assessments and care plans. Patients' records were managed in accordance with the Data Protection Act 1998. Records were securely stored, preventing the risk of unauthorised access to patient information.
- The hospital provided a system to recognise and safeguard the needs of vulnerable adults, children and young people. Staff were aware of their responsibilities and the correct procedures to follow if a patient was considered at risk. Safeguarding training formed part of the hospital's mandatory training programme and included information on Female Genital Mutilation and Child Sexual Exploitation. There was a lead nurse for safeguarding, who was available for guidance, this

Summary of this inspection

nurse had a place on the local authority safeguarding committees for both adults and children and young people. We saw evidence that concerns had been identified and actioned appropriately.

- We found that the 'duty of candour' regulations were being implemented appropriately following patient harm. 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. We saw examples of this process and were satisfied that this was in line with organisational policy and national guidance. Records showed that patients were involved and updated about investigations, invited to discuss the circumstances with senior staff and received an appropriate apology for the harm caused.
- There were effective processes to monitor, recognise and respond to patient risk. There were procedures in place to escalate and stabilise the deteriorating patient and means by which they could safely be transferred a more acute healthcare facility. Patient risk for surgery was assessed and monitored through effective pre-operative procedures and effective risk assessing.
- Staffing levels were planned and implemented to ensure that there was sufficient staff on duty to provide safe care. This included the resident medical officer (RMO) cover. There was very low use of agency staff.

Are services effective?

Good

We rated effective as good because:

- Local policies and procedures reflected latest guidance and best practice. We saw evidence that departments followed current recommendations and relevant patient pathways were in place for a wide range of treatments.
- The hospital kept their practices up to date and current by ensuring they were consistent with latest evidence based practice guidance such as those from the National Institute of Health and Care Excellence (NICE) and the relevant Royal Colleges'. Adherence to evidence-based practice was monitored as part of the annual audit plan to ensure a consistent approach to care.
- Pain was recognised, monitored and treated promptly and effectively. Patients said they were happy with the levels of pain control. Options for pain control were discussed with patients and their choice respected.

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- Holistic attention was paid to the nutrition and hydration needs of patients. There was a choice of nutritious and appetising food on offer. Fasting times for surgery were optimal and followed latest guidelines. Nutritional risk assessments were undertaken and additional interventions were provided for those identified to be at risk.
- Spire Healthcare used a clinical scorecard to benchmark the hospital's adherence against a set of standards. This enabled Spire Cheshire to be benchmarked against other Spire Hospitals. We reviewed the scorecard for April 2016 to September 2016 and found that Spire Cheshire Hospital was one of the top four performing hospitals against these standards.
- We found effective arrangements were in place to ensure that doctors and nurses were compliant with the revalidation requirements of their professional bodies. Consultants had clear and comprehensive agreements in place capturing their practising privileges arrangements, which set out the hospital's expectations of them. They undertook appropriate checks to ensure they fulfilled the required criteria and that they were competent to carry out the treatments they provided. Appraisal rates for staff were very high.
- We observed staff working in partnership with a range of staff from other teams and disciplines including allied health professional, consultants and administration staff. Staff told us there were excellent working relationships and a culture of respect and collaboration. There was a good external working relationship with the local NHS acute hospital, clinical commissioning group and local stakeholders. There were service levels agreements in place to facilitate arrangements with external service providers.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005 and the Children's Act 2004. We saw evidence of consent correctly documented in all the ten records we reviewed for consent.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients' emotional and social needs were highly valued by staff and this was embedded into their plan of care. We found a strong person centred culture with holistic care provided by highly motivated kind and caring staff who went the extra mile to care for their patients.

Summary of this inspection

- Feedback from people who used the service was exceptionally positive regarding the way they were treated by staff. Patient we spoke with were consistently extremely positive about staff attitude and stated they could not find fault with staff of all levels. The NHS friends and family test (FFT) is a survey, which asks NHS patients whether they would recommend the service they have used to their friends and family. From January 2016 to June 2016, hospital wide, 99% of NHS patients would recommend the service to their family or friends, the response rate was 40%. The hospital own patient satisfaction survey showed that the hospital was amongst the highest performing 'Spire' hospitals.
- The hospital had introduced the role of a Patient Services Manager who visited all inpatients daily to ensure they were satisfied with services they were receiving and all their needs were being met. Patients were very positive about this initiative.
- Staff were proud of the care they gave and valued patient feedback. The hospital provided training on 'compassion in practice' as part of the mandatory training programme.
- We found that patients were active partners in their care, they were involved and engaged in decisions and given the opportunity to voice their views and wishes. Individual preferences were explored and were reflected in the planning of care and treatment.

Are services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- There was a holistic and person-centred care approach to the delivery of care for patients across all age groups. We saw positive examples where patient's individual needs were met, such as patient activities that were planned and based on their personal preferences.
- The hospital exceeded all referral to treatment times, recommendations suggest that the time from receiving a referral up until receiving treatment is received should be less than 18 weeks. Between July 2015 and June 2016, referral to treatment times were on average 95.3% for admitted patients, 99% for non-admitted and 98.8% for those on incomplete pathways.
- Care was planned, organised and delivered with attention to the needs of patients. The hospital had been restructured with the needs of patients in mind such as ensuring the orthopaedic suite was close to the front entrance of the hospital, as these patients were more likely to have mobility problems and that the new radiology suite was close to the orthopaedic suite for

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patient convenience. The establishment of a new stand-alone endoscopy suite had resulted in patients not having to use the daunting environment of the operating theatre suite. This also provided more theatre time to allow more surgical treatments to be completed.

- We saw that appointments were flexible and patients were given a choice of time and date with some services being offered during the evenings and at weekends. We saw that patients who had to travel long distances were given double and treble appointments so that could get all of their appointments completed on the same day to prevent them having to undertake their journey a number of times. The hospital also provided satellite clinics in Nantwich and Northwich to offer greater choice and convenience to patients.
- The hospital offered a professional face to face interpreter service for patients whose first language was not English. They were able to use the services of a telephone translation service where an interpreter was required at short notice.
- There were systems in place to support vulnerable patients and care was planned based on a patients individual needs.
- The hospital had a robust system for dealing with complaints and all staff were familiar with this process. Complaints were actively reviewed, investigated thoroughly and dealt with an effective and timely manner. Patients were involved in the process of review and were invited to discuss concerns with managers. We saw positive changes as a result of complaints and learning from issues that had been raised.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The hospital developed a strategy based on corporate objectives and those determined collectively by departmental managers and staff representatives from each work stream. This led to a strategy that was owned and understood by staff who were invested in the shared ethos of the hospital.
- Governance and performance management was undertaken in a proactive and comprehensive manner. Managers actively sought to uncover areas for improvement using these systems to produce meaningful and useful data which could be used to measure success. The hospital was benchmarked against other Spire hospitals and this information was used to identify and drive improvements in quality, safety and the patient experience.

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- Managers, clinical leads, matron and the hospital director were visible and approachable. They inspired a cohesive, collaborative and focused workforce with a shared sense of purpose. They led by example and inspired individuality and creativity to overcome issues and raise standards.
- Staff felt motivated, happy and proud of their work and their achievements. There were comprehensive staff engagement strategies, staff were consulted in planning and decision making and received positive feedback and recognition in return. Staff of all grades formed an integral part of the identity of the hospital.
- The service had strategies for community and public engagement. The hospital held patient forum sessions to seek feedback from users of their services. Together with other feedback mechanisms they actively used patient views to improve services. The matron participated in the local healthcare community through his position on the local safeguarding boards for both adults and children. The hospital forged good communication and relationships with the local clinical commissioning group, local GPs and the healthcare community.

Outstanding ☆

Surgery

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

Are surgery services safe?

Good

We rated surgery as 'good' for safe. This was because;

- Staff felt supported to report and learn from incidents. We saw many positive examples of improvements made following incidents which included the changing of oxygen tubing in all rooms with oxygen, and changes to decontamination of endoscopy equipment.
- The hospital had robust and effective systems in place to reduce avoidable harm and monitor harm free care. There had been no pressure ulcers, falls, catheter acquired infections, or hospital acquired Venous Thromboembolism (VTE) or Pulmonary embolism (PE) during the period August 2015 to August 2016.
- Patients were protected against healthcare acquired infection. We saw evidence that equipment was cleaned following use on each patient to prevent the risk of cross infection and staff adhered to good hand hygiene procedures. There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile, for the period July 2015 to June 2016. Emergency equipment was readily available in theatres and the ward and records we reviewed confirmed that emergency equipment was checked daily.
- Staffing levels and skill mix were planned, implemented, and reviewed to keep people safe at all times. Any staff shortages were responded to and there had been no unfilled shifts in theatres or inpatients during the period April 2016 to June 2016.Safeguarding adults, children and young people was given sufficient priority and staff understood their role in this process. Staff mandatory training was well attended for safeguarding both adults and children and young people. We observed information available to staff on noticeboards within the departments and safeguarding leads were identified and staff knew who they were. The matron attended local safeguarding meetings with relevant organisations in the local area.
- Risks to people who used the services were well managed and assessed. Risks were identified at the pre-operative clinic and planning began at that stage to determine how to best manage identified risks. When patients were admitted, risks were continually monitored and any deterioration in the patient's condition was escalated in a timely manner with service level agreements in place should a patient require transfer to a NHS acute hospital.
- Medical records kept patients safe: they were fully completed, legible, and contemporaneous and included the consultants' documentation of the surgical procedure and ongoing monitoring.

However;

- Not all checklists in theatre three were completed to identify that all environmental cleaning had taken place after the theatre was closed down.
- At the time of our inspection we saw that sterile cement used for surgery was being stored in the 'dirty corridor' in theatre and presented a risk of contamination.
- We found a fire escape staircase from theatres being used for storage. We raised this as a concern at the time of our announced visit and when we returned on the unannounced element of the inspection all the storage had been removed from the area.

Incidents

- There were no never events reported for the hospital for the period July 2015 to June 2016. Never events are serious incidents requiring investigation, (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 be implemented by all healthcare providers). The hospital had an electronic system in place to record incidents. Staff had access to the system, knew how to report incidents, and felt supported to do so. We observed information on reporting incidents visible on staff information boards.
- There were a total of 160 incidents reported for surgery or inpatients from July 2015 to June 2016. Of these 160 incidents, 110 were deemed to have caused no harm, with five resulting in severe harm and two resulting in death. The two deaths were in relation to patients that had an emergency transfer to another hospital where they later died, we found investigations were comprehensive and thorough and that the deaths were not related to the surgical procedures the patients had received and that all appropriate measures had been taken. The hospital reported no deaths on site for the period July 2015 and June 2016. We observed two root cause analysis investigation reports that were completed following incidents and found learning and actions had been identified to disseminate learning.
- We saw an incident report with regard to decontamination procedures for endoscopy equipment which had been investigated through a root cause analysis. Staff told us that the test for Total Viable Count (TVC) levels were observed to remain high after routine decontamination of equipment on one occasion. This problem was raised to engineers at a national level through Spire Hospitals' processes. The endoscopy unit had cancelled the endoscopy lists for five days as a safety precaution until the test levels returned to normal range. There were a further two separate occasions were the same problem occurred and the unit had responded with increased decontamination procedures, including double disinfectant used prior to taking tests.
- Lessons learnt from incidents were shared with staff by using a number of processes, which included: the hospital management team, department team meetings, and notice boards: however, we reviewed ward team minutes for meetings held September 2016 and May 2016 and incidents was not a standard item on the agenda and there was no record of a discussion in relation to incidents. We reviewed team meeting minutes for theatre for June 2016 and August 2016 and although incidents was not a standard item on the agenda in one of the recorded minutes we saw reference that any root cause analysis from investigations from incidents was to be shared with staff. We observed records for October 2016 for the daily huddles held in theatre and observed any concerns raised within the huddle meeting, actions were identified, and signed off.
- Issues around morbidity and mortality and clinical effectiveness were discussed, analysed during medical advisory committee and clinical governance meetings, which included multi-professional surgical (including anaesthetic) attendance. The outcomes of which were recorded in minutes and circulated to staff to aid learning and sharing of information.
- There was evidence that learning took place from reporting incidents, and changes were made to reduce incidents of the same nature in the future. The theatre manager informed us of a serious incident that had occurred in April 2016 where a component of an instrument had been left in a patient. This was due to the way the instrument had been manufactured and the service no longer used this particular instrument to ensure there were no incidents of this nature in the future.
- A staff nurse on the ward told us that lessons were learnt from incidents and gave us an example where the oxygen tubing used in the extended recovery unit was not long enough and as a result, all rooms with oxygen now had longer oxygen tubing in place.

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.
- The provider had a duty of candour policy and staff were aware of the terminology. The staff we asked were able to articulate the meaning and process in relation to duty of candour.

- We reviewed the hospital's electronic reporting system, and noted that it included prompts to ensure duty of candour obligations were undertaken and we saw evidence within the root cause analysis investigations we reviewed that duty of candour had taken place.

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

- The Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins). Data from the safety thermometer showed there were no pressure ulcers, falls, catheter acquired infections, or hospital acquired Venous Thromboembolism (VTE) or Pulmonary embolism (PE) during the period August 2015 to August 2016.
- During the same period 100% of patients had received a VTE assessment and where indicated, 100% of patients had received prophylaxis medication to reduce the risk of developing a VTE following surgery.

Cleanliness, infection control and hygiene

- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile, for the period July 2015 to June 2016.
- Patient-led assessments of the care environment (PLACE) is a system for assessing the quality of the patient environment. The hospital achieved 100% for cleanliness for the period February 2016 to June 2016 which was better than the England average of 98% for the same time period.
- There were infection prevention and control policies and procedures in place that were readily available to staff on the hospital's intranet. Infection prevention and control was included in the mandatory training programme and 100% of staff on the ward and 98.4% of staff in the theatre department had completed the training at October 2016. This was better than the provider target of 75% at that time period and better than the end of year target of 95%.
- We saw an annual infection control plan 2016, which set out the proposed activities to ensure the hospital met the standards in relation to hygiene and infection control. We saw minutes from infection prevention and control meetings held in December 2015, April 2016, and July 2016 which included discussions of infection risks, incidents, and progress against the annual plan was monitored.
- The inpatient facilities which included the ward and the day case area were visibly clean and free from clutter. We observed daily record sheets for patient rooms which included equipment for cleaning and supplies, which were managed by the housekeeper. We observed equipment on the wards, endoscopy unit, and theatre areas which had 'I am clean' stickers in place to show that equipment had been cleaned after being used on a patient.
- The theatre area appeared clean and tidy but there was a lack of storage facilities and equipment was being stored in corridors. We observed at the time of our inspection that sterile cement for implants was stored in a metal cupboard on the 'dirty corridor' (used for transferring dirty instruments and waste) in between a sink and the cleaners cabinet. This had the potential to provide an infection control risk. We discussed this with the theatre manager at the time of our inspection and arrangements were made to move the cabinet to another area. At the time of the unannounced element of our inspection we found this cabinet had been removed from the corridor and was stored within the recovery storage area.
- Theatre staff adhered to best practice standards in relation to wearing sterile gowns, and antiseptic skin preparation for patients undergoing surgery was observed. Sterile packs for theatre were stored separately.
- Theatre one and two had laminar flow systems installed and were used for orthopaedic and other speciality surgery. Laminar flow systems provide positively pressured clean air in the theatres to reduce the risk of bacterial infection to the patients surgical wound site. The laminar flow systems were maintained and revalidated by a contracted provider and equipment was reviewed at six monthly intervals. At the time of our inspection we observed records that identified that the systems were last monitored in June 2016 and the survey concluded that compliance was good. If any faults were identified the contractor repaired them immediately and the system was revalidated.

- Theatre three was monitored annually by an external provider and we observed the last survey was completed on the 9 November 2015 with no areas of concern identified.
- There were hand gel dispensers on the wall outside each patient's room and staff were observed throughout our inspection using the gel on entering and leaving the patients rooms. All staff on the ward that we observed at the time of our inspection were 'bare below the elbows' which adheres to best practice guidance.
- There were hand gels and sinks available in the theatre area and we observed staff washing their hands and using personal protective equipment to reduce the risk of healthcare acquired infection. Staff adhered to the theatre dress-code when entering and leaving the theatre area and were 'bare below the elbows'.
- The hospital audited hand hygiene by asking patients if staff used the hand sanitising foam. An audit performed from 14 May 2016 to 21 May 2016 included 60 patients on the ward. All responses stated that nurses and the registered medical officer (RMO) used the hand sanitising foam prior to providing care and 100% of the responses were extremely or reasonably confident that staff were using the hand sanitising foam at the right time.
- The hospital had a sterile services department (SSD) where decontamination of reusable medical devices in line with national guidance took place. We reviewed the Medical Device Audit performed by an external organisation in April 2016. The audit concluded that the department had met the quality objectives and had demonstrated regulatory compliance and any non-conformity was rated as minor.
- The hospital had developed a local checklist for theatres to be completed when opening and closing down the theatres in relation to checking and cleaning equipment. In theatre three we observed in September 2016 that on eight occasions the open checklist had been documented however the closing checklist was not completed. In October 2016 all opening and closing documentation was completed and in August 2016 there were five occasions when the open checklist was documented but the closing documentation was left blank. We checked the lists for theatre one and theatre two for the same time period and found these to be completed. We discussed this with the theatre manager at the time of our inspection and observed it being highlighted to staff the next day at the morning huddle meeting.
- We observed cleaning schedules in the theatre recovery area all completed for August 2016 to October 2016.
- Adjacent to the endoscopy procedure room was the decontamination area. This area was separated into two rooms; a room for used equipment (dirty room) and a clean room for equipment that had been washed, each with separate lockable door entrances. There was no corridor or other access points between the two rooms, helping to reduce the risk of possible contamination between used and clean instruments.
- When procedures were complete, the used endoscopes were placed directly into a red plastic cover then into a hatch leading from the endoscopy procedure room to the decontamination room. From here, the used endoscopes were thoroughly cleaned in a sequence of set washing processes and then placed in the decontamination unit. The decontamination unit could open into both the clean room and the dirty room, but could never open into both rooms at the same time. The clean endoscope would then be taken out of the decontamination unit on the clean side, scanned through the electronic system and recorded into the drier cabinet.
- Alarms were set to ensure that endoscopes were used within the set time and daily checks were recorded on all the decontamination equipment. These were seen to be complete, dated and signed.

Environment and equipment

- Resuscitation equipment for children and adults was centrally located on the ward. Daily checks were completed and included a performance check of the defibrillator. We observed the checklists completed on the ward for September 2016 and October 2016 to the date of our inspection. There were security tags in place to seal the equipment from tampering and the codes on the tags correlated with the check list. We observed the same for the sepsis kit and the haemorrhage box.
- There was a sepsis emergency kit available within the ward clinical room. Sepsis is a potentially life threatening condition triggered by an infection or injury.
- In theatres we observed the checklists for the adult resuscitation trolley and the defibrillator completed, for September 2016 and October 2016 to the time of our

inspection. We observed the emergency tracheostomy trolley, the paediatric resuscitation trolley, and the adult and paediatric anaphylaxis kits clearly labelled and daily checks were complete.

- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books being kept and we saw evidence of these completed at the time of our inspection for the months August, September, and October 2016 to the date of our inspection. We checked two anaesthetic machines and these had been serviced within the last 12 months The inspection team identified the log books examined were all complete with signatures for the days theatres were in use.
- Recording systems for implants were in place and we observed the recording registers for the National Joint Register for hip, knees, and shoulders, and a separate register for breast implants was in place and observed at the time of our inspection.
- Hoists were available to be used for patients that had problems with mobility. Staff told us that two rooms on the ward had two beds in situ and if a patient needed a hoist they would remove a bed from the room to enable more space to manoeuvre the hoist in a safe manner.
- The endoscopy unit had nine individual patient rooms which were accessible from a central reception area, with a reception desk and nursing station. The view from the nurses' station allowed for appropriate monitoring of day to day activity for the unit. The main theatre recovery area was adjacent to the endoscopy unit. If patients required closer monitoring during recovery after sedation, they could easily be transferred to this area.
- The ward had 48 beds which included nine day-case beds with rooms on two corridors with private rooms for each patient. There were two nursing stations however, patients were not visible to the nurses and needed to use their call bell if they required assistance. We spoke with three patients and observed their call bells within reaching distance. Staff told us there was a discharge process in the recovery area which we observed in the patient records we reviewed, and patients were not discharged to the ward until they had met the criteria. If patients required additional observation, they were transferred to a two bedded extended recovery area within the ward where they received continuous observation from a nurse.
- The theatre department had identified the lack of storage as a risk on the hospitals risk register. At the time of our inspection we observed on the back staircase (which was used as a fire escape from the first floor theatres), items stored in the area half way down the stair case. There were metal cabinets which stored paperwork and on top of the cabinets were a number of empty endoscopy cases. There were also two cardboard boxes: one on top of the cabinets the other was stored in between two cabinets.
- We reviewed an enforcement notice that was issued to the hospital on the 23 September 2016 in relation to fire safety following a fire safety audit completed by an external organisation in July 2016. The enforcement notice clearly stated that 'all escape routes must be free from storage'. Within the enforcement notice the areas of concern were the administration escape on the medical records corridor, however the back staircase was also a fire escape route but was not highlighted in this enforcement notice.
- We informed the hospital of our concern at the time of our inspection and were presented with a risk assessment of the situation which had been completed on the day of our inspection. At the time of our unannounced part of our inspection all the storage and cabinets had been removed from the stair case.
- We saw evidence that equipment was maintained, and observed portable appliance testing stickers on a range of equipment which included: equipment used in recovery and on the wards to record the patients physiological readings, suction machines, thermometers, and defibrillators. This assured us that equipment tests were performed annually.

Medicines

- The hospital had a pharmacy on site and a pharmacist was available 9am to 5pm Monday to Friday and 9am to 12 noon on Saturday. During out of hours there was a pharmacist on call that could be contacted. The organisation had a provider that was used to deliver medication stock to the hospital.
- Twice weekly the pharmacist rotated medication and stocked the ward and theatre areas, and we observed

the drug log sheet for the period January 2016 to March 2016 completed to confirm this took place. We saw three medications for eye drops in the fridge in the ward clinic room and found all to be in date.

- We saw that medicines were stored in dedicated medication fridges on the ward and the day unit. We noted the temperature monitoring devices were integral to the drug fridges. We observed daily records from October 2016 to the date of inspection which we found were completed fully. We checked a fridge in the theatre department and found temperatures recorded, yellow stickers on drugs to identify the date of expiry and we checked four ampoules within the fridge and found all to be in date. Staff were able to tell us the action to take should the temperatures fall outside the controlled measures which reflected the organisations management of medicines policy 2016.
- We looked at controlled drugs (CDs) (medicines liable to be misused and requiring special management) in the ward and theatres. We checked CD registers and found entries signed by two staff and stock levels counted and checked in the theatres and on the ward.
- We found that medicine cupboards were orderly, neat, and tidy.
- We saw that robust management controls were in place to access the drug rooms. The keys to the CD drug cupboards were held by the nurse in charge and these were stored in a locked cupboard within a locked cabinet. When controlled drugs were dispensed from pharmacy, a controlled drug order was completed and the drugs were dispensed in a locked container and had a green seal in place which we saw evidence of at the time of our inspection.
- If a patient had their own CDs these were stored in the same way with a separate log book which was signed by two nurses when added, administered or returned to the patient. We observed random pages within the log book and found them fully completed.
- Each patient room on the ward had a lockable cupboard on the wall to store patient's own medication. Medication and prescription charts were reviewed by the pharmacist daily and if patients wanted to self-administer their own medication they were given a self-administration form to complete so that staff were aware of what medication they had taken and the time it was taken.
- Take home medicines were available on wards when the pharmacist was not on site. Staff told us that the Resident Medical Officer (RMO) prescribed medications to be taken home and would dispense them from a central cupboard, attach a patient label and document the dose and frequency to be taken on the label. We saw records of medications dispensed in this way at the time of our inspection. The medications were checked by a nurse to ensure they were correct and the nurse counselled the patient on the dosage and possible side effects of the medication with the patient prior to discharge. We saw laminated aide memoire cards in the medicine store room on the ward that nurses could refer to when counselling patients about their medication.
- During out of hours when a pharmacist was not on site and access to the pharmacy was an emergency, the RMO and senior nurse had access via a dual key alarm system where both staff needed to be present to gain access. Access to the pharmacy CD cupboard could only be accessed by a pharmacist.
- Pre-treatment medication was provided for patients at outpatient appointments where this was required. Full information and advice for administering pre-treatment was provided, together with a contact number for follow up queries or in case patients had any concerns.
- Medicines for endoscopy were stored in a secure drugs cupboard within the endoscopy procedure room.
- The drugs cupboard in the endoscopy theatre was checked every day when there was a list of procedures. Staff completed and signed checklists which we observed during our visit
- Sedative and anaesthetic medications were administered by theatre anaesthetists and when these were used.
- At the time of our inspection, we observed the anaesthetist only preparing drugs for one patient at a time and noted that the drugs were labelled, and wastage was recorded. Allergies were recorded on the patients prescription chart and on the first page of the patient record there was a yellow allergy alert sticker. We observed ten sets of records and found allergies were noted on the sticker, where no allergies were identified, this was written on the sticker. We found one of the ten records where the sticker was not completed. Patients identified as having an allergy wore a red wrist band.

Records

- Spire Healthcare had an Information Lifecycle Management and Patient Records Policy and we saw

staff adhering to this policy. Patients' records were managed in accordance with the Data Protection Act 1998. Records were securely stored, preventing the risk of unauthorised access to patient information for example; records on the ward were kept in a room that only staff had access to via a swipe card.

- We looked at ten medical and nursing paper records and observed a good standard of record keeping. Records were legible and contemporaneous. The surgical care pathways included pre-operative assessment such as previous medical history, social history, and anaesthetic assessment, input from physiotherapy, discharge planning, and allergies.
- The care records included multidisciplinary input where required, for example, entries made by physiotherapy.
- In all the records we reviewed we saw evidence of medical notes made by consultants working under practising privileges.

Safeguarding

- Spire Healthcare had a Safeguarding Vulnerable Adults Policy which was reviewed in January 2016, and a Procedure for the Care of Children and Young People which was reviewed in July 2016.
- Safeguarding training was part of mandatory training for staff and at October 2016, ward staff were 100% compliant with safeguarding adults and children. Theatre staff were 98.4% compliant with safeguarding adults and 96.9% compliant with safeguarding children. All staff caring for children were level three trained however, the matron had made a decision to have all clinical staff trained to safeguarding level three for children and at the time of our inspection 19 staff across the hospital had received the training.
- Staff could access the policies on the organisations intranet and we saw information on reporting a safeguarding issue on the staff noticeboard on the ward. Staff we asked were able to describe the process they would follow should they have any safeguarding concerns about a patient and were aware of their responsibilities.
- The matron was the dedicated safeguarding lead and had up to date level three safeguarding training. The matron attended safeguard meetings within the local authority.
- At ward level there was a designated registered children's nurse for safeguarding children and young people who was also the lead for any safeguard concerns in relation to female genital mutilation.
- We observed safeguarding cards with the photographs of the child safeguarding leads which were given to children staying on the ward.
- The hospital had a children and young person's policy in place to support patients staying at the hospital. The procedure was for a responsible adult to remain resident with all children and young people however, the child or young person must be allowed the choice as they may not wish a parent /carer to stay with them overnight, and this decision was respected. At the time of our inspection we saw parents/carers with the children on the ward. During standard working hours, the entrance to the ward was attended and monitored by a receptionist whose desk was at the entrance to the ward. All visitors were asked to state who they were visiting and access was restricted to only personnel visiting a specific patient or staff members. Personnel not visiting patients, such as workmen, signed in at reception and stated their purpose when entering the ward. Outside standard working hours a swipe card system was in operation limiting access to staff only.

Mandatory training

- Mandatory training was monitored and all staff were expected to complete training on an annual basis, the training was organised corporately by Spire Healthcare.
- Staff had a mandatory training booklet that identified the training they were required to complete and a record of attendance could be recorded in the booklet. We saw evidence of the booklet within the staff competency files we reviewed at the time of our inspection.
- Training was delivered via on-line modules and face to face training sessions.
- The Spire Healthcare mandatory training programme included topics such as Health and Safety, Infection Control, Information Governance, Manual Handling and safeguarding adults and children. Ward staff compliance against a range of training topics was 100% for all training apart from Information Governance where 95.3% was achieved at October 2016. The theatre staff were achieving a compliance rate of 89.2% to 100% across a range of topics at October 2016.

- Information governance was part of the mandatory training at the hospital and in October 2016 89.2% of theatre staff and 95.3% of ward staff were compliant with the training, which was better than the provider target of 75% at that time period and better than the end of year target of 95%.
- Basic life support training for adults and paediatrics was completed as part of the mandatory training programme. In October 2016 all staff in the theatres, the ward and the RMO that required advanced life support training for adults had received the training in the last 12 months. Of the four staff identified as requiring advanced paediatric life support training three had completed the training and one member of staff was awaiting an update to remain compliant. There were a total of 42 staff that had received training for basic life support for adults and paediatrics with 22 staff awaiting training to maintain compliance within the mandatory timeframes.
- All compliance within theatres and the ward for mandatory training was better than the trust target of 75% at that time period and better than the end of year target of 95%.

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

- During the pre-operative assessment period any potential complications in relation to surgery were identified. The hospital had a policy in place which identified criteria that the patient should meet prior to being listed for surgery at the hospital. If patients were assessed as requiring a longer recovery period for example, following bariatric or spinal surgery, the ward had an allocated extended recovery area. The area had two beds and was managed by a nurse at all times. When it had been identified that a patient would require extended recovery, additional staff were brought in to ensure safe staffing levels.
- The hospital kept a stock of blood and blood products on site to assist with the stabilisation of a patient who might experience a haemorrhage or bleed.
- The service sometimes undertook complex and protracted surgical procedures during the weekend. Where this was the case we were advised that a full resuscitation team would always be available and that the same safety infrastructure would be in place at weekends as would be present during the week.
- The WHO (World Health Organisation) Surgery Safety Checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room, to recovery and discharge from the theatre.
- We observed specific WHO checklists formed part of the pathway of care document for different surgical procedures in the form of a safe surgery checklist. A peer paper audit performed for the period July 2016 to September 2016 which included 72 records found that 100% of the pre-operation checklists were completed by both ward and theatre staff.
- We found evidence in all of the 10 records we reviewed that staff were completing the checklists. We observed four patients taken to theatre and observed good evidence of the safety checklist being used and included: checking it was the correct patient, asking the patient to describe what surgery they were having in their own words, consent, and allergies.
- In all the ten records we reviewed we saw that risk assessments were completed and included: VTE, moving and handling, and pressure ulcer risk assessments. The records had evidence of the National Early Warning Score which is used to identify any clinical deterioration in a patient's condition completed, and in the paediatric records there was evidence of the Paediatric Early Warning Score (PEWS) documented when physiological observations were recorded.
- The hospital had a policy in place for escalating concerns about the deteriorating patient and staff could access the policy on the intranet.
- The hospital used a national early warning (NEWS) track and trigger system. It was based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with additional support. We reviewed 11 completed physiological observation charts and found the NEWS score documented at regular intervals when observations were recorded. Two records were for children and these both had the Paediatric Early Warning Score (PEWS) recorded when observations were recorded.
- We reviewed an audit completed on the 22 June 2016 of 20 patient records and found that the NEWS for all observations on the ward and in recovery were documented. We were assured that patients were well

monitored to identify any deterioration of their condition. The clinical scorecard at the end of September 2015 showed that the hospital had achieved 100% for recording the early warning scores in the patient's record. We reviewed one set of case notes for a patient that had been transferred to another hospital and found that the patients NEWS had been appropriately escalated and acted on.

- There was access to a registered medical officer on site 24 hours a day. The patient's consultant had overall responsibility for their patients and could be contacted via telephone for advice. We saw evidence in one patient record where a consultant had been contacted out of hours due to a patients deteriorating condition and an increase in their NEWS and saw in the record that the consultant had reviewed the patient and had documented in the patient record within 45 minutes of being contacted off site.
- The hospital had policies and standard operating procedures in place for the transfer of patients to other hospitals due to unplanned circumstances or for emergency treatment. Staff were able to tell us about the process to follow should a patient require an emergency transfer. Service level agreements were in place with nearby hospital trusts for the transfer of children and young people, and adults.
- A patient had required an emergency transfer the night prior to our inspection. On reviewing the patient records, we observed an increase in NEWS documented and escalated, a review from the RMO, record of discussions with hospital, review from the patient consultant, and information shared with the consultant who was to receive the patient. This demonstrated adherence with the transfer procedures in place.
- There were daily nursing handovers on the ward when staff changed shifts. In addition at 9am there was a morning 'huddle'. This was a multi-disciplinary meeting where nurses, physiotherapists, the RMO, and pharmacists attended to discuss and plan patients care. Following this 'huddle' the nursing sister had an additional meeting with the administration staff and the hotel services staff to ensure all staff were up to date with the planned work for the day or the day. At the time of our inspection we attended a morning 'huddle' and a morning handover and found them to be efficient and informative.
- Theatre staff held a huddle each day prior to commencing surgery lists. We observed a huddle taking place at the time of our inspection which was attended by 18 staff. Areas discussed included: location of emergency manuals, blood giving sets, fluid labelling and warming cabinets. Two staff we asked told us that the huddles took place daily and they found them of value.
- A minimum of three theatre staff were always present in the endoscopy procedure room, an operating department practitioner (ODP), a nurse to ensure the patients position and comfort and another nurse recording medications and observations. In addition, there was one nursing staff member allocated for the decontamination room.
- Following endoscopy procedures, theatre staff remained with patients for ten to 15 minutes before handing over care to nursing staff from the endoscopy unit to continue observing the patients' recovery.
- A Registered Medical Officer (RMO) was on site 24 hours a day, seven days a week and could be contacted by the ward staff for advice and to review the patients. During out of hours the RMO had access to the patient's consultant and could contact them if required, as the consultant held the overall responsibility for the patient. We reviewed the records for a patient that deteriorated out of hours and saw that the RMO was contacted, they reviewed the patient and contact with the consultant was made.
- We observed equipment kits available on the ward and in the theatres to manage sepsis. Staff we asked were able to describe the signs and symptoms of sepsis and the action they would take. Training in the management of sepsis formed part of the Acute Illness Management (AIM) training that had been attended by all staff required to attend.
- When patients were discharged from the hospital they were given a 24 hour contact number to contact the ward for advice. Depending on the type of surgery the patient had undergone, they received, prior to discharge, information about potential scenarios that would require them to contact the hospital so that they could be given advice. A patient survey performed from August 2015 to August 2016 identified that for 11 months 97-99% of patients knew who to contact once they were discharged if they had any concerns. This was the same or better than the responses for all Spire Hospitals which averaged 97%. For one month in the period the response was 96%.

- Falls and mobility assessments formed part of the preoperative assessment and we observed these in the patient records we reviewed.
- The service had a nurse specialist who assessed patients that were considering cosmetic surgery. The role of the nurse included an appropriate psychological assessment and to address any anxieties the patient may have. We saw in patients records that had received cosmetic surgery that a two week cooling off period took place, from consultation to surgery.

Nursing and support staffing

- There were no unfilled shifts in theatres or inpatients for April, May, and June 2016.
- In theatres there were no vacancies for operating department practitioners (ODPs), healthcare assistants, or nurses at 1July 2016.
- For inpatient services at the 1 July 2016 there were two whole time equivalent (WTE) nurse vacancies which equated to an 8% vacancy rate which was lower/better than other independent health providers (IHPs) we hold data for. There was a 0.6WTE healthcare assistant vacancy which equated to 9% vacancy rate and was slightly higher than other IHPs. The hospital had identified recruitment of clinical staff as a challenge however; recruitment processes were ongoing to fill the vacancies identified.
- There was no sickness recorded for theatre nurses from July 2015 to June 2016 apart from February 2016. Sickness rates for ODPs and healthcare assistants were variable for the same period based on data we hold for other IHPs.
- There were no agency health care assistants working in inpatient departments in the last three months of the reporting period Jul 2015 to June 2016.
- Patient activity and dependency were estimated on a daily basis to determine required staffing on the ward, using a ratio of five patients per staff member on an early shift, six on a late shift and seven on a night shift. Nurses and healthcare assistants were included in the ratios. Nurses and healthcare assistants were allocated according to the predicted patient numbers and actual dependency on a daily basis. If patients required additional nursing care and were returned to the extended recovery area on the ward additional staff were on duty to provide care to no more than two patients at any one time in this area.
- We reviewed the off duty for two weeks in September 2016 and two weeks in October 2016 and found the minimum requirements were met, with evidence where additional staff had been put on the off duty to cover the extended recovery areas and due to children on the ward. We saw evidence that an additional children's nurse was placed on a night shift due to a child staying in hospital overnight.
- Staffing numbers were checked using the Shelford safer nursing care tool fortnightly to ensure the staffing ratio was safe and aligned to patient dependency. We saw that the Shelford Safer Nursing Tool had been completed on the 14th October 2016 and found that the actual staff on duty exceeded the numbers the tool predicted.
- Shift patterns in place were long days followed by night shift. However, there was flexibility with the start and finish times on a day shift which was based on the workload for that day.
- When a child or a young person was being admitted arrangements were made to ensure that a registered children's nurse was always on duty. The ratio was one registered children's nurse to no more than four children at any one time.
- When a child or young person was returned to the ward following surgery, the recovery nurse would accompany them if there were a number of children on the ward that had already had surgery. The corporate policy in place identified that where the number of children on the ward was minimal, and required only one registered children's the department should carry out a risk assessment to ensure that the registered children's nurse remained within the ward environment once the first child has returned from theatre, the risk assessment should consider the need for a second registered children's nurse or Adult nurse with paediatric competencies or alternatively the recovery staff could bring the children to the ward. At the time of our inspection and a review of the off duty we found that there were the correct ration of registered children's nurse to children on the ward.
- Nurses from the ward were used to provide cover for the endoscopy unit, with usually two nurses from the ward designated for the area, depending on the number of patients on the list for endoscopy. On days where there

was only one patient for endoscopy, the patient would be nursed on the main ward and brought through to the endoscopy procedure room rather than staying on the endoscopy unit.
- Theatre staffing was identified as one operating department practitioner (ODP) one scrub nurse and one runner allocated to each theatre. We reviewed the off duty for October 2016 and found these staffing arrangements to be in place as planned.
- A minimum of three theatre staff would always be present in the endoscopy procedure room, an operating department practitioner (ODP), a nurse to ensure the patients' position and comfort and another nurse recording medications and observations. In addition, there was one nursing staff member allocated for the decontamination room.
- We observed handovers taking place between night and day staff on the ward, morning huddles in theatre, handovers from theatre staff to the recovery nurses and handovers from theatre staff to ward staff which assured us that staff were communicating with each other throughout the patients care pathway.

Surgical staffing

- There were 180 doctors/consultants with practising privileges at the hospital, 51 doctors (28%) carried out over 100 procedures between July 2015 and June 2016 and 54 doctors (30%) did not have any direct patients but worked mostly as anaesthetists and radiologists. Practising privileges is a term which means consultants have been granted the right to practice in an independent hospital.
- The Registered Medical Officer (RMO) was available 24 hours a day and provided on going care to patients. Any concerns about patients were referred back to the consultant who held the overall responsibility.
- Surgeons visited each inpatient on a daily basis for the duration of their admission and were available 24 hours for any deviation or concern with patient's health progress. Any annual leave was supported by a cross cover arrangement as per the Spire Consultant Handbook . Anaesthetists had a 24 hour post anaesthetic responsibility for the care of their patients and were available 24 hours a day for any deviation or concern with patients' health progress. We saw evidence in a patient's record where the RMO contacted the consultant at 4.45am and the consultant had arrived at the hospital at 5.30am to review the patient.
- Should a patient require an unplanned return to theatre a theatre team were on-call and were available within 30 minutes.

Emergency awareness and training

- Spire Cheshire had a business continuity plan in place which addressed several major incidents and action required. Staff were aware how to access the policy on the intranet.
- Staff told us they participated in fire evacuation tests and evacuation plans and at October 2016 100% of ward staff and 98.4% of theatre staff had completed the mandatory training for fire safety.

Are surgery services effective?

Good

We rated surgery as 'Good' for Effective. This is because;

- Peoples care and treatment was planned and delivered in line with current evidence-based guidance, standards, and best practise legislation. Adherence to evidence-based practice was monitored as part of the annual audit plan to ensure a consistent approach to care.
- Spire Healthcare had a system in place to benchmark its hospitals against a set of standards and against each other. Spire Cheshire was meeting 35 out of 39 standards and was one of the top four performing hospitals out of 38 assessed against these standards.
- People received a holistic assessment of their needs, outcomes were identified, and care and treatment was monitored and reviewed.
- The hospital used a paediatric clinical scorecard to assess standards of care for children and young people. At the end of September 2016, all standards were achieved at the hospital which demonstrated adherence to best practice guidance.
- There was evidence of participation in local and national audits including: patient related outcome measures for hip and knee replacements and groin hernia repairs and cataract surgery.
- The endoscopy unit had been inspected on the same day of the unannounced visit, completing a year long programme of work to attain Joint Advisory Group (JAG) accreditation for this service. .

- Staff were supported to learn and develop and learning needs were identified through the staff appraisal process. Core competencies for specific roles were identified and were reassessed annually and we observed this in the three staff records that we reviewed.
- Staff worked together to understand and meet the range of complexity of people's needs. We observed handover meetings which included a range of multi-professional team members.
- Services were available seven days a week with continuous nursing and medical staff available.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005 and the Children's Act 2004. We saw evidence of consent correctly documented in all the ten records we reviewed for consent.
- Patients told us their pain was well manged, monitored and medication was administered in a timely manner.

However,

- There was no programme of formal clinical supervision in place for staff.

Evidence-based care and treatment

- Staff had access to national and local guidelines via the hospital's intranet. We observed information folders on the ward that were readily available to staff and included safeguarding and end of life care.
- There were a range of clinical pathways and protocols for the management and care of a range of surgical interventions which were based on best practice and National Institute for Health and Care Excellence (NICE) guidelines. We observed a range of surgical management pathways in the patient medical records which were easy to follow and were fully completed.
- On the date of our unannounced visit, the endoscopy unit had been inspected as part of the year-long implementation of an advanced clinical quality programme by the Joint Advisory Group (JAG), resulting in a nationally recognised accreditation. This programme was developed for all endoscopy services and providers across the UK, in the NHS and Independent Sector. The unit was awarded accreditation on the day of inspection and received a number of outstanding comments for excellence, reflecting the commitment and expertise of the clinical team involved. This activity supported the needs identified by the hospital's NHS partners' commissioning intentions to provide a high quality service in the local community
- The World Health Organisation (WHO) Surgical Safety Checklist was completed for each patient prior to endoscopy and surgical procedures and we saw evidence of this documented in patient records. We observed three patients being taken into theatre and the Surgical Safety Checklist was observed in all cases.
- A post anaesthetic score (PAS) rating was being implemented in the main theatres as an evidence based measure in the monitoring of patents recovering from anaesthesia. The endoscopy unit were in the process of reviewing a 'speedy PAS' based on this approach, for endoscopy patients recovering from anaesthetic.
- Care of patients undergoing cosmetic surgery adhered to the Royal College of Surgeons Professional Standards for Cosmetic Surgery. We saw evidence in patient records that patients had been given a cooling off period from attending consultation to having surgery, an explanation of the risks of surgery were documented, and a specialist nurse was available at consultation to discuss any anxiety or psychological issues. We observed registers that were kept which recorded details of any implants used should they be required by regulatory authorities.
- Staff were trained in the management of sepsis, guidelines and a sepsis kit was available in the recovery area of theatres and on the ward.
- The hospital had a policy in place for escalating concerns about the deteriorating patient and staff could access the policy on the intranet. The hospital used a national early warning (NEWS) track and trigger system for adults and a Paediatric Early Warning System (PEWS) for children. In the patient records we reviewed at the time of our inspection all NEWS and PEWS scores were completed when physiological readings were recorded. The hospital had systems in place to audit adherence to this policy which demonstrated high compliance.
- The hospital had processes in place to assess and reduce the risk of patients developing a Venous Thromboembolism (VTE) or Pulmonary embolism (PE). Adherence to best practice was monitored monthly and during the period August 2015 to August 2016 100% of

patients had received a VTE assessment and where indicated, 100% of patients had received prophylaxis medication to reduce the risk of developing a VTE following surgery.

- The hospital had processes in place to reduce the risk of surgical site infections in adherence to NICE Quality Standard 49 guidelines. We observed in patient records that patients had their temperature monitored before, during, and after surgery. We observed that skin preparation was performed prior to incision using an antiseptic preparation, appropriate laminar flow systems were in place in the theatres used for orthopaedic surgery. There were no surgical site infections for the period July to September 2016 which was either the same or better than other Spire Hospitals. Data provided on surgical site infections was scrutinised and monitored to identify if any patterns or trends existed and to inform the performance management process for the renewal of practising privileges and consultant's annual appraisal meetings. At the time of our inspection no trends had been identified.
- Patients undergoing bariatric surgery had access to a dietician in adherence to best practice guidelines. We spoke with one patient who had undergone bariatric surgery at the time of our inspection who told us they received one to one monitoring from a nurse on return to the ward and they had received a consultation by a dietician.
- Spire Cheshire does not participate in the Anaesthesia Clinical Services Accreditation Scheme.

Pain relief

- Pain assessment formed part of the physiological observation recordings. Adults were asked to rate their pain between a score of zero to four (none to severe) and we observed this recorded in the medical records we reviewed.
- The clinical scorecard for the period April 2016 to September 2016 identified that Spire Cheshire were achieving 100% against the standard to record a pain score at all physiological observation recordings.
- Children were shown a sequence of pictures with faces that went from being happy to sad to assist them to determine how they felt. This formed part of a new leaflet that had been developed for children and young people and their parents to assist to identify a child's level of pain and also listed different types of analgesia with information about the medication.
- We observed on prescription cards that analgesia was prescribed prior to surgery and was also offered as part of the discharge medication.
- At the time of our inspection we asked eight patients if they thought their pain had been well managed and all eight told us this had been well managed. All eight patients told us they were regularly asked about pain and nurses responded quickly if they identified they were in pain. One patient told us that when they were in the recovery area following surgery they were asked to score their pain (none to severe) and they were given analgesia immediately.
- At the time of our inspection we observed a registered medical officer (RMO) entering a patient's room to discuss pain control with the patient. The patient had an allergy to the analgesia that would be the first drug of choice and the patient was fully involved in the discussion as to what may be the best combination of medication to control symptoms of pain.

Nutrition and hydration

- There were systems in place to ensure that patients were appropriately starved prior to receiving a general anaesthetic. We saw evidence in the patient record that patients were asked when they last had something to eat and drink. The hospital kept the time for patients to be nil by mouth to a minimum with patients allowed to drink water up to two hours prior to surgery.
- The hospital used the Malnutrition Universal Screening Tool (MUST) as part of the assessment process to assess patients that may be at risk of under nourishment.
- All hydration and nutrition needs had been assessed in all the patient records we reviewed.
- There were menus available for patient to select their meals from. We observed there were different menus available for NHS and private patients: however we asked three NHS patients what they thought of the food and all three were extremely complimentary.
- Any nutritional needs or special diets were identified at the preoperative assessment and the kitchen staff were made aware when patients were admitted. There was a handover every day between the nurse on the ward and the kitchen staff to enable all patient needs and requests to be communicated in a timely manner.
- Age appropriate menus and cutlery were available for children and there was a referral process in place if children required a dietician.

- We observed that patients in the endoscopy unit were offered food and drink following their recovery after sedation. All the patients we spoke with were happy with the attention given to ensure their hydration and nutritional needs were being met in the endoscopy unit.

Patient outcomes

- The hospital had a local audit plan in place which was used to measure effectiveness and care processes. The audit plan identified audits and the timeframe for completion. We reviewed the audit plan for the period 2015 to 2016 and found audits had been completed in the timeframes identified, with the exception of two that were outstanding: cold chain compliance and surgical blood usage audits.
- National audits were completed and included Patient Related Outcome Measures (PROMS) for primary hip and knee replacements, and groin hernia repairs for NHS patients. The PROMS audit was used to assess a variety of patient factors pre and post-surgery.
- England adjusted average health gain for PROMs for groin hernia surgery was within the estimated range of the hospital's score for the following measures for the period April 2014 to March 2015: EQ-5D (Generic health status measure) where out of 30 modelled records 50% were reported as improved and 10% as worsened.
- Primary Knee Replacement was within the estimated range of the hospital's score for the EQ-5D Index (Generic health status measure) which identified out of 78 modelled records, 83.3% were reported as improved and 5.1% as worsened.
- The Oxford Knee Score is a PROM designed and developed to assess function and pain after total knee replacement surgery. For the period April 2014 to March 2015, out of 85 modelled records 96.5% were reported as improved and 2.4% as worsened.
- England adjusted average health gain for PROMs for primary hip replacement was within the estimated range of the hospital's score for the EQ-5D Index (Generic health status measure) which identified out of 68 modelled records, 95.6% were reported as improved and 1.5% as worsened. The Oxford Hip Score is a PROM designed to assess function and pain after undergoing hip replacement surgery. For the period April 2014 to March 2015 out of 72 modelled records 98.6% were reported as improved and none as worsened.
- Spire Healthcare used a clinical scorecard to benchmark the hospitals adherence against a set of standards. This enabled Spire Cheshire to be benchmarked against other Spire Hospitals. We reviewed the scorecards for April 2016 to September 2016 and found that Spire Cheshire Hospital was achieving 35 out of 39 standards and was one of the top four performing hospitals against these standards.
- Spire Cheshire had a paediatric scorecard to assess adherence to standards for care to children and young people which included; completion of PEWS, assessment of pain, patient satisfaction, and returns to theatre. We saw the paediatric scorecard for the period July 2016 to September 2016 and all the standards had been achieved, and there had been no unplanned admissions, returns to theatre or surgical site infections within 31 days.
- There were 12 surgical site infections reported for the period June 2015 to June 2016. The rate of infections during primary hip arthroplasty, other orthopaedic and trauma and urological procedures was similar to the rate of other independent acute hospitals we hold data for. However, the hospital reported no surgical site infections in revision hip arthroplasty, primary and revision knee arthroplasty and gynaecology, upper gastro-intestinal and colorectal, cranial or vascular procedures.
- The rate of infections during spinal and breast procedures was higher (worse) than other independent acute hospitals we held data for, however actual numbers were very low (two infections in 38 breast procedures and one infection from 231 spinal procedures).
- The hospital was working to share information with the Private Healthcare Information Network (PHIN) so that data could be submitted from April 2017 in accordance with legal requirements regulated by the Competition and Markets Authority (CMA).
- As at September 2016, unplanned readmissions year to date within 31 days of discharge and unplanned returns to theatre was better than the Spire target and better than the average across other Spire hospitals.

Competent staff

- Records we reviewed confirmed that there was a corporate and local induction processes in place for new staff.

- Staff were assessed against competencies that were required for their roles. We reviewed three staff files and found competencies signed off and reviewed annually. There was an identified theatre training lead that supported staff with learning and development.
- Consultants had their pre-employment checks completed in order to be granted practising privileges. The Medical Advisory Committee (MAC) reviewed and authorised all practising privileges applications.
- Consultants were required to provide evidence of satisfactory annual appraisal from their NHS practice as well as undergo a biennial review of Spire Consultant quality key performance indicators.
- There was a clear process for the granting of practising privileges for new consultants. This required consultants to send in a CV, a formal application, have an interview and have an endorsement from a medical advisory committee (MAC) representative.
- The role of the Medical Advisory Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document. The hospital checked registration with the General Medical Council, including the consultants' registration on the relevant specialist register, Disability and Barring Service (DBS) and indemnity insurance and provided assurance to the MAC that all checks were completed and there were no concerns. Practising privileges for consultants were reviewed every other year. The review included all aspects of a consultant's performance. The review included an assessment of their annual appraisal, volume and scope of practice, plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. The hospital used an electronic system to monitor compliance with all required documentation was in place to allow practising privileges to be maintained.
- More than 75% of nurses and health care assistants and other staff working in inpatient departments had received an appraisal in the current appraisal year of January 2016 to December 2016. More than 75% of staff, including nurses, operation department practitioners (ODPs) and health care assistants working in theatre departments in the same appraisals year had received an appraisal. The target was to reach 100% compliance by December 2016.
- Staff we spoke with told us they could discuss training needs during their appraisal and felt supported to learn and develop.
- Four nurses were identified as having special interest and knowledge for endoscopy work and shifts were managed to allow one experienced nurse to work with a junior nurse. This provided opportunity for staff to develop their competencies in endoscopy nursing. Ward rotas were managed to accommodate this staffing provision.
- There was no formal programme available for clinical supervision at June 2016, however, staff supported each other and discussed and reflected on incidents during handovers, and team meeting.
- All children receiving surgery were cared for by appropriately trained staff as per the hospital policy. There were a total of 17 overnight stays for children with 10 over the age of sixteen for the period July 2015 to June 2016.

Multidisciplinary working

- Care planning took place at pre-assessment with input from the multidisciplinary team, including doctors, nurses, allied health professionals, and housekeeping if any special needs in relation to diet were identified.
- The hospital staff from theatres, inpatients, and outpatients held weekly meetings to discuss future activity and theatre lists to ensure safe staffing and equipment was made available.
- We observed a good informative handover between the night staff and the day staff. This was then followed by a multidisciplinary handover which had a range of disciplines in attendance and included, the registered medical officer, a pharmacist, a physiotherapist and ward nurses. We observed discussions and shared decision making around medication and discharge planning with a good whole team approach to care.
- We observed a morning huddle in theatre which included: nurses, consultants, anaesthetists, ODPs and healthcare assistants. We observed staff treated as equals and a cohesive team approach.
- The hospital had good relationships with local NHS hospitals and the local authority and could make referral for additional services if required. There were service level agreements in place with NHS providers should patients require transfer to an acute hospital. There were processes in place to ensure the receiving consultant had all the necessary information to care for

the patient safely. There was a telephone handover from consultant to consultant, and written information was sent with the patient to the receiving consultant at the acute hospital. We saw evidence that this process had been followed for a patient that was transferred the day before our inspection.

- The patients' general practitioner (GP) was sent information about their patients care and any ongoing arrangements.
- The hospital had appointed a Referral Relations Executive to work more closely with local GP's to understand any issues with regards to the delivery of care or the referral of patients. This constructive challenge from this key stakeholder group was encouraged and seen as a vital way of holding services at the hospital to account.
- The hospital offered a medical terminology training programme to support local community health administrators and practitioners to provide an understanding of the terminology used within acute healthcare. The aim of this collaborative working was to enable all providers in the area to deliver more joined-up care to people who use services.

Seven-day services

- All care was consultant led at Spire Cheshire and surgeons visit each inpatient on a daily basis for the duration of their admission. In addition, they were available 24 hours a day for any deviation or concern with patient's health progress. Any annual leave was supported by a cross cover arrangement as per the Spire Consultant Handbook.
- Anaesthetists have a 24 hour post anaesthetic responsibility for the care of their patients and were available 24 hours a day for any deviation or concern with patients' health progress.
- Radiologists were available 24 hours a day seven days a week. Physiotherapy was available seven days a week with bank physiotherapist covering the service at the weekend.
- The hospital had a pharmacy on site and a pharmacist was available 9am to 5pm Monday to Friday and 9am to 12 noon on Saturday. Out of hours there was a pharmacist on call that could be contacted however; there were systems and protocols in place to allow the RMO to dispense discharge medication should a patient require discharge at a weekend.
- There was availability of an emergency theatre team 24 hours a day should an emergency arise and a patient required a return to theatre.

Access to information

- Paper based patient records were available on the ward and were taken to the theatre with the patient. All the records we reviewed at the time of our inspection included, assessments, risk assessments, diagnostic test results and a record of surgical procedures for both children and young people and for adults.
- Staff had access to the organisations intranet to obtain information. They could access local and corporate Spire policies and procedures, and e-learning. They could also access external reference sources such as NICE guidelines and professional guidance.
- Information such as incident reporting and safeguarding pathways along with other key messages were displayed on notice boards in staff areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Spire Healthcare had developed clinical briefs to provide staff with information for Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and dementia. At the 10 November 2016 theatre and ward staff were 85% and 84% compliant with MCA and DOLs training, which was better than the hospital target of 75% at that time and was on track to reach the end of year target of 95%.
- The hospital had a consent policy in place which included guidance for staff on obtaining valid consent. Staff that were caring for children could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made, with the involvement of parents.
- Staff were aware of their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and DoLS and could describe the process should it be required. At the time of our inspection there were no patients on the ward that lacked capacity or required a DoLS.
- We reviewed ten sets of records for patients that had undergone surgery and found all had a completed signed and dated consent form. Nine were consented on the day of surgery, one record identified that the patient had signed the consent form prior to the day of surgery however; the confirmation of consent was

completed by the consultant on the day of surgery to ensure the consent from the patient was still valid. Three of the ten records we reviewed were for children and young people and we saw consent documented from the parents.

- Consent for endoscopy procedures was discussed and noted by consultants at outpatient appointments. The endoscopy unit had developed an additional patient consent label for medical staff to affix to the patient record after they had seen the patient on the day of the procedure. This confirmed the further details of the potential risks that the consultant had fully explained to the patient, as part of the consent process.
- We saw evidence in records where patients were undergoing cosmetic surgery, a two week cooling off period had taken place prior to them receiving the surgery.

Are surgery services caring?

Outstanding ☆

We rated surgery as 'Outstanding' for Caring. This is because;

- There was a strong visible person-centred culture within the theatre and inpatient departments. Staff were extremely motivated to deliver care that was kind and compassionate. They anticipated the needs of their patients and ensured their needs were acknowledged and met. We observed this at the time of our inspection in the way that staff spoke with patients and their carers, and in the way they protected the patient's privacy and dignity.
- Staff went above and beyond their role in order to ensure patients were cared for, they were creative in the way they sought to meet patients' needs, for example; patients who lived alone were given food parcels on discharge as it was recognised they would have no basic food provisions on their return home.
- Staff were proud of the care they gave and valued patient feedback. The hospital provided training on 'compassion in practice' as part of the mandatory training programme which was well attended for inpatient and theatre staff.
- Feedback from patients that we received at the time of our inspection was extremely positive about staff attitude and how they went the extra mile and this in particular included a porter and cleaning staff that patients had identified as behaving in a kind and caring manner. Patients reported that care had exceeded their expectations and this assured us that the caring culture was embedded across the hospital.
- The hospital had introduced the role of a Patient Services Manager who visited patients daily to ensure they were satisfied with services they were receiving and all their individual needs were being met. Nine patients we asked told us they had been visited by the Patient Services Manager who was very accommodating and was 'a lovely lady'. Patients were involved in decisions about their care and felt that they were provided with sufficient information. We observed the registered medical officer discussing pain management with a patient at the time of our visit and a joint decision was made about which analgesia was to be prescribed.
- We found where patients were anxious about the procedure they were admitted for, staff gave extra care and responded compassionately to put the patient at ease. At the time of our inspection a patient told us she was nervous about having an anaesthetic and the anaesthetists had explained everything to her which gave her reassurance and put her at ease.
- Children were given a Spire cuddly toy when they were admitted to make them feel welcome and to create a friendly environment. A paediatric satisfaction survey had been developed and the results for the survey in November 2016 were positive.

Compassionate care

- We observed staff on the endoscopy unit speaking to patients in an attentive and caring way. Nursing staff made frequent checks on patients' comfort, and were available to respond to patients when they made requests.
- Staff did not merely react to patient needs or requests, they consistently anticipated need and ways to help by striving to build personal relationships and understand their patients' needs and preferences. Staff demonstrated a genuine desire to enhance the patients' experience and to ensure needs were met and exceeded.
- We saw nurses taking extra care to ensure that patients' dignity and privacy was maintained, by ensuring that room doors were closed for patients changing into gowns.

- A patient told us that the staff always knocked on the door before entering their room and we observed this at the time of our inspection.
- Patients said that all staff were pleasant and they helped to make them feel relaxed, and theatre staff made them feel looked after.
- We spoke with ten patients that were on the ward at the time of our inspection and asked them what was the best thing about their care. All responses were positive and patients told us 'everyone takes time to know about you, that's nice', 'staff are excellent and this makes all the difference, even the porter that brought me back from theatre just popped his head in to see how I am', 'staff are kind and caring', 'confidence in staff, they know what they are doing, are experienced, and the food is fantastic'.
- One patient told us that she had been very touched by the kindness and consideration of a 'cleaning lady', she said she had been feeling a little unwell when the 'cleaning lady' came into her room, she asked how she was and expressed concern that the patient did not look so well and went to get a nurse to ensure she was attended to and comfortable.
- We asked ten patients what could be done to make their experience better. There were eight patients that said they had no issues to raise and were satisfied with everything. We received two comments, one was in relation to poor Wi-Fi connection, and the other was no shelf in a cupboard and everything was placed low down and they were not supposed to bend.
- The hospital had a Patient Services Manager who visited every patient on the ward during their stay to check they were satisfied with everything or if they needed any additional support for example a special diet or equipment. Nine patients we asked told us they had been visited by the Patient Services Manager who was very accommodating was 'a lovely lady' and the one person that had not met her had not been back from theatre long. One patient told us that she had picked the wrong choice on the menu and the Patient Services Manager arranged for her to have a sandwich straight away.
- Friends and Family test results for the period August 2015 to August 2016 identified that for 11 months 98-100% (with one month recorded as 96%) of patients would recommend the services they received at the hospital to friends and family if they required the same service. The average for all Spire Hospitals for the period was 98%.
- A patient satisfaction survey was completed across all Spire Hospitals to enable hospitals to benchmark the feedback they received from patients and their carers. For the period August 2015 to August 2016 positive feedback for consultants, nurses and theatre staff consistently met or exceeded all Spire hospitals responses of 98%. The care and attention from nurses exceeded all Spire hospitals responses of 98% for the whole 12 month period.
- Compassion in Practice' training was included as part of the hospitals mandatory training. At October 2016, 100% of ward staff and 96.9% of theatre staff had completed the training which was already better than the provider's end of year target of 95%.

Understanding and involvement of patients and those close to them

- Patients reported that they had all been provided with clear information about their treatment and care by the consultant and nursing staff, with opportunity available to ask further questions for clarification. Patients felt that they had been fully supported in making decisions regarding their treatment and that they had all that they needed to know for this.
- Patients' relatives were happy with the level of attention they received whilst in the waiting area of the endoscopy unit.
- At the time of our inspection we observed a registered medical officer (RMO) entering a patients room to discuss pain control with the patient. The patient disclosed issues relating to her tolerance and effectiveness of medication, the RMO listened and respectfully took into account the patients views and experience and was fully involved in the conversation and a joint decision on medication was formulated. This was typical of the accounts patients' relayed to us during our inspection. They expressed their satisfaction which was not only to do with the outcome but more in the way they were consulted, involved and empowered by staff.
- The patient satisfaction survey for August 2015 to August 2016 audited if patients and those close to them felt involved in their care. For nine months during this

period the hospital had responses of 91-95% which was the same and better than the responses for all Spire Hospitals which averaged 91%. The responses for three months ranged from 89-90%.
- The paediatric patient survey completed in November 2016 which included seven patients all stated they knew what was going to happen to them whilst at the hospital.
- The hospital hosted free information evenings for prospective patients in order to provide them with knowledge and understanding of what they can expect from the patient journey at Spire Cheshire. These were well attended and advertised on the Hospital's social media platforms.

Emotional support

- We observed patients on the ward, in the anaesthetic room and in recovery being reassured by staff that were empathetic when patients were nervous or anxious. A patient told us that they had been very nervous about having an anaesthetic, the nurses on the ward had responded to this and had informed staff in the theatres. The patient told us 'staff were first class in the anaesthetic room' and the anaesthetist had been to the ward after the patient returned to see that they were settled.
- Nursing staff told us that one patient who had been quite anxious on the day of the endoscopy procedure had asked if her husband could accompany her in her private room. Nursing staff were flexible to allow for this as otherwise it may have meant the patient cancelling her appointment. Staff took extra care to ensure that the particular patient was reassured and felt as prepared as they could be for undergoing the procedure.
- The hospital employed a clinical nurse specialist that supported patients undergoing cosmetic surgery. The nurse took time to discuss and explore patients' feelings and concerns in particular patients that were undergoing breast reconstruction following treatment for breast cancer.

Are surgery services responsive?

Outstanding ☆

We rated surgery as 'Outstanding' for responsive. This was because;

- The services were flexible and tailored to meet individual needs and preferences of patients. Staff had adopted a flexible approach to working during times of high demand, with staff working together with a strong team ethos.
- In the past, some endoscopy patients reported that they found their experience stressful and uncomfortable as they were treated in the operating theatres environment. This often resulted in delays by operations running over and staff recognised the environment was not ideal for this service. In response to and using this feedback, the hospital sourced funding, designed and built a new state of the art endoscopy suite. This resulted in better access to surgical facilities for surgical patients and provided a pleasant and appropriate environment for those requiring endoscopy procedures.
- Theatre services were available to patients seven days a week which was a response to local demand. Theatre lists were planned around patient's needs, for example, patients with dementia or a learning disability could be placed on the beginning of the theatre list to reduce the amount of time they needed to spend at the hospital thus reducing any anxiety.
- The hospital had consistently achieved 91-100% for patients being seen within 18 weeks of referral for the 12 month period from July 2015 to July 2016.
- Discharge planning took place at the pre-operative assessment to ensure there were no delays in meeting patient's complex needs.
- The hospital had systems in place to learn and share information in relation to complaints and actively tried to identify complaints at service level with daily contact to patients from the Patient Services Manager.
- Patients rated the overall admission procedure, including promptness and efficiency as a positive experience and were rated as the same or better than all Spire Hospital responses of 94% for 11 of the 12 months reviewed.
- When patients surgery was cancelled on the day it was planned, patients were rebooked within 28 days. There had been 62 cancellations for the period July 2015 to June 2016. There were 41 cancellations due to clinical reasons which were predominately due to the patient being unfit or unwell on the day. Ten patients choose not to proceed with surgery and the remainder were rebooked within 28 days.
- The service booked complex surgery that was expected to take several hours on a weekend day to prevent any

disruption to theatre lists in the week should the surgery take longer than expected. The required support services for example imaging, and biochemistry were available to access should they be required.
- Take home medications were available to the patient on average within 45 minutes of being prescribed which enabled patients requiring take home medication to be discharged without delay.

Service planning and delivery to meet the needs of local people

- The hospital had recently built a new endoscopy suite. The hospitals vision was that this would enhance the current service and further their ability to provide a comprehensive quality range of services to their patients. The new endoscopy suite had nine individual "pods" or patient rooms, each room had its own door, rather than a curtained bay. Each room had a height adjustable couch, a locker, an adjustable tray, and an emergency call bell. The hospital planned to increase the episodes of care offered for endoscopy services.
- The inpatient and theatre services operated a staff shift pattern however, during busy times staff worked together as a team and this could involve working beyond their shift.
- A registered children's nurse told us that if she had been rostered to work a day shift but a child was coming in later in the afternoon, and would need overnight care, she would change her shift the same day to cover a night shift. Staff told us they were able to take time back by finishing shifts early at less busy times, or they could be paid overtime for the additional hours.
- Theatres were operational at weekends to enable people who work during the week access without needing to take time away from work.
- The hospital worked closely with the clinical commissioning groups to improve services to patients.
- The hospital worked closely with commissioners of care to respond to the needs of the local community.
- The hospital had a number of specialist nurses in place to support the provision of individualised patient care.

Access and flow

- There were 7,566 inpatient and day case episodes of care for the period July 2015 to June 2016 of which 43% were NHS funded.
- Weekly hospital planning meetings were held and attended by multidisciplinary staff and were aimed at reconciling patient admission times, theatre scheduling, safe staffing, and diagnostic and specialist care support.
- A patient survey performed for 12 months from August 2015 to August 2016 identified that patients rated the overall admission procedure, including promptness and efficiency as a positive experience and was rated as the same or better than all Spire Hospital responses of 94% apart from one month where a rating of 90% was achieved in March 2016.
- Comprehensive pre-operative assessment of patients identified any patient individual clinical and social needs, with planning to meet those needs beginning prior to the patient being admitted to ensure all care was in place to meet the patients' requirements which included preparation for safe discharge home.
- The hospital had admission criteria and if patients did not meet the criteria and it was deemed unsafe for them to receive care at the hospital, they were referred to a local NHS acute hospital to provide their care. The consultant was responsible for patients in their care and made the decision to treat or refer.
- Above 90% of patients were admitted for treatment within 18 weeks of referral in the reporting period July 2015 to June 2016. The hospital had exceeded this standard for the whole 12 month period achieving a range of 91-100%.
- When patients arrived for their surgery, they reported to reception and were taken by staff to the inpatient ward. Here patients were prepared for their procedure, taken to theatre, remained in the recovery area in theatre until they met the criteria to be sent back to the ward. They were later discharged from the ward or remained on the ward in a private room overnight, depending on the procedure they had undergone.
- A paediatric patient survey of seven patients completed in November 2016 identified that all patients and/or their carers thought they were seen quickly.
- If patients required a return to surgery, or unplanned surgery, the theatre team were available on call out of hours. There were ten cases of unplanned return to theatre from July 2015 to June 2016 which was minimal compared to the number of theatre attendances for the same period.
- Of the 7,566 procedures carried out between July 2015 and June 2016, the hospital reported 62 cancellations on the planned day of surgery. 21 of these were due to

non-clinical reasons such as failure of equipment and staff not being available. The remaining 41 were due to clinical reasons, which were predominately due to the patient being unfit or unwell on the day. 10 of these patients chose not to proceed with their surgery, the remainder were rebooked within 28 days.

- When patients were discharged, information was sent to the patients GP and referrals to other required services were made. The patient was given a contact number to the ward should they have any concerns and require advice.
- Spinal surgery and complex surgery which was expected to last for several hours were scheduled for the weekend and if a complex case was booked it would be the only case on the theatre list. This was to ensure that other patients were not waiting long periods for their surgery should the surgery take longer than expected. If surgery lists were delayed during the week, patients were kept informed.
- The pharmacy used a visible electronic system to reduce delays in providing take home medication for patients who were ready for discharge. This allows the pharmacy staff and ward staff a visual display of how long the process from prescribing take home medication to actually dispensing it from pharmacy to the ward. The pharmacy provided approximately 250 to 350 take home prescriptions a month. The electronic system provided data to audit wait times, for the period April 2016 to June 2016 the average time from prescribing to dispensing was less than 45 minutes.

Meeting people's individual needs

- Access to interpreting services could be arranged by telephone or face to face for those patients who did not speak English. Staff were aware of the service and reported no delays with access.
- Arrangements were in place to commence discharge planning at the pre-operative assessment for patients with complex needs. Staff gave examples of working with social services and district nurses. If patients were known to community services these were contacted to share information to support the patient whilst in the hospital and to ensure the services were prepared for any additional needs of the patient following discharge.
- There was no dedicated prayer room for patients however; managers advised us that they would make a private room available should a patient or their relatives require it however, they had few requests for this service.
- Equipment such as theatre trolleys could accommodate bariatric patients.
- An information booklet was given to patients about their stay at the hospital prior to coming into hospital.
- Patients with dementia or a learning disability were placed first on the theatre list where possible, and their carer was allowed to accompany them to the anaesthetic room and could meet them after theatre in the recovery room. The same arrangements were in place for children and young people if required.
- There was a nominated lead on the ward for dementia who was a point of contact for other staff if they were nursing a patient with dementia. The lead also ensured the environment was adapted where needed for example placing picture cards on the door to the bathroom and ensured assistance was available at meal times.
- NHS patients used the NHS referral system for a date and time of surgery however, self-funded patients were able to choose a date and time that they wanted to attend.
- There was a lift available to the first floor where the ward and day-care unit were. The areas we observed were able to be accessed by a wheelchair. Staff told us that if a patient had mobility problems and required more space they would be aware of this prior to admission, and they would remove a bed from one of the double bedded rooms to allow more space for moving and handling the patient.
- One patient told us that they lived several hours away from the hospital and travelling there was difficult. The hospital arranged for the patient to have their three necessary appointments on the same day to reduce the burden of travelling.
- A nurse on the ward told us about a housebound patient that had been discharged who required some additional medication. A nurse from the ward delivered the medication to the patient's home after she had finished her shift.
- Spire Cheshire had dedicated staff with skills and interests in the management of patients with mobility and cognitive issues due to a disability.

Outstanding ☆

Surgery

Learning from complaints and concerns

- The organisation actively sought the views of patients and provided several ways in which their views could be captured. These were online, in person, by letter and by telephone and how to complaint and provide feedback was promoted around the hospital on posters and leaflets.
- Patients were given an information booklet in advance of treatment which contained information how to make a complaint. A " Please Talk to Us" leaflet was also available to advise patients how to register their concerns.
- What happened following feedback was also promoted and displayed on information boards, posters and leaflets around the hospital through the initiative 'you said we did'.
- Staff we spoke with knew how to support patients to make a complaint.
- Details of complaints were discussed with staff in monthly team meetings and briefings.
- There were four complaints in relation to inpatients received for the period January 2016 to June 2016. Complaints had been received by telephone calls and in writing and three related to the cost of the service. We saw that the hospital had reviewed the complaints and sent the patients a written response.
- The hospital wards were proactive in seeking out potential complaints and had introduced the role of the Patient Services Manager who visited patients on the ward daily to ensure they were satisfied with services they were receiving. They took patient dissatisfaction very seriously, they would involve the patient services manager to see if they could resolve any dissatisfaction straight away.
- Complaint trends were identified and shared at monthly meetings with a focus on one complaint each month to discuss in depth with the team, looking at it objectively and from the position of the patient (complainant) and identifying areas for improvement. If changes or processes were identified, these were agreed and implemented by the relevant heads of departments.

Are surgery services well-led?

Good

We rated surgery as 'Good' for Well-led. This is because;

- The hospital had a clear vision and set of values which staff were engaged with at the time of our inspection.
- Quality and risk were the focus of senior management team meetings, and meetings at all levels in the hospital.
- Staff told us that managers, and clinical leads, which included the matron and the hospital director, were visible and approachable.
- Clinical governance meetings took place quarterly to discuss risks, incidents and key issues and quality and performance were monitored through the clinical scorecard and Key Performance Indicators.
- Quality and improvement received great focus and these were interwoven through various clinical governance and quality and safety committees where surgery services were represented and involved in initiatives and learning.
- Staff felt supported by their local managers and staff recognised that the Matron had made a significant and positive impact on supporting staff and leading the service since being appointed earlier in the year. We observed good team working in all the departments we visited. Clinical leaders told us they were proud of the teams they worked in.
- We observed good team working in both the theatre and ward setting. Staff had been empowered following allocation of lead roles within their departments, which engaged staff in the focus of continuous learning and improvement.
- The views of patients were actively sought within theatres and inpatients using the NHS Friends and Family Test and Spire patient satisfaction surveys.
- A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future service users.
- The hospital had recently built a new endoscopy suite to enhance these services for patients. Positive feedback had been received following the hospital's inspection for Joint Advisory Group Accreditation for endoscopy services.

Outstanding ☆

Surgery

Vision and strategy for this this core service

- The vision and strategy was formulated through engagement and collaboration of staff. The senior management team secured representation from every staff group who solicited contributions and ideas from all staff. These representatives fed these ideas back in order to create the hospital and the surgery core service plan for the forthcoming year. Heads of departments and representatives totalling 36 in number attended the hospital's 'away day' in order to reflect on the previous year's performance and formulate an individualised and challenging strategy for the future. This practice produced a hospital and service strategy borne from the staff themselves, who were invested in and passionate about the future.
- The hospital's core values revolved around delivering high quality clinical care, backed by a customer focused service model aimed at protecting the hospitals customer base, increasing their share of the market and an increased focus to widen their service area in the community.
- The vision of Spire Cheshire was 'To be recognised as a world class healthcare business'.
- Staff were aware of the hospitals' values of delivering high quality clinical care supported by a customer focused service model and felt connected to the wider Spire network through management feedback and the sharing of information and benchmarking areas of good practice.
- The hospital values were reviewed as part of the staff appraisal process
- At the time of our inspection the theatre department were preparing for the newly purpose built endoscopy suite to become Joint Advisory Group (JAG) accredited. The unit was assessed for this accreditation on the day of our unannounced inspection and received positive report feedback from this assessment. The feedback particularly reflected the strength or leadership and team working in this area of service provision.

Governance, risk management and quality measurement

- The hospital held a range of meetings where governance issues were addressed which included: Medical Advisory Committee (MAC), Hospitals Management Team (HMT), Paediatric Steering Committee, and weekly hospital planning meetings.
- We reviewed minutes from the MAC meeting and found practice privileges compliance and quality assurance as standard agenda items. We reviewed the HMT meeting minutes for June, July, August 2016 and items included a directorate update, complaints review, business development, regulatory issues, and outcome of any root cause analysis investigations. Terms of reference were available for these meetings.
- The hospital held weekly planning meetings which reviewed the admission schedule, on-call rota, and any items for escalation to ensure safe staffing levels were in place.
- We saw that quality measures of procedures were reported, for example to the National Joint Registry. Monitoring against best practice standards was audited and outcomes were benchmarked across all Spire hospitals. The hospital used a clinical scorecard and key performance indicators to consistently monitor and review quality measures.
- There were service level agreements in place with NHS acute hospitals which included the transfer of children or adults should they require acute care.
- We reviewed data that the hospital provided that confirmed that incidents, risks, and complaints were logged and a system of governance was in place to monitor, and review actions to mitigate risks. The hospital held a hospital risk register and we observed a departmental risk register in the theatre department.
- There was a paediatric steering group that had recently been established where issues in relation to paediatrics were discussed and resolved including safety and quality of children's services and service level agreements.

Leadership / culture of service related to this core service

- Staff we asked at the time of our inspection told us that managers, clinical leads, the matron and the hospital director were visible and approachable. Senior management were reported to have "an open door policy" for all staff. Staff recognised that the Matron, who had been appointed earlier in the year, had already made a positive impact on supporting and leading the staff to make improvements to services.
- Staff we asked told us they would feel comfortable to raise any concerns and were confident that they would be considered and action taken if required. Staff were

positive about the new hospital matron that had been appointed earlier in the year and that the changes and ideas the matron had brought to the hospital were positive.
- Monthly meetings took place on the ward and theatre departments, and both had daily huddles and handovers where staff could discuss clinical concerns.
- We observed good team working in both the theatre and ward setting. Staff had been empowered following allocation of specific role leads in their department for example there was a training lead in theatre that was responsible for coordinating training to maintain a highly skilled team.
- Managers told us there were good working partnerships with consultants which fostered a seamless service for patients.
- Staff told us that poor performance was dealt with by the development of improvement plans and managed through the Enabling Excellence process.
- Staff told us managers regularly thanked them for their work and rewards were given to acknowledge good work. Staff felt really passionate about the new endoscopy unit and was visibly proud of their achievement in this development.
- Clinical leaders told us they were proud of the teams they worked in and knew they did a good job because of the feedback they received from patients.
- There was no sickness recorded for theatre nurses from July 2015 to June 2016 apart from February 2016.

Public and staff engagement

- The hospital used various means of engaging with patients and their families. These included surveys, such as the 'Friends and Family Test', and Spire Hospital Group surveys which included a survey to gain feedback from children and young people.
- A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future service users. The hospital enlisted individuals who had made complaints to join the group in order to provide insight and cast a critical eye on their services. They used this to identify areas of improvement and make changes based on the experiences of patients.
- The hospital proactively used social media platforms to capture feedback from previous patients, acting upon information received to improve the patient experience. They also used these methods to engage with communities to deliver health messages and provide information about services and events.
- The hospital engaged with the local Healthwatch who performed a site visit during our inspection. Healthwatch is an independent consumer champion that represents the views of the public in health and social care.
- There was a corporate annual staff survey to gain feedback from staff. We observed the survey results for the survey completed September 2015 to October 2015. The response rate was 86%. The total index scores for senior leadership was 55% and for working together was 52% which were lower than the Spire hospitals average. We observed the action plan following the survey with all actions completed. We saw that one action had included involving staff with decision making which was reflected in the staff engagement in developing the new endoscopy suite. The negative results identified in the survey did not reflect what staff told us at the time of the inspection: however, staff did tell us that the new matron who was employed after the survey had taken place had made a positive impact to the hospital.
- The hospital celebrated high performing staff and innovation through the provider's staff recognition scheme, 'Inspiring People'. Members of staff nominated other members of staff they felt worthy of recognition and these were celebrated by the hospital.
- Consultant engagement results in 2016 showed that 100% of consultants felt the hospital were easy to do business with when compared to other providers. This was the best result in the Spire Group for 2016 and a 8.5% improvement on the previous year's results
- The hospital held a hand hygiene event one evening in the summer which was attended by 86 delegates made up of members of staff and members of the public. This imparted information regarding the importance of hand hygiene not only in the hospital but also in the community setting. Members of the public were asked to observe if their consultants and clinical staff washed their hands and this information was fed back to produce a report and develop action plans where necessary.
- Staff had been consulted and involved in the design and development process for the new endoscopy suite. They had provided feedback for placement of equipment such as plugs and suction apparatus. Theatre staff had

visited other endoscopy units, including services in Wales and the North East who had already achieved JAG accreditation, to observe and share best practice. Staff felt really passionate about the unit and were visibly proud of their achievement in this development.
- In response to Consultant feedback through the Endoscopy Users Group, the hospital had secured funding for 17 new endoscopes to further enhance standards of care and services for patients.

Innovation, improvement and sustainability

- The hospital had recently built a new endoscopy unit to enhance and increase endoscopy services to patients. The service completed its assessment to become Joint Advisory Group (JAG) accredited at the same time of the unannounced inspection. The JAG Accreditation Scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards. The JAG inspection team report reflected “the new unit is well positioned to take on more endoscopy work should it wish to do so” and, “the new unit has been a significant catalyst for other change”.
- The hospital delivered a regular free GP education programme. GP’s were invited to attend education sessions run by specialist consultants with an aim to working with them more holistically to improve patient outcomes. The hospital also worked closely with the CCG and a GP representative advisor to ensure that any programs of education met with the needs of local GPs with the underpinning objective of retaining patients at primary care, up-skilling GP’s and avoiding hospital admissions to secondary care, in turn supporting the local health care economy.

Outstanding ☆

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging as 'Good' for safe. This was because;

- Of the 20 clinical incidents and two non-clinical incidents within outpatients and diagnostic imaging between July 2015 to June 2016 all were classed as low or no harm. Staff were aware of how to report incidents and reported receiving feedback. All of the clinical areas we visited were visibly clean and tidy and completed cleaning checklists were observed.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Hand gel was readily available in all clinical areas and we observed staff using it.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Personal protective equipment such as aprons and gloves were in place and available for staff to use and occupational exposure to radiation was monitored.
- All medicines and contrast in outpatients and diagnostic imaging were consistently checked, found to be in date and stored securely in locked cupboards or refrigerators as appropriate.
- Safeguarding policies and procedures were in place across the hospital network. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Outpatients and diagnostic imaging staff met the hospital target for compliance with mandatory training.
- Staff were able to describe the procedure if a patient became unwell in their department.
- A risk assessment was completed for children attending for minor procedures in the outpatients department and a paediatric nurse was onsite during the clinic.
- Outpatients and diagnostic imaging staff met the hospital target for compliance with mandatory training.

However,

- Toys used for paediatric outpatient clinics were stored in a locked cupboard in a patient changing room that contained a toilet.
- Not all medical records in the outpatient department had all entries that were timed, had clear designation of staff or completed patient alert sheets.

Incidents

- Incidents were reported using an electronic reporting system. Not all staff had access to the online system however an adverse event /near miss report form could be completed and this was recorded on the electronic system with management support. Senior members of staff with appropriate access and training were available to ensure this was completed in a timely manner.
- Staff were aware of how to report incidents and reported receiving feedback.

Outpatients and diagnostic imaging

- No serious incidents were reported between July 2015 to June 2016 within outpatients and diagnostic imaging. There were 20 clinical and two non-clinical incidents in this time period all of which were classed as low or no harm.
- No radiation incidents were recorded between July 2015 and the time of our inspection however, a radiation incident occurred during the onsite inspection. This was reported internally and externally as required and investigated using a root cause analysis approach. Action was identified and completed and evidence of duty of candour was noted.
- The hospital used a pause and check process which aimed to ensure that the right person got the right x-ray on the right part of the body.
- Incidents were discussed at monthly team meetings within the physiotherapy and diagnostic imaging departments. Staff in the outpatients department had not held a team meeting since March 2016, however we observed daily communication briefings where information relating to incidents was shared.
- Feedback regarding incidents from across the Spire network was observed on the notice board in the outpatient manager's office and staff gave examples of changes in practice as a result of previous incidents. This included the process for dealing with specimens in colposcopy clinic.
- Staff were aware of duty of candour and could describe circumstances when it would be exercised. 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.

Cleanliness, infection control and hygiene

- All of the clinical areas we visited were visibly clean and tidy.
- Completed cleaning checklists were observed in outpatient and radiology departments however, radiology used a laminated checklist which was wiped clean each day. This meant there was no record of any cleaning completed on previous days and did not allow for any audit. We raised this with staff and observed on our unannounced visit that monthly checklists were now in place.
- Toys were available for children who attended a paediatric clinic however staff told us they were not included on the departmental cleaning schedule. The toys were stored in a locked cupboard in a patient changing room that contained a toilet. We raised the infection control risk with staff during our inspection. We reviewed the situation again on our unannounced inspection and noted the toys in the same storage area.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Hand gel was readily available in all clinical areas and we observed staff using it.
- Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and we saw evidence of this being used.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled.
- Staff in both outpatients and radiology could describe the process when patients attended with suspected communicable diseases or requiring isolation including the use of protective equipment, deep cleaning following the procedure and scanning patients at the end of the list, if possible.
- A patient survey of hand hygiene compliance in the outpatient department for Q2 2016 showed that from a sample of 20 patients, all 20 agreed that as far as they were aware, nurses used the hand sanitising foam before attending to their care. This reduced to 18 out of 20 when asked if consultants used the hand sanitising foam before attending to their care.
- The hospital performed better than the England average for cleanliness in the patient-led assessment of the care environment (PLACE) audit for independent sector acute providers in 2016.
- Within the outpatient and imaging departments curtains were used to screen patients in the waiting and consultation areas. All curtains were labelled to identify when they had been changed and staff were aware of the schedule for replacement.

Environment and equipment

- There were separate waiting areas for NHS and self-pay/ insured patients in the outpatients department.
- The diagnostic imaging department was undergoing refurbishment during our inspection and plans were in progress to provide a reconfigured reception, waiting area and changing rooms.

- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Safety testing for equipment was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and safety warning lights were in place in the x-ray departments to warn people about potential radiation exposure.
- Occupational exposure to radiation was monitored for radiology staff. This ensured that the amount of radiation staff were exposed to as part of their work was checked.
- Personal protective equipment such as aprons and gloves were in place and available for staff to use.
- Emergency resuscitation equipment for both adults and children was in place, trolleys we reviewed were visibly clean and daily and monthly checklists were completed.

Medicines

- All medicines and contrast in outpatients and diagnostic imaging were found to be in date and stored securely in locked cupboards or refrigerators as appropriate.
- We observed medicine cupboard temperatures in outpatients and diagnostic imaging were consistently checked.
- Temperatures of refrigerators that store medicines and vaccines should be between two and eight degrees and any deviations and corrective action should be recorded. . Checklists reviewed in the outpatients department indicated minimum and maximum refrigerator temperature readings however, this was not always consistently recorded.
- No controlled drugs were stored in the outpatients department.
- Prescription pads were stored securely and usage tracked.
- Medicine cupboard keys were held by the qualified nurses in the outpatient department and in a coded cupboard within the office in the radiology department.
- Analgesia to take home following endovenous laser ablation treatment was dispensed by staff in the outpatient department.

Records

- The hospital used a single patient record for all inpatient and outpatient attendances. This ensured continuity of care during attendance and treatment.
- Information from the hospital showed that in the three months prior to our inspection less than 1% of patients were seen in the outpatients department without the full medical record being available.
- Medical records were stored on-site for patients seen within the previous six months. Beyond this time notes were secured off site and could be retrieved within 24 hours.
- If patients were required to be seen at short notice, records could be faxed from the off-site storage or if records were unavailable a temporary record was prepared which would be tracked and merged with the original.
- We reviewed 21 sets of individual care records in the outpatients department. All records had patient identification details on each page, were signed and dated and contained details of previous consultations, treatment and consent as appropriate. However, not all entries were timed, had clear designation of staff or completed patient alert sheets. One set of records also contained the prescription chart of another patient.

Safeguarding

- Safeguarding policies and procedures were in place across the hospital network and were available electronically for staff to refer to.
- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Staff could name the designated members of staff to contact for advice regarding safeguarding children, safeguarding adults or patients with dementia. We observed internal and external contact telephone numbers for staff to refer to on the notice board in the outpatient manager's office.
- The head of clinical services was the hospital lead for safeguarding children and adults and was a representative on the Local Safeguarding Children's Board (LSCB).
- A corporate chaperone policy was in place, staff in the outpatients department could describe the policy and locate it on the hospital intranet. Notices were observed in waiting areas and consultation rooms advising patients of the availability of chaperones if they wished.
- Safeguarding training was incorporated within mandatory training and staff completed level 1 and level

2 for both children and adults. The hospital target for training compliance was 75% by the end of Q3. Compliance rates for safeguarding children training at the time of our inspection was 73.3% for outpatient staff, 96.8% for diagnostic imaging staff and 100% for physiotherapy staff. Compliance rates for safeguarding adults training was 73.3% for outpatient staff, 98.4% for diagnostic imaging staff and 100% for physiotherapy staff.

- Level 3 safeguarding training was being introduced for all staff working with children with a completion date of December 2016. At the time of our inspection 19 staff across the hospital had completed the training.
- Safety procedures were observed in radiology to ensure the right patient got the right scan at the right time.
- Staff in interventional radiography and minor procedures in outpatients used the World Health Organisation (WHO) Surgical Safety Checklist. This aims to reduce harm during operative procedures by using consistently applied evidence-based practice and safety checks to all patients. Audit of adherence to the WHO Surgical Safety Checklist in diagnostic imaging in April 2016 showed 80% compliance however, this rose to 100% in August 2016.

Mandatory training

- Mandatory training was available via on-line courses as well as face to face and included subjects such as fire safety, health and safety, infection control and information governance.
- Staff told us mandatory was easy to access and staff could complete on-line learning from home.
- The hospital target for training compliance was 95% by the end of December 2016. At the time of our inspection, excluding Cardiopulmonary Resuscitation (CPR) training, compliance rates for outpatient staff ranged from 91.6% to 100%, 96.8% to 100% for diagnostic imaging staff and 100% for physiotherapy staff.
- Training compliance for Basic Life Support (BLS) for diagnostic imaging staff was 100% and 94.1% for Paediatric Basic Life Support (PBLS).
- Outpatient staff compliance was 75% for Immediate Life Support (ILS), 75% for BLS, 80% Paediatric Immediate Life Support (PILS) and 75% for PBLS. Plans were in place for the remaining staff to complete training by the end of the year.

Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure took place and access to Magnetic Resonance imaging (MR) was controlled.
- Paper referrals were used to request diagnostic imaging for both inpatients and outpatients.
- A poster was observed in the radiology waiting area advising patients who think they may be pregnant to inform the radiographer before their x-ray. Female patients from the age of 12 years were asked about their last menstrual period (LMP) as appropriate to the investigation prior to exposure to radiation and a signature was obtained to confirm this discussion. An audit of this procedure in September 2016 showed that of the records reviewed 95% had the patients name and date of birth, were signed and dated and scanned onto the patient record however, only 70% had the LMP date recorded on the form.
- Notices were in place in x-ray rooms to remind staff to 'pause and check' before scanning. Pause and check is a further process to ensure safe and effective patient care and includes checking a patients name, address and date of birth as well as previous images. This is also a requirement of the Ionising (Medical Exposure) Regulations (IR (ME) R 2000).
- We observed staff in the Computerised Tomography (CT) completing a checklist prior to the procedure.
- Local Rules were signed and available to all staff. Details of medical physics support were observed within the diagnostic imaging department and two Radiation Protection Supervisors were appointed. Staff could identify these personnel.
- Staff were able to describe the procedure if a patient became unwell in their department including calling the resident medical officer (RMO) or the emergency team depending on the nature of the illness. If a patient required hospital admission following review and treatment by medical staff, transfer was arranged by ambulance to the nearest accident and emergency department.
- A risk assessment was completed for children attending for minor procedures in the outpatients department and a paediatric nurse was onsite during the clinic. An environmental checklist was also completed prior to the commencement of paediatric clinic.
- A range of completed risk assessments were observed in diagnostic imaging for example administration of drugs and lone working.

Outstanding ☆

Outpatients and diagnostic imaging

Nursing staffing

- Outpatient nurse staffing was planned in advance to manage the workload.
- A weekly hospital planning meeting was held which included a review of any additional staffing requirements for the following week taking into consideration the number of clinics and minor procedures taking place and the numbers and requirements of patients expected. Staffing was also reviewed on a daily basis as required.
- Managers and staff told us that off duty for the week was available at the end of the preceding week. With the exception of the outpatient manager all qualified staff in the outpatient department were part-time and were reported to be very flexible if required, to accommodate the needs of the department.
- Between July 2015 and June 2016 the use of bank and agency nurses and healthcare assistants was lower than the average compared with information we have collected from similar independent health providers, with the exception of March 2016.
- Following completion of a risk assessment, if additional support was required for minor procedures involving children, this was provided by paediatric nurses from the inpatient ward.
- A nurse manager led the outpatient department supported by the hospital matron.

Allied Health Professionals Staffing

- Radiology staffing was discussed at the weekly hospital planning meeting. This ensured appropriate staffing was in place to meet requirements for clinics, weekend cover, out of hours work and theatres.
- There was a radiographer on call 24 hours a day to deal with any out of hours and emergency tests should they be required.
- Modality leads were in place in diagnostic imaging to support the medical imaging and physiotherapy manager.

Medical staffing

- The radiology department was staffed by consultant radiologists with practising privileges.
- Radiologists were on-site Monday to Friday and could be contacted by telephone if an urgent report was required out of hours.
- Consultants with practising privileges undertook outpatient clinics at the hospital. They maintained responsibility for their own patients and were available for advice by telephone if not on-site.
- A resident medical officer (RMO) was on site for 24 hours a day, seven days a week. If required the RMO could attend the outpatients and radiology departments to provide advice and assistance.

Emergency awareness and training

- Fire safety training was included within the hospitals mandatory training programme. Compliance rates at the time of our inspection were 98.4% for diagnostic imaging and 100% for outpatients and physiotherapy staff.
- Managers informed us that back-up generators were available in the event of a disruption to the power supply.
- The hospital had a major incident policy which listed key risks that could affect the provision of care and treatment.
- Staff members were aware of the policy and how to locate it on the provider's intranet and in paper format within the post room in the outpatient department.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate ●

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostic Imaging. Positively we saw that;

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice and patient pathways were in place for a wide range of treatments.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were completed and radiation safety committee meetings were held annually to monitor radiation safety in the hospital.
- An audit programme was in progress assessing compliance in relation to a number of activities including the World Health Organisation (WHO) Surgical Safety Checklist, patient care pathways and hand hygiene.

Outpatients and diagnostic imaging

- Services were benchmarked across the Spire network using the Spire national clinical scorecard. This detailed 39 quality indicators such as infection rates and patient satisfaction and were used for both adult and paediatric services.
- Competency assessments were in place for outpatients and diagnostics and induction processes were in place for new staff. We saw evidence of completed induction checklists and competency assessments.
- Appraisal rates for outpatient nurses, diagnostic imaging and physiotherapy staff were 100% at the time of our inspection and staff felt supported to develop in their roles.
- A planning meeting was held weekly and attended by senior representatives from each hospital department. This ensured appropriate staffing levels and allowed identification and forward planning for patients with additional requirements such as children, vulnerable adults or those with complex care needs.
- A one-stop breast clinic was provided at the hospital which ensured patients received prompt results to reduce anxiety and prevented the need for patients to return for further appointments.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Staff described the use of NICE protocols and guidelines for image reporting in radiology, for minor procedures in outpatients and the treatment of spinal conditions in the physiotherapy department.
- Patient pathways were in place for a wide range of treatments and this incorporated both inpatient and outpatient treatment.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were completed and radiation safety committee meetings were held annually to monitor radiation safety in the hospital.
- Diagnostic reference levels (DRL's) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part.
- We reviewed minutes from staff meetings in diagnostic imaging which were held to share information and promote shared learning.
- Staff in the outpatient department received clinical updates electronically and any policy updates were discussed at the twice daily staff briefing.
- An audit programme was in progress assessing compliance in relation to a number of activities including the WHO checklist, patient care pathways and hand hygiene.

Pain relief

- A paediatric pain management leaflet was provided to support parents with the assessment and treatment of their child's pain following treatment.
- Analgesia was prescribed for individual patients to take home in outpatient clinics following endovenous laser ablation treatment.

Nutrition and hydration

- Refreshments were available in outpatient waiting areas and following investigations and treatment.

Patient outcomes

- Services were benchmarked across the Spire network using the Spire national clinical scorecard. This detailed 39 quality indicators such as infection rates and patient satisfaction and were used for both adult and paediatric services.
- Radiologists' completed peer reviews of other radiologists' reports in each speciality to ensure adequate standards and share learning. Changes in practice were reported as a result of this process.
- All images were quality checked by radiologists who would contact the consultant with any abnormal or significant findings.

Competent staff

- Competency assessments were in place for outpatients and diagnostics and induction processes were in place for new staff.
- We saw evidence of completed induction checklists and staff told us they had found the process beneficial.
- Completed competency assessments were observed in outpatients and diagnostic imaging
- Plain x-ray and ultrasound imaging only was provided for patients under 18 years and all radiographers imaged children.
- Staff identified their training needs through the hospitals' enabling excellence appraisal process. This included an annual review of competencies and

resulted in objectives being set that were relevant to the needs of the individual and the department. A further mid-year review was held to assess progress against the objectives. Data from the hospital indicated that appraisal rates for outpatient nurses, diagnostic imaging and physiotherapy was 100% at the time of our inspection.
- Staff told us they felt supported to develop in their roles and development opportunities were available.
- Managers described how they managed poor performance including the development of improvement plans as necessary.

Multidisciplinary working

- A planning meeting was held weekly and attended by senior representatives from each hospital department. This ensured planned staffing levels were appropriate to meet the needs of patients due to be admitted the following week, including on call arrangements. It also allowed identification and forward planning for patients with additional requirements such as children, vulnerable adults or those with complex care needs to ensure a comprehensive, multi-disciplinary approach.
- A one-stop breast clinic was provided at the hospital. This meant that, following consultation and examination, patients could undergo investigations such as a mammogram or ultrasound and receive the results within the same visit. Joint working by outpatient, medical and diagnostic staff ensured patients received prompt results which helped to reduce anxiety and also prevented the need for patients to return for further appointments.
- Two specialist breast care nurses were in post in the outpatient department.
- Monthly team meetings were held within the diagnostic imaging and the physiotherapy departments to exchange information.
- Managers told us no regular team meetings were team held in the outpatient department however, short briefings were held twice a day to provide updates on issues such as clinical incidents and policies. Any specific patient needs were also discussed within this forum.
- Letters were sent from the outpatients department to patient's GPs to provide a summary of the consultation.
- The hospital had appointed a Referral Relations Executive to work more closely with local GP's to understand any issues with regards to the delivery of care or the referral of patients. This constructive challenge from this key stakeholder group was encouraged and seen as a vital way of holding services at the hospital to account.
- Radiology results were sent by letter to GPs or the referring consultant however, urgent findings would be relayed either by telephone or fax. The hospital offered a medical terminology training programme to support local community health administrators and practitioners to provide an understanding of the terminology used within acute healthcare. The aim of this collaborative working was to enable all providers in the area to deliver more joined-up care to people who use services.

Seven Day Working

- The diagnostic imaging department provided services Monday to Friday 8am-5pm however x-ray and MRI services were available until 9pm on Monday and Wednesday.
- A 24hour on call x-ray service was available seven days per week.
- Outpatient appointments were offered five days per week until 8.30pm and on Saturday mornings.

Access to information

- The radiology department used a nationally recognised system to report and store patient images.
- Staff could access previous images from across the Spire network and the NHS.
- Data from the hospital showed availability of records for outpatient appointments was above 99% in the three months prior to our inspection. In the event that records were unavailable a temporary record could be raised which included the last clinic letter.
- Staff were able to access information such as policies and procedures from the hospital's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A consent policy was in place across the Spire network and a specific consent form was in use relating to investigation or treatment for a child or young person.
- Staff in outpatients and diagnostic imaging worked on the principle of implied consent. Implied consent is consent which is not verbally expressed but granted by a person's actions and the circumstances of a situation.

Outpatients and diagnostic imaging

- If written consent was required for more complex procedures this was obtained by the consultant in outpatient clinic.
- We reviewed seven sets of records for patients who had attended for minor procedures in the outpatient department and found consent was recorded in all seven as required however, one set did not have consent confirmed as per the policy.
- Staff described how they would involve the safeguarding lead if they had concerns regarding a patient's capacity while attending the department.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) formed part of the mandatory training programme and the hospital target for training compliance was 75% by the end of Q3. Compliance rates for outpatient staff were 66% and 87% for medical imaging.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging as 'Good' for caring. This was because;

- We witnessed reception and nursing staff being polite and helpful and introduced themselves by name.
- Staff valued the ability to give patients time in all interactions and patients we spoke with confirmed how much they appreciated this. We also observed this throughout our inspection.
- Patient satisfaction trends were recorded and between June 2016 and August 2016 patient satisfaction with outpatient nurses was 99% compared to the Spire average of 97%. In the same period, satisfaction with x-ray and imaging staff ranged from 96% to 100% compared to the Spire average of 96% and physiotherapy ranged from 98% to 100% compared to the Spire average of 95%.
- The NHS Friends and Family Test, which assesses whether patients would recommend a service to their friends and family showed that between April 2016 and June 2016 over 99% of NHS patients would recommend the hospital.
- A process was in place to inform patients on arrival of any delay to their clinic appointment and staff told us that they would contact patients by telephone prior to their arrival to advise of any significant delay. This enabled patients to reschedule their appointment if it was more convenient.
- All of the patients we spoke with told us that their experiences at the hospital had been positive, "consultants have time to explain everything" and they felt involved in the decision making regarding their care.

However,

- Following refurbishment, when the new changing rooms were in use in diagnostic imaging patients would be required to walk through a corridor area to reach the x-ray and ultrasound scanning rooms.

Compassionate care

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- We witnessed reception and nursing staff being polite and helpful and introducing themselves by name.
- Staff valued the ability to give patients time in all interactions and patients we spoke with confirmed how much they appreciated this. We also observed this throughout our inspection.
- The main reception area in outpatients had measures in place to respect patient confidentiality and privacy screens were observed in the x-ray room.
- The provider had a chaperone policy in place, staff could locate this on the intranet and discuss its application.
- Gowns and dressing gowns were available for patients in the diagnostic imaging department who were required to undress.
- New changing facilities were being developed as part of the refurbishment of the diagnostic imaging waiting area. When in use, patients would be required to walk through a corridor area to reach the x-ray and ultrasound scanning rooms however, staff told us patients could choose to change in the scanning room if they so wished.
- Patient satisfaction trends were recorded and between June 2016 and August 2016 patient satisfaction with outpatient nurses was 99% compared to the Spire average of 97%. In the same period, satisfaction with x-ray and imaging staff ranged from 96% to 100% compared to the Spire average of 96% and physiotherapy ranged from 98% to 100% compared to the Spire average of 95%.

Outstanding ☆

Outpatients and diagnostic imaging

- The NHS Friends and Family Test, which assesses whether patients would recommend a service to their friends and family showed that between April 2016 and June 2016 over 99% of NHS patients would recommend the hospital.
- A 'Compassion in Practice' module was included within the mandatory training programme and had been completed by 91.6% of outpatient staff, 96.8% of diagnostic imaging staff and 100% of physiotherapy staff.

Understanding and involvement of patients and those close to them

- Information was provided to patients before admission from the hospital bookings team.
- Patients told us that following diagnostic investigations, a further outpatient appointment was arranged promptly to discuss the results and they could contact the service by telephone if needed, in between.
- Letters were sent to a patients' GP to advise of the outcome of consultations however, not all patients we spoke with reported receiving a copy.
- A process was in place to inform patients on arrival of any delay to their clinic appointment and staff told us that they would contact patients by telephone prior to their arrival to advise of any significant delay. This enabled patients and staff to work together and allowed patients to reschedule their appointment if it was more convenient.
- As part of the patient assessment process, patients with carers were identified and referred to local carer support services as appropriate.

Emotional support

- All of the patients we spoke with told us that their experiences at the hospital had been positive, "consultants have time to explain everything" and they felt involved in the decision making regarding their care.
- We observed a member of staff explaining a procedure to a patient and providing appropriate information. Patients stated information given to them was "good".
- Two specialist breast care nurses were available for patients to talk to about their condition.
- One patient told us that all staff were very professional and "smiley" while another described their experience as being "like heaven".

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

We rated outpatients and diagnostic imaging as 'Outstanding' for responsive. This was because;

- Patients told us they received instructions with their appointment letters and we observed information packs provided to both private and NHS patients.
- Waiting areas had sufficient seating available with access to toilets, baby changing facilities and refreshments. Newspapers and free car parking was available.
- Patients who had been referred to diagnostic imaging were contacted by telephone to arrange an appointment. This allowed staff to identify any additional support required if not already noted on the referral form.
- Patients had a choice of appointment date and time.
- Clinics were held in the evenings and at weekends for the convenience of patients.
- Between July 2015 and June 2016, the hospital consistently exceeded the standard of 92% of National Health Service (NHS) patients on incomplete pathways waiting 18 weeks or less from time of referral, achieving an average of 98.8%.
- The hospital had no patients waiting six weeks or longer for Magnetic Resonance imaging (MRI), Computerised Tomography (CT) or ultrasound scanning.
- An audit in July 2016 showed the average report time for diagnostic imaging was 1.7days.
- Patients we spoke with told us they were kept informed of any delay and were usually seen on time.
- Between April 2016 and September 2016 DNA rates for outpatient cases including physiotherapy ranged from 4.2% to 5.5% and 0.1% to 0.5% for diagnostic imaging.
- Relatives were encouraged to accompany patients in vulnerable circumstances and double or triple appointments could be provided if necessary.
- Access to interpreting services could be arranged by telephone or face to face for those patients who did not speak English and a notice was displayed in the outpatient waiting area advising patients of this service in a variety of languages.

- Patient information leaflets relating to cardiac investigations were displayed in English but were accessible in other languages on request.
- There was a system in place to actively review and improve services following complaints. Staff we spoke with knew how to support patients to make a complaint and details of complaints were discussed with staff in monthly team meetings and in briefings.

However,

- Toys were available in the consultation room for children attending paediatric clinic but there were no separate waiting areas or provision for children in the outpatient waiting areas.

Service planning and delivery to meet the needs of local people

- We observed clear signposting in the hospital to the outpatients and diagnostic imaging departments.
- Patients told us they received instructions with their appointment letters and we observed information packs provided to both private and NHS patients.
- Waiting areas had sufficient seating available with access to toilets, baby changing facilities and refreshments however, while refreshments were complementary for private patients, NHS patients were charged.
- Newspapers and a vending machine were available in the outpatients department.
- Free car parking was available however some patients told us that finding a space could be difficult. This had been raised with the hospital previously and in response, designated parking and additional spaces had been created.
- All patients who had been referred to diagnostic imaging were contacted by telephone to arrange an appointment. This allowed staff to identify any additional support required if not already noted on the referral form.
- NHS patients were able to choose their appointment date and time through the NHS referrals scheme.
- Self-funded and insured patients had a choice of consultant as well as the date and time of their appointment.
- Clinics were held in the evenings and at weekends for the convenience of patients.
- Toys were available in the consultation room for children attending paediatric clinic but there were no separate waiting areas or provision for children in the outpatient waiting areas.
- The outpatient orthopaedic suite had been redesigned to improve the patient journey and minimise the distance between consultation rooms, x-ray and physiotherapy.
- Clinic utilisation was reviewed monthly to accommodate existing clinics and provide additional capacity. The hospital worked closely with commissioners of care to respond to the needs of the local community. In partnership with local GP practices two satellite clinics had commenced in Nantwich and Northwich to provide outpatient care in more local settings.

Access and flow

- The outpatients department undertook 57,761 appointments between July 2015 and June 2016; of these 32% were NHS funded and 68% were funded through insurance or self-paying patients.
- Private patients we spoke with told us they received their appointments very quickly, with one being seen on the day of referral.
- Between July 2015 and June 2016 the hospital consistently exceeded the standard of 92% of National Health Service (NHS) patients on incomplete pathways waiting 18 weeks or less from time of referral, achieving an average of 98.8% incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- Standards for non-admitted patients' treatment beginning within 18 weeks were discontinued in 2015. However, it is positive to note that between July 2015 and June 2016 the hospital consistently achieved above 95% of NHS patients on non-admitted pathways starting treatment within 18 weeks of referral. Non-admitted pathways means those patients whose treatment started during the month and did not involve admission to hospital.
- The national standard for diagnostic imaging waiting times is less than 1% of patients waiting more than six weeks. The hospital had no patients waiting six weeks or longer for Magnetic Resonance imaging (MRI), Computerised Tomography (CT) or ultrasound scanning.

Outstanding ☆

Outpatients and diagnostic imaging

- The hospital aimed to complete all imaging reports within five working days unless findings were urgent. An audit in July 2016 showed that this standard was met in 100% of cases and the average report time was 1.7days.
- Urgent radiological findings were telephoned or faxed to the referrer.
- The length of appointments in the outpatient department varied according to consultant and ranged from 30-45 minutes for an initial consultation and 10-20 minutes for a follow up appointment.
- Data was not collected regarding patient waiting time in the outpatient department however patients we spoke with told us they were kept informed of any delay and were usually seen on time.
- The hospital had a number of patients who did not attend (DNA) for their appointment. Between April 2016 and September 2016 DNA rates for outpatient cases including physiotherapy ranged from 4.2% to 5.5% and 0.1% to 0.5% for diagnostic imaging.
- Staff told us that in the case of non-attendance the patient would be sent a further appointment or contacted by telephone to reschedule depending on the reason for referral.

Meeting people's individual needs

- The knee injury and osteoarthritis outcome score and the patient-specific functional scale were used in physiotherapy to measure functional outcomes for patients.
- Appointments for outpatient consultations and diagnostic investigations were arranged on the same day to prevent patients attending on more than one occasion.
- Patients told us that following diagnostic investigations, a further outpatient appointment was arranged promptly to discuss the results and they could contact the service by telephone if needed, in between.
- Staff described how people with particular needs were accommodated in the diagnostic imaging department. Relatives were encouraged to accompany patients and double or triple appointments could be provided if necessary.
- Telephone contact with patients prior to attending for diagnostic imaging allowed staff to identify any specific patient requirements and make reasonable adjustments for example if a patient attending for an MRI scan was claustrophobic.
- Outpatient staff told us they had time to spend with patients and could obtain support from dementia leads on the ward if required.
- The hospital had a number of specialist nurses in place to support the provision of individualised patient care.
- We observed reception staff taking time to speak with an elderly gentleman and discuss his individual circumstances.
- Information was provided to patients verbally and in written format regarding their condition and treatment. Information regarding cardiac investigations was observed in English, however this could be provided in other languages on request.
- Access to interpreting services could be arranged by telephone or face to face for those patients who did not speak English. A notice was displayed in the outpatient waiting area advising patients of this service in a variety of languages. However we did not see this system in use as we did not observe any patients requiring translation services during our inspection.
- Sign language support and a hearing induction loop were available for patients with a hearing impairment.
- Scanning tables in the diagnostic imaging department could accommodate bariatric patients and weighing scales and gowns were available.
- Patient information in the diagnostic imaging department was kept electronically and printed as required. This allowed literature to be printed in a larger font if a patient was visually impaired.
- Spire Cheshire had dedicated staff with skills and interests in the management of patients with mobility and cognitive issues due to a disability.

Learning from complaints and concerns

- Complaints were actively reviewed and pro-active approaches to learning were implemented
- Staff we spoke with knew how to support patients to make a complaint.
- Initial complaints were dealt with by managers in the outpatients and diagnostics departments in an attempt to resolve issues locally. If this was unsuccessful a "Please Talk to Us" leaflet was available to advise patients how to register their concerns.
- Details of complaints were discussed with staff in monthly team meetings and briefings.

Outstanding ☆

Outpatients and diagnostic imaging

- The hospital had a complaints policy and between January 2016 and June 2016, 27 complaints were received by the outpatients and diagnostic imaging department and one by the physiotherapy department.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated outpatients and diagnostic imaging as 'Outstanding' for well-led. This was because;

- Staff were aware of the hospitals' values of delivering high quality clinical care supported by a customer focused service model and felt connected to the wider Spire network through management feedback and the sharing of information and good practice.
- Staff told us that managers, clinical leads, matron and the hospital director were visible and approachable. Senior management were reported to have "an open door policy" for all staff.
- Clinical governance committee meetings took place quarterly to discuss risks, incidents and key issues and quality and performance were monitored through the clinical scorecard and key performance indicators. These processes were used to drive improvement of service delivery.
- Radiation safety committee meetings were held annually to ensure that clinical radiation procedures and supporting activities in the hospital were undertaken in compliance with ionising and non-ionising radiation legislation.
- Staff felt supported by their local managers and we observed good team working in all the departments we visited. Staff described a 'family' atmosphere and during our inspection staff reported that was due to the ethos cascaded down from managers, who empowered and inspired staff to believe they could make a difference.
- Staff told us managers regularly thanked them for their work and rewards were given to acknowledge good work.
- The views of patients were actively sought within outpatients and diagnostic imaging using the NHS Friends and Family Test and patient satisfaction surveys. A child friendly feedback form was also available.
- A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future service users.

Vision and strategy for this this core service

- The vision and strategy was formulated through engagement and collaboration of staff. The senior management team secured representation from every staff group who solicited contributions and ideas from all staff. These representatives fed these ideas back in order to create the hospital and outpatient, diagnostic imaging and physiotherapy core service plans for the forthcoming year. Heads of departments and representatives totalling 36 in number attended the hospital's 'away day' in order to reflect on the previous year's performance and formulate an individualised and challenging strategy for the future. This practice produced a hospital and service strategy borne from the staff themselves, who were invested in and passionate about the future.
- The vision of Spire Cheshire was 'To be recognised as a world class healthcare business'.
- Staff were invested in and actively demonstrated the hospitals' values of delivering high quality clinical care supported by a customer focused service model and felt connected to the wider Spire network through management feedback and the sharing of information and good practice.
- Both the outpatient and diagnostic imaging departments described how they were contributing to the overall hospital strategy through the provision of additional consulting rooms following refurbishment, the development of satellite clinics and investment in technology to increase capacity.
- Staff told us that managers, clinical leads, matron and the hospital director were visible and approachable. Senior management were reported to have "an open door policy" for all staff.
- The outpatient department was led by an outpatient manager and diagnostic imaging by a radiology manager supported by a number of modality leads.
- At the time of our inspection the diagnostic imaging department was undergoing refurbishment to improve the patient journey.

Governance, risk management and quality measurement

Outpatients and diagnostic imaging

- Hospital wide governance procedures were in place with scrutiny provided by the Medical Advisory Committee (MAC). Quarterly meetings were held and a review of meeting minutes indicated topics discussed regularly included regulatory compliance, practising privileges and proposed new clinical services.
- Outpatient and diagnostic leads contributed to the overarching governance of the hospital and met monthly as part of the Hospital Management Team. This allowed information to be disseminated to staff within team meetings and daily briefings ensuring learning was promoted throughout the organisation.
- The radiology and outpatients department recorded risks on the hospital risk register and these included radiographer's lone working in the department outside normal working hours
- Clinical governance committee meetings took place quarterly to discuss risks, incidents and key issues. A comprehensive report and detailed minutes of meetings were produced and circulated to all staff. Governance relating to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and radiology were standard agenda items.
- Radiation Safety Committee meetings were held annually to ensure that clinical radiation procedures and supporting activities in the hospital were undertaken in compliance with ionising and non-ionising radiation legislation.
- Quality and performance were monitored through the Clinical Scorecard and Key Performance Indicators (KPI's) and included items such as achievement of cancer standards, infection rates, levels of staff training, complaints and patient satisfaction.

Leadership and culture of service

- The hospital was managed by a visible, competent and enthusiastic team who placed patient care as central to their success. The team inspired and motivated staff and promoted a collective ethos of patient care and improving standards. Staff were committed and motivated and demonstrated ambition to achieve high standards, which led to a professional, efficient and caring service and one which staff felt able to go the extra mile for their patients, their managers and their hospital.
- The outpatient and diagnostics departments were led by clinical managers. The diagnostics manager was also supported by a number of modality leads.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Staff felt supported by their local managers and said the matron and hospital director were visible and approachable. Managers undertook a daily hospital wide walk around.
- Monthly team meetings took place in physiotherapy and diagnostic imaging.
- Briefings took place twice a day in the outpatients department to ensure staff received clinical and corporate updates however, the last formal team meeting took place in March 2016.
- We observed good team working in all the departments we visited.
- There was an open and honest culture within the service and staff were candid about the challenges they faced.
- Recent challenges in the outpatient department due to staffing pressures as a result of sickness and holidays had impacted on morale however, every member of staff we spoke with were positive about the department, managers and other team members. Staff said they felt "part of a family" within the hospital and were proud of the hospital as a place to work and of the work they did.
- Managers told us poor performance was dealt with by the development of improvement plans and managed through the enabling excellence process.
- Staff told us managers regularly thanked them for their work and rewards were given to acknowledge good work.
- Physical and psychological support services were available to staff and staff we spoke with told us they were aware of how to access them.

Public and staff engagement

- The views of patients were actively sought within outpatients and diagnostic imaging using the NHS Friends and Family Test and patient satisfaction surveys. A child friendly feedback form was also available.
- The hospital held a hand hygiene event one evening in the summer which was attended by 86 delegates made up of members of staff and members of the public. This imparted information regarding the importance of hand hygiene not only in the hospital but also in the community setting. Members of the public were asked

to observe if their consultants and clinical staff washed their hands and this information was fed back to produce a report and develop action plans where necessary.
- The hospital engaged with the local Healthwatch who performed a site visit during our inspection. Healthwatch is an independent consumer champion that represents the views of the public in health and social care.
- Larger gowns were made available in diagnostic imaging in response to patient feedback and we observed a 'You said we did' poster in the hospital reception. This detailed feedback from patients regarding difficulty experienced finding a parking space and the hospitals response by adding extra spaces and creating designated parking areas.
- The hospital proactively used social media platforms to capture feedback from previous patients, acting upon information received to improve the patient experience. They also used these methods to engage with communities to deliver health messages and provide information about services and events.
- A patient feedback engagement forum had been launched to solicit comments and opinions from present and patients in order to seek improvements and raise standards. The hospital invited individuals who had made complaints to join the group in order to provide honest and critical insight on suggestions, plans and patient services. They used the feedback to identify areas of improvement and make changes based on the experiences of patients.
- Consultant engagement results in 2016 showed that 100% of consultants felt the hospital were easy to do business with when compared to other providers. This was the best result in the Spire Group for 2016 and a 8.5% improvement on the previous year's results
- In 2016 a patient engagement forum that included both National Health Service (NHS) and self-pay patients had been launched. The aim was to obtain feedback from past patients to improve the patient journey for future service users and patients who had made a complaint were often invited to join.
- An annual staff survey and consultant survey were undertaken and a bi-monthly newsletter sent to all staff electronically and in paper copy.
- Results from the 2015 staff survey showed if a friend or relative needed treatment 96% of staff would be happy with the standard of care provided in the hospital and 93% felt what they did at work made a positive difference to the hospital and they got personal satisfaction from it. However, only 28% of staff felt other departments understood the impact of their actions on the team and 50% felt senior managers provided a rationale for decisions that impacted on them. An action plan produced in response to the survey included forming an Active Quality Circle with staff representatives and involving the wider staff base in decision making where applicable.
- Since this survey a new matron had been employed and staff were overwhelmingly positively about the relationship between the hospital director, matron and the departments. Staff told us both the hospital director and matron were accessible, visible and had an "open door policy" for all staff.
- Results from a Consultant Satisfaction Report in 2016 showed 86% of consultants rated the overall service to them from the hospital as excellent or very good and the hospital were above average for the Spire group in 29 out of 30 measures.
- Physical and psychological support services were available to staff and staff we spoke with, told us they were aware of how to access them.
- The hospital celebrated high performing staff and innovation through the provider's staff recognition scheme, 'Inspiring People'. Members of staff nominated other members of staff they felt worthy of recognition and these were celebrated by the hospital.

Innovation, improvement and sustainability

- The hospital championed a proactive approach to raising standards and seeking improvements, they engaged with the public, community groups and staff to solicit ideas and canvass opinion, responding to feedback and individual needs by acting upon areas highlighted and implementing initiatives to promote satisfaction and increase their responsiveness.
- Capital expenditure plans were in place in diagnostic imaging to ensure that equipment was upgraded as technology advanced and to support expansion of the service.
- In partnership with local GP practices two satellite clinics had commenced in Nantwich and Northwich to provide outpatient care in more local settings.
- GP engagement events and newsletters were provided to update community colleagues regarding the hospital and the Spire Network.

Outstanding ☆

Outpatients and diagnostic imaging

- The hospital delivered a regular free GP education programme. GP's were invited to attend education sessions run by specialist consultants with an aim to working with them more holistically to improve patient outcomes. The hospital also worked closely with the CCG and a GP representative advisor to ensure that any programs of education met with the needs of local GPs with the underpinning objective of retaining patients at primary care, up-skilling GP's and avoiding hospital admissions to secondary care, in turn supporting the local health care economy.

Outstanding practice and areas for improvement

Outstanding practice

- Patients' psychological, emotional, physical and social needs were highly valued by staff and this holistic approach was embedded into their plan of care. We found a strong person centred culture provided by highly motivated kind and caring staff who took satisfaction in going the extra mile for their patients.
- The role of Patient Services Manager proved to be a very effective initiative, which was well received by patients. This ensured optimum individualised nutrition was provided to each patient which was tailor made to suit their individual palate and singular needs.
- There was great flexibility in accommodating patients' choice of appointment time and date, with appointments being offered to suit patients' circumstances, including evenings and at weekends. Double or treble appointments could be allocated in order for patients to get actions completed on the same day to prevent them having to undertake long journeys. Some appointments and treatments were available at very short notice. The hospital provided satellite clinics in other locations to enhance convenience and choice.
- The hospital director and the matron were instrumental in leading positive and welcome changes to the hospital for both patients and staff. Their passion and commitment to their cause was both inspirational and infectious and without exception staff told us they had led the hospital to its current much improved position. The management strategy and style was both inclusive and supportive. Staff felt valued, satisfied and encouraged. Managers provided opportunities to contribute to initiatives and ideas and felt empowered and inspired to strive for advances in quality and patient care.
- The hospitals approach to governance was both logical and clear and was interwoven through the clinical governance, medical advisory committee and quality improvement groups within the hospital. This embedded approach provided measurable and relevant data which aided advances in improvement and quality.

Areas for improvement

Action the provider SHOULD take to improve

In Surgery Services:

- Monitor completion of checklists in all theatres to ensure cleaning had been documented when theatre was closed.
- Store sterile equipment safely to reduce the risk of contamination in the theatre department
- Should continue to keep all fire escape routes clear of clutter and storage.
- Consider the discussion of incidents to be a standard item on ward and theatre monthly team meetings.
- Consider options to implement formal Clinical Supervision sessions for staff.

In Outpatients and Diagnostics Services:

- The provider should consider resuming team meetings within the outpatients department.
- The provider should ensure toys used in the outpatient clinic are included in the cleaning checklist and stored appropriately.
- The provider should ensure consistent recording of the minimum and maximum of fridge temperatures.
- The provider should ensure records are correctly filed, have the patient alert sheet completed and include the time of the consultation and designation of the consulting professional.