Spire Bristol Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The inspection of Spire Hospital Bristol – The Glen, was part of our programme of comprehensive inspections. We inspected the hospital on 14, 15, 16 September 2016 and unannounced on 29 September 2016.

Our key findings were as follows:

We rated the hospital as good overall. All of the key questions were rated as good in all areas that we rated. However, we have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The report is limited as there was insufficient evidence and a very small number of procedures carried out at the hospital. During the inspection the provider decided to withdraw the termination of pregnancy service at the hospital and removed this as a condition of their registration.

Are services safe at this hospital

- We rated the safety of the hospital as good although some improvements in record keeping were required.
- The hospital had a good safety culture. Staff throughout the hospital were supported and empowered to report incidents and there was clear learning and actions taken as a result of investigation.
- There were processes in place for the duty of candour, and we saw evidence that this occurred sensitively and in a timely manner where things went wrong.
- There were sufficient staff to meet patient needs. The hospital used a recognised nurse staffing tool to ensure sufficient planned staffing levels on inpatient wards. We observed that the actual staffing levels met this. Earlier in the year prior to our inspection, there had been a period of time where the ward had 10 nursing staff vacancies which had an impact on the continuity of care provided to patients, although safe staffing numbers had been maintained through the use of agency and bank staff. Subsequent recruitment had been successful and at the time of the inspection there was only one remaining vacancy.
- There were some radiography vacancies. However, staff were flexing their working patterns to cover this.
- There were sufficient medical staff within the hospital and processes in place to ensure that consultant cover was in place both out of hours and when the responsible consultant was on leave. There was also a resident medical officer (qualified to speciality training level 3 – ST3) on site 24 hours a day, to provide medical care to patients throughout the day and night.
- There were clear processes for recruitment and for engaging consultants under practising privileges. There was clear boundaries on each consultant's scope of practice, with biennial reviews in place to monitor each consultant's performance.
- We observed that the hospital was visibly clean and that there was hand washing facilities, hand sanitising gel and personal protective equipment available which staff used. Although there were auditing practices in place for the use of hand sanitising gel by staff, this was by weighing it rather than by observing and auditing staff hand hygiene practice.
- There were low rates of infection at the hospital, with no incidences of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA), methicillin-sensitive Staphylococcus aureus (MSSA), E-Coli or Clostridium difficile. In addition the incidence of surgical site infections was lower than the national average for hospitals in England.
- Medicines were mostly secured safely within the hospital, although not all treatment room doors were locked on the wards and some patients own medicines were left on the reception desks during our inspection. Staff rectified this immediately it was drawn to their attention.
- The ordering, storage, and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and associated regulations.
- Patient records, risk assessments and observational documentation maintained by nursing staff were completed fully, although there were improvements required in the documentation of patient care rounds.

Summary of findings

- The maintenance of a single patient record was identified as one of the top three risks in the hospital. This was predominantly as a result of consultants holding their own records which meant that there was not a full and complete record which remained in the hospital. There was an ongoing project in the hospital to rectify this. However, we saw the impact of this in records reviewed during the inspection with incomplete patient records for surgical patients, because consultants had not maintained the hospital patient record fully. This included missing pre-operative consultant records; no consultant record following a patient's return to the ward from the high dependency unit and an illegible anaesthetic record. All of which contravened the General Medical Council record keeping standards. In addition, there was no evidence of, or consent for medical photography in applicable patient notes, which contravenes the Royal College of Surgeons Professional Standards for Cosmetic Surgery.
- Patient records stored by the hospital were secure and out of sight of patients and visitors.
- There were systems and processes in place to assess and respond to patient risk. The hospital used the national early warning score system (NEWS) and compliance with completion was 100%. In addition the hospital had a critical care outreach team to support ward nurses and patients who were discharged from intensive care.
- The hospital used the World Health Organisation (WHO) surgical safety checklist. We saw that this was fully used in the operating theatre and that surgical safety briefings took place prior to theatre lists in an open manner, including all staff. However, we found that although an amended WHO checklist was available within interventional radiology, this was not always used or completed. When we raised this with the hospital swift action was taken.

Are services effective at this hospital

- We rated the effectiveness of the hospital as good, although some improvement in the monitoring of patient outcomes was required.
- Relevant and current evidence-based practice, guidance and standards were incorporated and used to develop services, care and treatment throughout the hospital. This included the use of care bundles, which were linked to NICE (National Institute for Health and Care Excellence) and other best practice guidance, for example from Royal Colleges. Policies and procedures were also developed in this way.
- The clinical governance group provided sign off of new policies and guidance, linking in with the hospital medical advisory group (MAC), risk committee, quality assurance group and heads of department meetings as necessary. Variations to standard practice were also reviewed and approved or declined via this sign off process. For example, the hospital follows the British Orthopaedic Association guidance on venous thromboembolism chemo-prophylaxis rather than NICE guidance. This was in line with practice in a local NHS trust, but had been thoroughly reviewed in line with evidence prior to approval for use at the hospital.
- Proposed new procedures were authorised by the hospital director, only when reviewed and approved by the medical advisory committee.
- There was an audit programme in place which linked to the corporate and hospital scorecard. This monitored compliance and benchmarked performance against other Spire hospitals for the effectiveness of the service for areas such as: pain score monitoring; evidence of patients with cancer being discussed at an MDT meeting; monitoring compliance with venous thromboembolism (VTE) assessment and prophylaxis best practice. Data supplied showed that the hospital performed well in comparison with other Spire hospitals with the exception of VTE chemoprophylaxis because they used a differing protocol to other hospitals in the group.
- National safety standards for invasive procedures had been introduced in the hospital to ensure continued focus and compliance with the WHO surgical safety checklist. This was an ongoing process and would result in local safety standards for invasive procedures when embedded.
- Patients throughout the hospital received effective pain relief in a timely manner. Assessment tools were used and assessments were monitored and audited quarterly.
- Patients' nutrition and hydration were monitored and assessed using the malnutrition universal screening tool (MUST). There were effective systems in place to ensure that patients were not 'nil by mouth' for extended periods of time.

Summary of findings

- The hospital used a clinical scorecard to benchmark all of Spire hospitals key performance indicators, many of which were based on national external benchmarks. They also submitted data to the National Joint Registry, National Institute for Cardiovascular Outcomes Research and patient related outcome measures (PROMs) audits, although they did not always receive outcome data back in order to benchmark and drive improvement in services or patient outcomes. Information about the outcomes of patient's care and treatment in critical care was not benchmarked against other similar units.
- There were processes in place to ensure that there were competent staff working in the hospital. There was a comprehensive system for approving and renewing practising privileges in the hospital and clear records in place to support this. Hospital staff were able to gain additional specialist training and qualifications associated with their role.
- There was excellent multidisciplinary working throughout the hospital and patient pathway, from prior to admission for a surgical procedure to following discharge. This included engagement at the weekly resource meeting where patients being admitted for a surgical procedure who may have complex or additional needs were highlighted, this included staff from all areas of the hospital including administrative, catering and hotel services.
- Consent was taken effectively for surgical procedures. However, not all consultants documented consent for medical photography. Nursing staff understood the complexities of consent and decision making.
- Staff understood the Mental Capacity Act 2005 and said that they would escalate any concerns to the ward sister or matron should any concerns arise.

Are services caring at this hospital

- Staff within the hospital were seen to be caring throughout, outpatient and diagnostic imaging services were rated as outstanding and all other services were rated as good.
- Throughout the hospital we saw that all staff were caring and compassionate towards patients and their relatives. All were treated with dignity, respect and professionalism.
- Patients spoke highly of the care received. The feedback provided through comment cards during the inspection window was unanimously positive about the whole patient journey. One patient commented that the service had been exceptional throughout. They also stated that "without exception, staff are warm, caring professional and thorough – reception staff, cleaners, catering staff, nurses, consultants – everyone." A second patient commented that, by all staff, they had always been treated with respect and a listening ear. A third patient commented that the care they had received from the car park on arrival to leaving the hospital had been wonderful, friendly, efficient but not rushed. They also said that staff were happy to answer questions. Another patient said that staff were caring and treated them with dignity as well as medicines.
- The NHS Friends and Family Test was used for all NHS patients visiting the hospital. The response rates were above the England average and the scores were similar to the England average. In addition the hospital carried out their own patient satisfaction surveys which were monitored. Patients consistently rated their satisfaction at 98% or above.
- We observed a caring approach to patients throughout the hospital and there was no difference in the manner, standards or care provided to NHS and private patients. All patients were treated with the same level of care, dignity and respect.
- Patients were involved in their care and staff ensured that they understood what was happening. Carers and relatives were involved in discussions as patients wished, and we observed thoughtful and considerate discussions throughout.
- One patient commented that their fears and anxiety about their surgery had been allayed by the consummate professionalism and kindness of staff throughout the hospital.

Are services responsive at this hospital

Summary of findings

- Services were planned and delivered to meet the needs of the population and also patients' individual needs. Services were planned to complement those in the NHS as well as the needs of the private self-funding and insured patients within the area. This included the development of the cardiac catheterisation laboratory as well as plans to develop day case and endoscopy facilities further at the hospital.
- Services were tailored to patients individual needs during the weekly resource meeting, where all surgical admissions to the hospital in the following week were discussed and planned to ensure that staffing, equipment, catering needs and any key individual needs were made available.
- The hospital took account of and delivered effective care to patients with differing and complex needs such as those living with dementia. Staff were Dementia Friends and had received specific training to support patients living with dementia. They also provided tailored care to meet patients' religious and cultural needs. Translation facilities were available in the hospital and staff had a clear understanding of how and when they needed to gain access to this support.
- Patients received timely access to assessment, care and treatment. The hospital mostly met the NHS constitutional standard for patients to begin treatment within 18 weeks of referral. There were relatively low levels of cancelled procedures in the year prior to our inspection. Most were rebooked within 28 days of the cancelled procedure. Those that weren't were due to patient choice.
- Patient transfers from critical care to the ward did not occur outside of core hours, and on the rare occurrence of a delay in transfer from critical care patients were kept informed.
- There were processes in place for the management of complaints. We reviewed five complaints files and found that they were fully investigated, learning and actions were identified and circulated to staff by a number of means. Staff supported patients to make a complaint either formally or informally, although some patients were not aware of how to make a complaint. However, we saw leaflets displayed across all departments which provided this information, and further details were available on the hospital website. There were also posters displayed for patients in English and other languages on how to raise a concern

Are services well led at this hospital

- There was a clear vision and strategy within the hospital which was patient and quality focused. The values of the hospital were clearly articulated by all staff we spoke with throughout the hospital.
- There were very clear governance systems which engaged risk and quality measurement across the hospital. Risks were identified and responded to and quality was measured through the clinical scorecard. Incident and complaint monitoring was thorough and learning was very clear throughout. There was clear visibility of the escalation of issues and risk from wards and departments to the senior management team and feedback to staff within the hospital.
- There were some areas where this could be further strengthened and developed, for example in benchmarking of the quality, outcomes and performance of, in particular, the critical care service.
- The leadership and culture within the hospital was very strong. All staff we spoke with felt supported, not only by their immediate line managers but also by the senior management team in the hospital. There was an overwhelmingly positive morale within the hospital with staff not just proud of the work they did but also about working at the hospital.
- There was clear and visible leadership throughout the hospital. Staff held the leadership team in high regard, and there was a clear open door policy for all managers and leaders in the hospital.
- There was a strong emphasis on promoting the safety of patients and the wellbeing of staff within the hospital, which had developed over the year prior to our inspection. The hospital director and matron had set this tone.
- There was a collaborative working system within the hospital, with action taken to address behaviour and performance which was not consistent with the values of the hospital. There had been initiatives implemented to promote the collaborative working focused around developing a clearer understanding of the challenges and services offered in other departments.

We saw several areas of outstanding practice including:

Summary of findings

- The weekly multidisciplinary resource meetings, which involved managing patient risk, staffing and proactive planning for admission and discharge to ensure effective use of resources.
- The provider had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Senior leadership approach to engaging and empowering staff was outstanding. As was the leadership focus on patients and the quality of care delivered. Both staff and the senior management team were resoundingly complimentary of each other's practices, commitment and ethos towards a shared goal.
- The physiotherapy team consistently went above and beyond their responsibilities in making sure NHS patients did not suffer adverse recovery due to a delay in receiving NHS physiotherapy.
- A new induction for outpatient staff had been developed in conjunction with staff and was tailored to suit their individual needs.
- In the children and young people's service, nursing staff had two different coloured uniforms, bright pink or blue, and would ask older patients how they would like to be treated, as a child, teenager or adult and would therefore change their nursing uniforms to suit the patient.

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

Importantly, the provider must:

- The hospital must ensure that all patient records are accurate and fully completed records and ensure all surgeons record consent for medical photography and keep copies of photographs in the single patient record. The hospital must continue with its project to create a single clinical record across the hospital and reduce the need for separate inpatient and outpatient medical notes as quickly as possible.
- The diagnostic imaging department must make sure that the WHO surgical safety checklists for interventional radiology are fully completed for every patient and every procedure.

In addition the provider should:

- The hospital should consider the removal of the carpets in corridors where patients and staff have access.
- The hospital should ensure systems are in place to benchmark and compare patient outcomes with other similar critical care units.
- The hospital should take steps to ensure the internet provided has suitable measures in place to protect children and young people accessing inappropriate content.
- The diagnostic imaging department should ensure that they clearly document asking women of child bearing age about the possibility of them being pregnant before radiological procedures taking place.
- The diagnostic imaging department should work closely with the consultant staff to improve the compliance with the proper completion of imaging request forms

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	Good	We rated surgery services overall as good because: • There was a good culture of incident reporting and response to risk at all levels. The rate of clinical and non-clinical incidents in surgery and inpatients was lower than the average rate in other similar sized independent acute hospitals. • Staff at all levels were clear about how and when to apply the Duty of Candour. • Maintenance of the facilities kept people safe and engineering governance arrangements were in place and managed effectively. • We observed and patients told us that staff complied with safe systems and processes to prevent and control infection, in line with hospital policy and national guidance • The hospital delivered good surgical outcomes to patients. We saw effective multidisciplinary team working, from the pre-admission assessment, through to the patient's discharge. A weekly resource meeting facilitated effective planning of admission and discharge for complex patients. • There were plans in place to introduce a single patient record to maintain effective contemporaneous record keeping. • There were excellent systems in place to facilitate the smooth access of patients on to the ward typically within 15 minutes and in line with the hospital's admission and discharge policy. • The senior management team had a clear vision and strategy and this was cascaded to all members of clinical and non-clinical staff. • There were effective governance systems in place to support the delivery of good quality care However: • Consultants' records and some nursing care records were not always complete, so we could not be

Summary of findings

assured that assessments, care and treatment had taken place. We could not be assured of the appropriate consent for and storage of medical photography.
- On the day of our inspection, some medicines were not stored securely and could have been at risk of theft.

Critical care

Good

We rated critical care services overall as good because:

- There was a good culture of incident reporting and no serious incidents had occurred on the unit.
- The equipment and the unit appeared visibly clean.
- We observed and patients that staff complied with safe systems and processes to prevent and control infection, in line with hospital policy and national guidance.
- We saw effective multidisciplinary team working, including the outreach team who could treat patients who became acutely unwell.
- Nursing and medical staffing met the current guidelines, and all staff were experienced and had access to a wide range of training courses.
- The staff used evidence based practice and treatments.
- Patients were treated with dignity and respect and patient feedback was used to make improvements.
- There were effective governance systems in place to support the delivery of good quality care

However,

- We found the unit did not participate in national benchmarking of patient outcomes, made it difficult to fully assess performance.
- There was nowhere for critical care staff to have private conversations with relatives or carers within the unit.

Services for children and young people

Good

We rated children and young people's services as good overall because:

- The "Ispire" children's booklet, which included child friendly information about the hospital and its service, was effective to support children to be involved in, and understand, their care.

Summary of findings

- There was a clear service vision and strategy in place and feedback from staff about the culture within the service was very positive.
- Staff worked effectively as a team, were dedicated and very passionate about children and young people' services.
- Feedback received from children and their parents was positive. Parents said that staff were kind and went above and beyond to support them and their child.
- Parents said they felt involved in their child's care and treatment and understood the plan of care in place.
- The use of the Spire Paediatric scorecard, much like that of the NHS safety thermometer was placed in the hospital as a visual promotion of how well the hospital was providing care for children. Parents we spoke to said they liked the open approach that this demonstrated the hospital had.
- Staff provided information for parents and for children in suitable formats.
- Governance systems oversaw standards of care and ensured appropriately trained staff cared for children and young people.
- All hospital staff were aware of when they would need support from registered children's nurses or a paediatrician and how to access them.

However:

- At the time of our inspection the Wi-Fi offered was unsecured and graphic images and content not suitable for children were easily accessible.
- No dedicated children's waiting area was available.
- We found missing clinician signatures within patients notes.

Outpatients and diagnostic imaging

Good

We rated outpatient and diagnostic services overall as good because:

- Clear systems were in place for incident reporting, investigation and learning from incidents.
- All departments were visibly clean and tidy and all equipment had been tested and serviced in line with manufacturer's instructions to make sure it was safe to use.

Summary of findings

- Up to date and appropriate risk assessments were in place across outpatients, physiotherapy and diagnostic imaging.
- There was good evidence of multidisciplinary team working practices.
- Staff were competent and well trained. Enabling Excellence (appraisal and professional development) files were available for all staff to demonstrate their individual competencies.
- A new induction programme had been developed in conjunction with staff. This provided an induction that met the needs of each individual member of staff to orientate themselves to the hospital and department.
- There were sufficient staff to meet the needs of the patients.

- The patients we spoke with were overwhelmingly complimentary about the hospital, staff and the care they had received.
- Staff were able to give examples of where they had made a difference to individual patients' experience and their journey through the outpatients department.
- Staff were aware of their patient's emotional needs and gave examples of where staff had been able to reduce patient anxieties. Additional support was available from specialist and link nurses.
- Staff were experienced in recognising patients individual needs and gave examples of where this had improved the patient experience.
- The leadership, governance and culture promoted the delivery of person centred care. There were clear governance structures and systems in place with defined accountabilities for assurance.
- Managers provided clear leadership and motivation to their teams.
- Staff were overwhelmingly complimentary about their immediate line managers and the overall hospital management teams.
- There was an open and transparent culture within outpatients, physiotherapy and the diagnostic imaging departments. Staff told us they felt proud to work in the departments and for the hospital.
- The departments regularly engaged with patients and staff in the development of the service.

- One member of staff summed up what all the staff we spoke with felt. “We have time to listen, time to talk and time to care”.

However:

- It was not clearly documented that all women of child bearing age were asked about the possibility of them being pregnant before radiological procedures taking place.
- WHO checklists for interventional radiology were not always fully completed. Referral forms for radiological procedures were not always fully completed. Swift action was taken by the hospital to rectify this prior to the unannounced visit.

Termination of pregnancy

- At the hospital the termination of pregnancy service was not provided as a distinct service but was facilitated through the general outpatient department and surgical services.
- There was evidence that compliance had not been met with a number of the Required Standard Operating Procedures. This was necessary to maintain the licence from the Secretary of State to provide a termination of pregnancy service at the hospital. The senior management team were informed of our findings during the inspection and they took immediate actions to deregister and cease the termination of pregnancy service.
- We received written confirmation that applications had been made to the Care Quality Commission to remove the condition of registration that the regulated activity termination of pregnancy be carried out at Spire Bristol Hospital. An application had also been made to the Department of Health to remove the Secretary of State licence. Written confirmation of the intent to cancel was received on 15 September 2016. The senior team at the hospital notified us that all relevant staff had been informed of these changes. Termination of pregnancy information was also removed from the Spire Bristol website.
- Between April 2015 and March 2016 there had been no reported incidents or hospital acquired infections.

Summary of findings

- Patient records showed risks had been assessed and relevant actions taken. Written information confirmed the legal requirements for a termination had been followed.
- Care records were stored safely. However medical records were not accessible to all staff. These were maintained by the consultants and stored off site.
- The majority of staff had in date mandatory training, including safeguarding vulnerable adults and children.
- Records documented compliance with abortion law and regulations.
- The provider's clinical guidance and policy had limited reference to national guidance and standard. There was no audit plan in place to monitor standards, care and practice for termination of pregnancy patients' treatment and care.
- We were told there had been no complications for the last five termination procedures completed.
- Consent was documented as checked and pain assessments were completed and appropriate actions taken.

Summary of findings

Contents

Good

Spire Bristol Hospital

Services we looked at

Surgery; Critical care; Services for children and young people; Outpatients & diagnostic imaging; Termination of pregnancy;

Summary of this inspection

Background to Spire Bristol Hospital

Spire Hospital Bristol – The Glen, is a large independent acute hospital opened in 1987 and is part of the Spire Healthcare Group (previously BUPA Hospitals LTD). In 2007 a private equity company called Cinven bought the company from BUPA Hospitals LTD, and Spire Healthcare was established. Spire Healthcare became a public limited company when it floated on the London Stock Exchange in July 2014.

The hospital provides surgical, diagnostic, critical care and outpatient services to patients in the South West of England and South Wales and undertake some complex surgery with an intensive care unit on site.

The specialities carried out at the hospital include:

- Cardiology
- Cardiothoracic surgery
- Chest medicine
- Dermatology
- Ear nose and throat surgery
- Endocrinology
- Gastroenterology
- General medicine (outpatient and daycase only)
- General surgery
- Gynaecology
- Haematology
- Nephrology
- Neurology
- Neurosurgery
- Oncology
- Oral surgery
- Orthopaedics
- Paediatrics
- Plastics/cosmetic surgery
- Rheumatology
- Urology
- Vascular surgery

The hospital has 74 single private rooms and an additional six critical care beds providing both intensive care and high dependency care within the hospital after surgery. There are four operating theatres, which are equipped with laminar flow air filtration systems (designed to reduce the risk of airborne contamination), a fifth operating theatre without laminar flow air filtration, a cardiac catheter suite and an endoscopy and minor injuries suite.

The hospital has a registered manager: Mr Daniel Rees-Jones, who has been the registered manager since January 2016. He is also the controlled drugs accountable officer for the hospital.

We inspected all aspects of the hospital, as part of our programme of comprehensive inspections of independent healthcare.

Our inspection team

Our inspection team was led by:

Inspection Lead: Catherine Campbell, Care Quality Commission, Inspection Manager

The team included six CQC inspectors and a variety of specialists: a consultant surgeon; a consultant anaesthetist; a paediatric nurse; a general nurse with experience of ward and outpatient work; a midwife and a board level director with experience of governance.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 14, 15 and 16 September 2016, held staff focus groups on 22 September 2016 and an announced visit on 29 September 2016. We spoke with a range of staff in the

Summary of this inspection

hospital, including nurses, consultants, administrative, ancillary and clerical staff. During our inspection we reviewed services provided by the hospital in the ward, operating theatre, outpatients and imaging departments.

During our inspection we spoke with patients, staff, including consultants, who are not directly employed by the hospital and family members/carers from all areas of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Information about Spire Bristol Hospital

The hospital has 74 single private rooms and an additional six critical care beds providing both intensive care and high dependency care within the hospital after surgery. There are four operating theatres, which are equipped with laminar flow air filtration systems (designed to reduce the risk of airborne contamination), a fifth operating theatre without laminar flow air filtration, a cardiac catheter suite and an endoscopy and minor injuries suite.

There are 20 outpatient consultation rooms and the diagnostic imaging department provides x-ray, CT (Computed Tomography), PET (Positron Emission Tomography), DEXA (Dual-energy x-ray absorptiometry) and MRI (Magnetic Resonance Imaging) scans, ultrasound, mammography and dental x-ray facilities.

The hospital employs 303 whole time equivalent staff of which 107.7 whole time equivalent roles are nurses, operating department practitioners and healthcare assistants. There are 366 consultants working at the hospital. They are not directly employed but are engaged via practising privileges. This is sometimes known as admitting rights. The hospital also engages four regular resident medical officers who provide onsite medical care 24 hours a day.

There were 9,656 inpatient and day case episodes of care reported during the reporting period (April 2015 to March 2016). Of these patients, 48% were inpatients and stayed overnight. There was a mixture of funding for patient care: 30 % of patients were NHS funded and 70% had alternative funding such as private or insurance company funding.

From April 2015 to March 2016 the outpatients department saw 77,312 patients of all ages, including children. Patients that were referred under the NHS accounted for 16% of the total number of patients seen in outpatients. Those patients that were self-funding or via their insurance accounted for 84% of the total number of patients seen within outpatients.

Spire Hospital Bristol – The Glen has been inspected 3 times by the Care Quality Commission, once in March 2014 in February 2013 and again and in December 2011. The hospital was found to be meeting the standards of quality and safety assessed during these inspections. The termination of pregnancy service was reviewed in March 2012 and all standards were met.

Good

Surgery

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

Information about the service

Spire Bristol Hospital offers a wide range of NHS and private elective surgical procedures for a range of specialities. This includes major surgery and complex and advanced procedures such as cranial, neurosurgical and cardiothoracic surgery. Other specialities offered at the hospital are general surgery, gastroenterology, spinal surgery, urological and gynaecological surgery, orthopaedic surgery (such as total hip and knee replacement), ear, nose and throat, oral and maxilla-facial, cosmetic and plastic surgery.

The hospital comprises of 74 single private rooms, three critical care level three beds and three level two beds. There are four operating theatres, which are equipped with laminar flow air filtration systems (designed to reduce the risk of airborne contamination), a fifth operating theatre without laminar flow air filtration, a cardiac catheter suite and an endoscopy and minor treatment suite.

There were 9,656 inpatient and day case episodes of care reported during the reporting period (April 2015 to March 2016). Of these patients, 48% were inpatients and stayed overnight. There was a mixture of funding for patient care: 30 % of patients were NHS funded and 70% had alternative funding such as private or insurance company funding.

During the inspection period, we visited the inpatient ward, operating theatres, the cardiac suite, the endoscopy and minor injuries suite, and the preadmission suite. We spoke with members of the staffing team including nurses, consultants, pharmacists and the engineering and sterile services team. We also spoke with patients and some of their relatives' pre and post-operatively.

Summary of findings

We rated surgery services overall as good because:

- There was a good culture of incident reporting and response to risk at all levels. The rate of clinical and non-clinical incidents in surgery and inpatients was lower than the average rate in other similar sized independent acute hospitals.
- Staff at all levels were clear about how and when to apply the Duty of Candour.
- Maintenance of the facilities kept people safe and engineering governance arrangements were in place and managed effectively.
- We observed and patients told us that staff complied with safe systems and processes to prevent and control infection, in line with hospital policy and national guidance.
- The hospital delivered good surgical outcomes to patients. We saw effective multidisciplinary team working, from the pre-admission assessment, through to the patient's discharge. A weekly resource meeting facilitated effective planning of admission and discharge for complex patients.
- There were plans in place to introduce a single patient record to maintain effective contemporaneous record keeping.
- There were excellent systems in place to facilitate the smooth access of patients on to the ward typically within 15 minutes and in line with the hospital's admission and discharge policy.
- The senior management team had a clear vision and strategy and this was cascaded to all members of clinical and non-clinical staff.

Good

Surgery

- There were effective governance systems in place to support the delivery of good quality care.

However:

- Consultants' records and some nursing care records were not always complete, so we could not be assured that assessments, care and treatment had taken place. We could not be assured of the appropriate consent for and storage of medical photography.
- On the day of our inspection, some medicines were not stored securely and could have been at risk of theft.

Are surgery services safe?

Good

We rated safe as good because:

- There was a good culture of incident reporting and response to risk at all levels.
- The rate of clinical and non-clinical incidents in surgery and inpatients was lower than the average rate in other similar independent acute hospitals
- Staff understood the Duty of Candour and we saw evidence that it was applied following serious incidents.
- Maintenance of the facilities kept people safe and engineering governance arrangements were in place and managed effectively.
- We observed and patients told us that staff complied with safe systems and processes to prevent and control infection, in line with hospital policy and national guidance.
- During our inspection, we witnessed how efficiently the multidisciplinary team responded to an emergency call.

However:

- Patients' records were not always complete and legible so we could not be assured that assessments, care and treatment had taken place. Consent for and storage of medical photography did not always support the confidentiality of the people using the service and we could not be assured they were held securely. However, with exception of care rounds the nursing records were complete and legible.
- Staff did not always complete venous thromboembolism (VTE) risk assessments.
- Health Building Guidance Notes (HBN) do not recommend the use of carpets in hospital corridors. Staff told us that the carpeted areas made it hard to push beds, senior staff told us this had been risk assessed.
- On the day of our inspection, some medicines were not stored securely and could have been at risk of theft.

Incidents

Good

Surgery

- There was a good culture of incident reporting. The staff we spoke with on the ward, in the preadmission clinic and theatres were aware of their responsibility and felt supported to report incidents.
- Staff used an electronic incident reporting system. We reviewed some of the risks reported and saw clear evidence of actions taken and lessons learnt.
- Over the 12 months prior to our inspection, there were 338 clinical incidents and 64 non-clinical incidents within surgery and inpatients. The rate of clinical and non-clinical incidents in surgery and inpatients was lower than the average rate for other similar sized independent acute hospitals.
- Staff reported serious incidents and never events to the hospital director, unit manager, national lead, and the clinical commissioning group (CCG), in line with the Spire group policy.
- Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers, are available at national level and should have been implemented by all healthcare providers. In the previous twelve months there were two never events. The first never event in November 2015 regarded an incorrect match and implantation of a prosthesis. Senior staff carried out a root cause analysis and from the investigation, introduced a bar code system, which warns of any mismatched components. The second never event in June 2016 involved the incorrect siting of a central line, which had an adverse impact upon the patient. This incident was still under investigation at the time of our inspection, and the hospital was making efforts to ensure that this was completed in a timely manner. Although the investigation was not yet complete, the hospital was considering how they could ensure that the incident did not happen again. This included plans to put a central line checklist in place and an external anaesthetist to visit the hospital and look at the whole process including the equipment.
- Senior teams cascaded all learning from serious incidents and never events to staff at all levels. We saw documentation at all senior level meetings, the resuscitation-working group and at departmental team meetings. In the year prior to our inspection, two inpatients had died unexpectedly, one after a transfer to the local trust and one in the hospital. At the inquests, the coroner found no issues with the way the hospital had cared for these patients. We saw a review form of the local NHS trust discussing one of the patient's at its mortality and morbidity meeting This group looks at the levels of death and ill health in the local community and identifies learning and future improvements. The form documented how there was a good response from staff in starting emergency treatment and returning the patient back to theatre. The hospital reviewed its mortality and morbidity during medical advisory committee meetings.
- An investigation into one of the patient deaths showed inaccurate and incomplete fluid balance records. Fluid balance is the accurate recording of input and output of fluids in the body and inaccurate recording of these can lead to complications such as dehydration or fluid overload, which may lead to a prolonged hospital stay. In response to this finding, teaching regarding the importance of accurate fluid balance recording was included in 'care of the deteriorating patient' and immediate life support training (ILS) study days. We saw that the quality of fluid balance monitoring-compliance to NICE guideline was added to the hospitals audit tracker but audits had not commenced at the time of our inspection. Accuracy of some fluid monitoring was audited through the national early warning scores (NEWS) audit programme. Out of 20 sets of records audited, compliance for fluid monitoring was 100%.
- From the minutes of the hospital medical advisory committee and clinical governance meetings, we saw clear evidence of discussions about a serious adverse event, in March 2016, which involved incorrect marking of a patient before their operation. The hospital developed a clear action plan, all surgeons would mark patients before they left the ward and all surgical teams completed every step of the World Health Organisation (WHO) surgical safety checklist. The WHO checklist is an internationally recognised system of checks designed to prevent avoidable harm during surgical procedures. All actions were completed following the root cause analysis with exception of a National Safety Standards for Invasive Procedures (NatSSIPs) working group which were looking at safety practices across theatres such as, scheduling, list management, surgical site marking, prosthesis verification and patient hand-over.
- The hospital carried out in-depth investigations into the practice of members of staff who had been involved with higher numbers of clinical incidents. The investigations had identified no themes.

Good

Surgery

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Staff we spoke to about the regulation all knew it was about being open and honest. Staff gave us examples of when it should be applied and some staff gave us examples of their experience of when it had been applied.
- We could see a clear process of its application after the never events, a serious adverse event and after the unexpected patient death. The clinical governance, the senior management team and the medical advisory committee meeting minutes documented this. The completed root cause analysis investigation showed us how often and who met with the patient and when verbal and written apologies were given.

Safety thermometer

- The ward collected monthly data for the NHS safety thermometer. The NHS safety thermometer is a collection of data submitted by all hospitals treating NHS inpatients. The data collected is a snapshot of inpatients suffering avoidable harm, usually on one day each month. TheNHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls,urine infections (in patients with acatheter) and venous thromboembolism (VTE). The hospital reported 100% harm free care for NHS patients during the reporting period but chose not to display this information rather they preferred to use a clinical score card.
- The hospital collated and displayed data from all Spire hospitals for all patients in the form of a clinical scorecard. The clinical scorecard collated data across the five CQC domains: safe, effective caring, responsive and well led. This included audit results for VTE, record keeping, pre-operative nil by mouth times and patient satisfaction. The hospital rated itself non-compliant for VTE prophylaxis administered within the recommended time scale as surgeons chose to follow the British Orthopaedic Standards in line with practice in local NHS trusts rather than National Institute for Health and Care Excellence (NICE) guidance. In the last 12 months, the scorecard showed the percentage of patients receiving risk-assessments for VTE was 100%. However, when we looked at six patients' VTE assessments in their medical records, we saw that staff did not always complete the VTE risk assessments or document preventative treatment as indicated. Out of six patient records reviewed: one patient care plan did not have a VTE assessment, a second patient record did not have the VTE documented as re-assessed within 24 hours and two other patients did not have medicine prophylaxis prescribed when the risk assessment indicated an increased risk of developing VTE (no significant bleeding risk).
- There were two cases of hospital-acquired venous thrombosis and pulmonary embolism. Root cause analyses were carried out for all VTE incidents and the hospital discussed all VTE incidents at their quarterly governance meetings

Cleanliness, infection control and hygiene

- During the reporting period, between April 2015 and March 2016, there were no incidences of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA), methicillin-sensitive Staphylococcus aureus (MSSA), Escherichia coli (E-Coli) or Clostridium difficile.
- The hospital reported 16 surgical site infections between April 2015 and March 2016. These ranged from nine superficial surgical site infections and seven deep surgical site infections. The rates of infections during spinal, cranial and vascular procedures were lower than the national average for NHS hospitals. There were no surgical site infections from primary hip or knee arthroplasty, upper gastro-intestinal and colorectal, urological or cardiothoracic procedures. However, the hospital had identified that the rate of infections for breast surgery was slightly higher than the national average from April 2015 to March 2016. Out of 282 breast operations, three infections were reported, this was being closely monitored and investigated. We saw evidence of investigation of individual consultants' practice. No common themes had been identified between cases or through the investigations carried out.

- Practice in theatres during the pre-operative, peri-operative and post-operative phases was in line with NICE guidance (CG 74) and the prevention of surgical site infections.
- We saw that the hospital provided consultants with single use antiseptic skin marker pens for pre-operative site marking. These were readily available on wards.
- Staff on the wards and in the preadmission clinic decontaminated their hands in line with the World Health Organizations five moments for hand hygiene and NICE guidance (QS 61 statement three). This standard states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. All the patients that we spoke with told us that they saw staff decontaminate their hands before and after patient contact.
- The hospital used a method of weighing the hand sanitizer gel to monitor usage as a way of auditing compliance. Each quarter, 20 hand-sanitising units in patient's rooms were weighed at the start of the audit and a week later. Information was entered into a computer audit tool, which calculated the number of shots taken per day. A benchmark of over 18 shots per room per day was set across the Spire network. The results showed that the hospital met the benchmark in quarter one and two of 2016. Hand hygiene practical sessions were available for staff, and the hospital also provided Hand Glo events where exposure of non-compliance could be identified and the correct technique advised.
- The hospital participated in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people known as patient assessors, assessing how the environment supported the provision of clinical care. The hospital scored 'outstanding' and above the national England average for cleanliness and condition, appearance and maintenance of the hospital premises.
- The areas we inspected were all visibly clean and free from dust. Any ward equipment which was stored in the corridors had stickers indicating it was cleaned with in the last 24 hours. The ward sluice was visibly clean and tidy and the sticker on the commode showed it had been cleaned in the last 24 hours.
- The ward had a staff cleaning task list, which showed that cleaning took place consistently. The list clearly identified which team member was responsible for cleaning certain equipment and areas. The task list clearly identified if staff had missed areas and it was clear which member of staff was accountable.
- There were appropriate arrangements for the disposal of sharps to prevent accidental injury or cross contamination. The wards, pre-admission area and theatres had appropriate numbers of properly assembled sharps bins. These were labelled correctly and filled to the recommended level.
- The decontamination of surgical equipment, including endoscopes, was in line with Health Technical Memorandum (HTM) 01-06. We saw that all mandatory daily tests for pre-vacuum sterilizers were complete and up to date.
- Records assured us that every three months, up to four instruments were sent for bioburden testing. This test providesthe quantity of viable microorganisms in or on a medical device or raw material before implantation and use and is an important aspect of pre-sterilisation quality control monitoring**.**
- Storage of mobile equipment in the theatre corridors appeared cluttered however did not block any entrance, exit or emergency exit routes.
- Patient's rooms had laminate flooring, which was clean and in good condition; however, there were carpets in the corridors. The carpets were in good order and had no visible damage and staff told us they were deep cleaned every three months. The Health Building Guidance Note (HBN) 0.0_10 Part A, advises that, in order to facilitate cleaning flooring should be impervious, smooth and seamless, and where possible hard flooring should be run up the walls for a short distance. The note recommends carpets should not be used in clinical areas where spillages can occur and this includes corridors and entrances. The hospital told us that if a spillage occurred than a protocol was in place to clean or replace the carpet. The hospital had a refurbishment plan in place to replace the carpets in line with advice provided in the Health Building Guidance Note (HBN) 0.0_10 Part A, which had been issued since the hospital's last refurbishment programme. Staff told us that the carpeted areas made it hard to push beds, senior staff told us this had been risk assessed.

Environment and equipment

- The design, maintenance and use of the facilities kept people safe.
- The hospital had its own team of engineers for all daily maintenance tasks. The chief engineer oversaw all the equipment compliance checks. Equipment in theatres and the ward areas had stickers to indicate recent electrical testing and servicing. There was documented evidence which showed monthly checks had been carried out for the theatre laminar flow
- We saw evidence of the back-up generators weekly off-load checks and monthly on-load checks. These checks are weekly functionality checks and monthly checks of the generator supporting normal hospital demand. An automatic mobile phone message would alert the chief engineer that the backup generator had started up. We saw evidence of six monthly oil changes and fan belt checks.
- We saw the capital request log and it was clear that each piece of equipment that either needed replacing (red) or was nearing its time of replacement (amber) had been authorised for replacement.
- There was appropriate resuscitation equipment throughout the hospital for use in an emergency. The resuscitation equipment and trolleys on the ward and in theatres were visibly clean and free from dust. There was evidence of daily and weekly checking of the equipment on the trolleys. All records of these checks were completed and the trolleys were sealed with tags to show they had not been tampered with since this check.
- Staff checked fridge temperatures in the kitchen twice a day; all checks were signed and dated.
- The theatre sterile services unit (TSSU) had a recent unannounced visit from the, Société Générale de Surveillance (SGS). This is an accreditation body, which certifies electrical and electronic products against a range of national and international standards. Actions arising from the visit in January 2016 had been completed. The department carried out stringent checks and we saw evidence of up to date ventilation verification, decontamination certificates and Medicines and Healthcare and Products Regulatory Agency (MHRA) returns log. The ventilation systems for theatres, endoscopy suite and the cardiac catheterization laboratory were compliant with Health Technical Memoranda (HTM) 03-01.
- Patient feedback collected over 2015 had identified that patients' bedrooms were looking tired and were not up to standard. In response to this in-patient bedrooms had recently been fully refurbished. The ward area was clean and tidy and patient's rooms we inspected were in a good condition. All the bathrooms we inspected were clean and fresh had no visible areas of wear and tear.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of February 2015 to June 2015 assessed how the environment supported the provision of clinical care. The hospital scored the higher than the England average for condition, appearance and cleanliness.

Medicines

- Systems, processes and practices were identified, put in place and communicated to staff. However, staff did not always adhere to them.
- The ward stored medicines in treatment rooms and medicine trolleys. While the trolleys were secure when not in use, the treatment room doors on level three were not locked and on the day of our inspection, two medicine cupboards were not locked. This meant that unauthorised staff, patients or visitors could access medicines. During the admission process, staff placed patients' own medicines on the reception desk in a labelled bag. The reception area was accessible to all staff and the public, and this practice posed the risk of theft and/ or misuse of medicines. When we raised concerns about this practice, ward staff moved the medicines to the treatment room. The Royal Pharmaceutical Society's 'Professional Standards for Hospital Pharmacy' states Medicines are safely and securely distributed from a pharmacy and stored in a secure and suitable environment prior to administration.
- The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Departments we visited had suitable cupboards to store controlled drugs. The hospital pharmacy team audited controlled drug processes once every three months and the departments conducted daily stock checks. We saw actions identified from the audits, which helped to keep processes safe.
- Staff recorded the temperature of the treatment rooms and refrigerators used to store medicines, once a day. All records we saw indicated that medicines were stored at

the correct temperatures. The pharmacy department conducted temperature audits several times a year. We saw audit reports from November 2015, September 2016 and August 2016.

- Medicine advice was available 24 hours per day via the on-call pharmacist.
- Patients told us their regular medicines were discussed during their pre-admission appointment and on admission. We saw medicine histories recorded in patients' notes. The pharmacy team checked patients' own medicines against the prescription chart and completed medicine reconciliation on a sample of these. Medicines reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines from at least two sources. The provider did not audit medicine reconciliations so it is not possible to judge whether they were complying with National Institute for Health and Care Excellence (NICE) guidance NG5 of completing medicine reconciliation within 24 hours of admission.
- The resident medical officers completed prescription charts and registered nurses completed accurate records of administration of medicines.
- The hospital had governance processes to manage medicine safety. Staff regularly reported medicine incidents and the hospital conducted investigations to try to prevent recurrence of errors.
- The staff used the Spire medicine and antibiotic policies, which they accessed via the intranet. The policies were in date. Although there was a programme of medicine related audits and a biennial clinical review, the hospital did not audit the safe and secure storage of medicines as recommended by the Duthie report and the Royal Pharmaceutical Society's document, The Safe and Secure Handling of Medicines: a team approach (March 2005).

Records

- The hospital had identified that one of its three key risks and priorities was the maintenance of the single patient record. We saw this had been added to the hospital wide risk register and the register stated that there was a project underway. The hospital provided us with a clear, in depth up to date action plan and dates after our inspection for the record to go live.
- All nursing documentation was signed, dated, legible, with clear communication from the nurses and physiotherapists. Fluid charts, observation charts and where necessary, nutritional and pressure ulcer risk assessments were all accurately completed. Of the eight sets of inpatient nursing records we reviewed, we saw poor compliance in documenting patients' care rounds. The hospital told us that their care rounds were hourly comfort checks to see if patients needed anything, rather than a clinical visit, however one care round record we looked at had the patient's name missing and four other records we checked had hourly rounds missing.
- We reviewed eight sets of consultants' patient records. Five sets were not comprehensive, legible or contemporaneous. Documentation of patient and consultant conversations were not always accurate. One patient record had no consultant pre-operative documentation; one patient's records had no consultant documentation after returning from the high dependency unit the morning before. This was escalated to the nurse in charge who told us this had later been rectified. One patient's anaesthetic record was illegible and one patient had no pre-clerking documented in their records. This contravened the General Medical Council's (GMC) record keeping standards. There was no evidence of, or consent for, medical photography and this was not in line with the Royal College Surgeons (RCS) Professional Standards for Cosmetic Surgery (recommendation 24). This was also not in line with the hospital's policy on clinical photography, which clearly states this is part of the patient's healthcare record. We asked ward staff if this was normal practice and they told us that some consultants in certain specialities kept their own notes, with photographs, in a separate location. This was not reflected in hospital compliance checks, which audited 10 sets of cosmetic surgery records. The last audit, which took place in April 2016, covered consent, including for medical photography, and a cooling off period and the hospital was 100% compliant. The hospital had planned the introduction of the single patient record, which would enable the hospital to combat all of these notes issues.
- Patients' records were stored securely, and out of sight of patients and visitors, in a filing cabinet in the nurses' office, which was locked when not occupied.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse and staff were aware of their duties to report any concerns. Staff in all departments were aware of who the lead for safeguarding was, for both adults and children.
- Ward staff we spoke with were aware of female genital mutilation (FGM). Although no staff member had come across this, they understood their responsibility to report concerns to the safeguarding lead or safeguarding team.
- We saw evidence of reviews of safeguarding incidents recorded in the minutes of heads of departments meetings and followed through in clinical governance meetings. These incidents were dealt with appropriately, in line with policy and appropriate external referrals were made. Discussions documented in other departmental meeting minutes, such as the physiotherapy team brief, ensured that all teams learnt from these incidents.
- The hospital had recently introduced safeguarding training modules. At the time of our inspection, hospital-wide compliance with mandatory training for safeguarding children was 86.4% and safeguarding adults was 87.5%.Compliance rates were ahead of the 75% training target for that point in the training year.

Mandatory training

- The hospital had a target of 95% staff attendance at mandatory training modules. These included fire safety, health and safety, infection control, compassion in practice, equality and diversity, manual handling and safeguarding adults and children. The hospital monitored its training data on a year to year basis, at the beginning of the year hospital training would score zero. The hospital supplied data for all hospital staff, this showed that the training attendance were on target to achieve the 95% compliance level. For example, manual handling had a training rate of 94.5%; safeguarding children, level one and two combined was at 86.4%; and safeguarding adults level one and two combined was at 87.5%.
- We reviewed the ward data for mandatory training. All 54 substantive ward staff were up to date with all of their mandatory training. The regular bank staff, of which there were 11, were not yet fully compliant with their mandatory training although the deadline for this was not until the end of the year.
- Staff nurses were updated with the sepsis protocol during their resuscitation training. A member of the hospital's outreach team facilitated this and included not only the identification of sepsis but also the escalation and involvement of the wider team such as the RMO, consultant and the pathology team.

Assessing and responding to patient risk

- The hospital had clear systems and processes in place to assess and respond to patient risk. The hospital used the national early warning scoring system (NEWS). This tool allows clinicians to use the observation of patients' vital signs to identify and escalate concerns about the deterioration in a patient's condition, escalating concerns. We checked eight patient observation charts. All were fully completed and accurately scored, and we saw the appropriate documented escalation of one patient.
- The hospital used a clinical scorecard which audited hospital data and compared this with the other hospitals across the Spire company. The hospital audit for quarter one and two of 2016 scored 100% for NEWS compliance. This was above the 95% Spire target and above the 96% Spire average compliance.
- The hospital had identified the need for a critical care outreach team (CCOT) to support the ward nurses and post intensive care discharges. The CCOT comprised of senior nurses and a consultant anaesthetist who held a bleep that alerted them to an emergency. We witnessed three incidents of how efficiently the teams responded to an emergency call during the inspection.
- The hospital's outreach team facilitated the training in sepsis recognition and management. All staff members we spoke with felt confident in recognising the signs and symptoms of sepsis and the importance of rapid escalation.
- The resuscitation working group discussed cardiac arrests and serious adverse events and any issues identified were cascaded to staff. The group also planned emergency scenarios and we saw the documented evidence of an emergency scenario during a night shift. Feedback given to each staff member after the scenario identified issues with effectiveness of compressions, leadership, airway management and confidence with the use of the defibrillator. There was much-improved performance during a repeat scenario.

- The senior management team meeting documented in the clinical update the results from the recent coroner's inquest and major haemorrhage incident, identifying areas of good practice, key learning points, and changes to practice.
- There were arrangements for transferring acutely unwell or deteriorating patients by emergency ambulances for emergency care. The hospital had a service level agreement (SLA) with a nearby NHS acute hospital to transfer patients when their condition had deteriorated. The SLA identified clear lines of responsibility for communication with the acute trust's consultants in intensive care. Staff were able to tell us about the process, the documentation they would complete to provide to the trust and that they would provide a full copy of all of the patient's notes to the trust on transfer.
- Patients seen at the pre-admission clinic and identified as a potential risk, such as an increased risk of falling, or risks associated with bariatric patients, allergies, such as latex, or anaesthetic risks, were discussed at a weekly resource meeting. At this meeting, staff assessed risks prior to the patient's admission and plans could be put in place to ensure patient safety for example those patients who had higher co-morbidities could be booked into the high dependency unit.
- The National Patient Safety Agency (NPSA) issued a patient safety alert recommending that all providers of surgical care use the WHO surgical safety Checklist. The hospital used the World Health Organisation's (WHO) surgical safety checklist. This was incorporated into the 5 Steps to Safer Surgery which included pre-list briefings, the steps of the WHO Surgical Safety Checklist and post-list debriefings in one framework. The checklist focuses the whole team on the safety of practices before, during and after a procedure. The WHO checklist contains core content appropriate to all surgical procedures; however, through the usual clinical governance procedures it may be adapted locally or for specific specialties. Senior staff told us they would be developing these local safety guidelines in the near future and a senior member of the theatre team had been given the responsibility to develop these.
- We attended surgical safety briefings that took place prior to the day's theatre lists. Briefings took place in a discreet, confidential location. All of the team were present and introduced themselves; this included the surgeon, anaesthetist, operating department practitioner and scrub nurse. The team discussed the day's list and patient's specific requirements. We observed three further cases in theatres and witnessed the full completion of the WHO surgical safety checklist. The WHO checklist was audited for observation compliance and documentation compliance quarterly.
- We witnessed the daily 'team huddle' in the cardiac catheterisation suite prior to the start of the day's lists. The team discussed each individual's blood results and renal function, ensuring the appropriate use of radio opaque contrast. The team applied a systematic and safe approach to the WHO checklist.

Nursing staffing

- There was sufficient staffing to meet patients' needs. Use of bank and agency staff for theatre nurses, operating department practitioners and health care assistants was lower than the average of other independent acute hospitals during the reporting period (April 2015 to March 2016). The theatre departments had not required agency staff during the last three months of the same reporting period.
- During quarter one of the financial; year the hospital's risk register had identified an over-reliance on agency staffing as the hospital had ten nursing vacancies. This affected continuity of care for patients and increased costs for the hospital. The hospital used a clinical scorecard to audit agency use across the wards and theatres internally, and across the Spire hospitals group as a whole. This showed that spend on agency during quarter one was 8.4 % which was above the Spire 3 % target of Spires agency budget. The matron was supported to actively recruit and retain staff by offering enhanced recruitment incentives. This had been successful; staffing on the wards had increased, and at the time of the inspection, only one registered nurse position was unfilled and agency costs had decreased to 1.3% in quarter two.
- The ward had trialled the use of the Shelford staffing tool. This is an evidence-based tool that enables nurses to assess patient acuity and dependency. The ward found the tool to be unworkable and so the hospital chose to follow the 2014 NICE guidance (SG1) safe staffing for nursing in adult inpatient wards. This saw the development of a 'red flag' algorithm for safe staffing and the planned nurse to patient ratios of one to five on

an early shift, one to six on a late shift and one to seven on a night shift. Staff told us that these ratios would be adjusted according to patients' needs, in line with NICE guidance SG1 (1.4).

- The hospital carried out electronic identification checks when agency staff were employed. The agency sent the hospital up-dated compliance lists of nurses who were appropriately qualified to work at the hospital. All agency nurses had a complete induction to the ward and we saw copies of completed induction checklists. There was a comprehensive flow chart which could be used and which detailed who was responsible for what area of the induction and who should have oversight of the paperwork.
- The ward held a daily safety briefing when patient's individual care needs, ward resources and staff levels were discussed. This was attended by representatives from all key areas of the hospital to ensure all staff were aware of any potential safety issues, such as patients allergies and falls risks. All of this information was recorded on the handover sheet for all ward staff to have a copy of.

Surgical staffing

- An electronic database recorded availability of consultant surgeons, anaesthetists and physicians and nominated consultant deputy cover. This was also available to staff on the shared drive, with a hard copy kept in on-call folders in case of emergency. Monthly lists were printed off to ensure contact details were up-to-date.
- However, an investigation into an incident where a patient had to be transferred to a local NHS trust intensive care unit (ITU) had highlighted problems in contacting the anaesthetist and the surgeon. The investigation identified that on call arrangements were incorrect, this was rectified immediately and as a result the matron reviewed all on call arrangements at consultants' biennial reviews. Cross cover arrangements and the biennial review report was a standard agenda item at the clinical governance meetings and documented in the minutes. There were processes in place for consultants to provide a handover of their patients to their colleague providing cover for them prior to leave.
- All staff we spoke with knew how to contact surgeons out of hours for both NHS patients and privately funded patients. Staff told us they felt comfortable to phone consultants out of hours.
- The hospital provided a consultant led service and employed four resident medical officers (RMOs) who had completed corporate mandatory training. All of the RMO's were qualified to specialty training level 3 (ST3). The Royal College of Surgeons (RCS) recommends in their publication Emergency surgery 2011, in case of emergency return to theatre an ST3 or someone with Membership of the Royal College of Surgeons (MRCS) and Advanced Trauma Life Support, (ATLS) must be able to see urgent patients within 30 minutes. When a locum RMO was required, the matron reviewed their training record prior to the commencement of their shift.
- The matron oversaw the RMO's working hours. The hospital did not formally monitor sleep interruptions; however, if an incident overnight disturbed the RMO, the matron would be informed so that they could ensure steps were taken to provide cover until he/she was fit to work again.
- The hospital had processes in place, which were aligned to the corporate policy, to monitor and maintain the practicing privileges in place. We checked 11 sets of consultant's records and all practice privileges were accurate and up to date.
- The hospital carried out a biennial review of each consultant's performance, which included details of any incidents, complaints and any behaviour, which was not in line with the values of the organisation. The hospital used this as a review of the consultant's suitability to maintain their practising privileges. There was also a review of the consultant's scope of practise document.
- Processes were in place to ensure that consultants provided updates to required documentation, for example, their appraisal and updated indemnity insurance. We saw evidence in the medical advisory meeting minutes that the hospital made regular checks of the practising privileges report. This ensured that all checks were in place and the hospital and consultant addressed any outstanding actions.

Major incident awareness and training

- Senior staff told us that the hospital kept a copy of the major incident and lockdown plan in a file in the hospital management offices, with a copy at the main headquarters.

Good

Surgery

- The major incident policy contained actions and phone numbers to use in the event of an unplanned event or emergency. Unplanned events included the loss of water supply and heating failures, and detailed contingency advice.
- The hospital had a lockdown policy, which detailed advice on what to do in the event of child abduction or shooting threat. We saw a date in the senior management team meetings for a 'live lockdown' scenario training session.
- The hospital had a business continuity plan. This detailed what staff needed to do in response to a variety of scenarios that could affect the operation of the hospital. These scenarios ranged from a fire, loss of the telephone system, through to loss of the operating theatres or a local major incident. The plan included help available from other Spire hospitals, for example, if the diagnostic imaging department was unavailable, the hospital could access services at the next nearest Spire hospital. Staff we spoke to new where the folder was kept and who to contact in a case of an event or scenario, they also knew that a duplicate file was held at the main offices, which was at another site.

Are surgery services effective?

Good

We rated effective as good because:

- The hospital routinely collected data about the outcomes of patients' treatment.
- We saw effective multidisciplinary team working, evidenced during the pre-admission assessment, through to the patient's discharge.
- A weekly resource meeting facilitated effective planning of admission and discharge for complex patients.
- There was an effective outreach team.
- There were effective processes in place to ensure all consultants with practising privileges were monitored and up to date.
- There were plans in place to introduce a single patient record to maintain effective contemporaneous record keeping.

Evidence-based care and treatment

- The wards used care bundles in line with NICE guidance and the institute for healthcare improvement. A bundle is a structured way of improving the processes of care and patient outcomes with small, straightforward sets of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcome. The hospital used peripheral, central line, urinary catheter and surgical site infection bundles. The infection prevention and control meetings, theatre department meetings and ward meetings discussed departmental compliance.
- Training in the identification and treatment of sepsis training was included in the intermediate life support training and the 'deteriorating patient' study day. The staff we spoke with described the 'Sepsis Six' pathway for identifying and treating sepsis, in line with NICE guidance (NG 51). We saw clear guidance displayed at the nurses' station.
- Clinical governance meetings reviewed new guidelines and identified actions that were required to ensure compliance. During the infection control teams analysis of serious surgical infections (SSIs) it was identified that NICE guidelines were not always being followed in relation to hypothermia and the practice of taking temperatures every 30 minutes in theatre. NICE had linked hypothermia to an increased incidence of wound infection. The clinical audit undertaken to assess continued compliance with recommended practice identified an improvement in the practice from quarter one, which was 90% compliant, to quarter two which was 100% compliant. This was above the Spire target of 85% and the Spire network average of 85%.
- We observed the assessment process in the pre-admission clinic, which was in line with NICE guidance (NG45). Patients who were being booked for two night stays were brought in for full screening and had completed a comprehensive questionnaire. This enabled staff to order specific tests that may be required for certain conditions. All of this information was gathered and assessed and any issues highlighted at the weekly resource meeting.
- The hospital rated itself non-compliant on the clinical scorecard for VTE prophylaxis administered within the recommended time scale. Although, contrary to National Institute for Health and Care Excellence (NICE) guidance, the hospital with the input of surgeons had made a decision to follow the British Orthopaedic Standards in line with the policy at local NHS trusts. The medical advisory committee meetings discussed this and the hospital developed a preference sheet for each

consultant. Quarterly audits scored 100% compliance with the variation per consultant. The clinical scorecard identified that the hospital scored 100 % for VTE assessments and staff documentation for the last two quarters.

- The hospital monitored the average length of stay of patients having joint replacements and they told us that they discussed this at the discharge working groups. The hospital also had a resource meeting every week where the multidisciplinary team discussed issues identified at pre-admission. This meeting ensured effective planning, enabling safe pre-, peri-, post-operative care and safer discharge.

Pain relief

- We saw and patients told us that they received effective pain management and timely pain relief.
- Discussions with patients regarding effective pain control and analgesia commenced at pre-admission appointments. Staff informed patients about what pain and what analgesia to expect post-operatively. Staff gave effective advice around the importance of pain free movement and recovery, fluid intake and management of constipation as a side effect to opioid analgesia.
- Staff assessed post-operative pain on the ward in a comprehensive and consistent manner, in line with the Faculty of Pain Medicine's core standards. Patients who reported pain had analgesia offered, explained and administered in a timely and efficient manner.
- The hospital had a dedicated pain team as part of the intensive care unit staff. Staff told us that any issues, such as uncontrolled pain, would be discussed at the resuscitation working group meeting and any actions would be identified.
- Every quarter the hospital audited the percentage of pain scores recorded with every set of observations. The hospital consistently scored 100% from 2014 through to quarter two 2016.

Nutrition and hydration

- The pre-admission staff discussed the length of time a patient needed to fast prior to their operation and ensured patients were fully aware of their 'nil by mouth' regime for fluids and food. The patients who were on an afternoon list were not asked to be nil by mouth for an excessive amount of time pre-operatively and could eat on the morning of the operation and have fluid up to two hours prior to their anaesthetic. Quarterly hospital audits identified 100% of patients were fasted within hospital guidelines.
- We witnessed ward staff managing post-operative nausea effectively. Staff responded by quickly giving an anti-sickness medicine when a patient rang to complain of post-operative nausea. The patient was able to drink fluids once this had taken effect and we saw the nurse return to ask the patient if the medicine had been effective.
- The hospital used the malnutrition universal screening tool (MUST). This is a five- step-screening tool to identify possible risks of malnutrition. Staff assessed patients' nutritional status assessed on a daily basis. We identified one patient who was at risk of malnutrition. A family member told us how the staff had gone 'above and beyond' to try to encourage their family member to eat to gain the strength they needed to recover. The pharmacists had ordered special drinks, not normally stocked by the hospital, specifically for the patient to increase their calorie intake.
- Staff told us that, when required, patients could access the local NHS trust's dietician services. The hospital NCEPOD gap analysis for bariatric surgery identified that 100% of bariatric patients were referred to a dietician and had a dietician followed up.
- The weekly multidisciplinary resource meeting, which planned effective admission and discharge of patients, highlighted that a patient due to be admitted to the hospital required a specific diet due to religious reasons. As this was identified a week before admission, specialist food was ordered from a single provider in London.
- The hospital participated in Public Health England Surveillance and Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people (known as patient assessors) assessing how the environment supported the provision of clinical care. They assessed things such as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment was able to support the care of those with dementia. The hospital scored the same or higher than the England average for ward food and organisational food.

Patient outcomes

Good

Surgery

- The hospital collated a clinical scorecard to benchmark against Spire hospitals key performance indicators (KPIs). Many of the scorecard measures were based on national external benchmarks, such as those published by Public Health England (PHE). KPIs were reported on quarterly and staff could see what the hospital scores were in comparison to the Spire network and the performance of their hospital against the targeted percentage. The quality assurance group, clinical governance committee and the medical advisory committee reviewed performance during recorded meetings. Areas that achieved a red or amber rating had action plans developed for the specific KPIs. For example scores were red for venous thromboembolism (VTE) chemoprophylaxis as the surgeons chose to follow the British Orthopaedic Surgeons guidelines. This had been risk assessed and the hospital had an audit plan in place to monitor any risks
- NHS Digital developed a Breast and Cosmetic Implant Registry (BCIR) in order to monitor and improve patient safety. This recorded implants used for both NHS and private patients and the organisations and surgeons that carried out the procedures. The main aim of the registry is to be able to trace and inform affected patients in the event of any future recall of a failed implant. The registry would also allow the identification of possible trends and complications relating to specific implants. The hospital had informed all cosmetic surgeons that they would need to submit consented data to the system for the registry (Clinical Audit Platform - CAP) for collecting the data on all patients that undergo a surgical procedure and have a breast implant. This process was due to commence after our inspection. The hospital had documented all implant data into a hospital-based implant register, pending the national system going live.
- The hospital sent data to the National Joint Registry (NJR) and Patient Related Outcome Measures (PROMS) audits for NHS-funded patients undergoing hip and knee replacements. Patients gave consent for this at the pre-admission clinic and we observed staff fully inform patients as to the reasons why their information would be included in the registry. The information obtained helped the NHS measure and improve the quality of care patients experience during and after joint replacement surgery. Results for the reporting period (April 2015 to March 2016) showed the results to be above the national average for NJR data.
- The Private Health Information Network (PHIN) publishes independent information to help patients make informed decisions about their treatment. Data is collected from hospitals and produces vital safety and quality indicators, such as mortality rates, readmission rates and patient feedback. All hospitals in the UK that offer privately funded healthcare, including NHS hospitals, are required to send data to PHIN. The hospital was due to start this data submission in 2017 and we saw evidence of discussions at senior level in the minutes of meetings.
- The hospital submitted data to the National Institute for Cardiovascular Outcomes Research (NICOR). UK hospitals provided clinical information to secure registries established by the cardiovascular specialist societies. This information helped the NHS, the government and regulatory bodies improve quality of care by checking that the care received by heart disease patients meets good practice standards. NICOR achieved this by conducting clinical audit and comparing patient outcomes, such as case mix-adjusted survival and readmissionrates. The hospital provided reports that showed data collected from 2015 had good hospital reported outcomes. National comparative data was not made available to the hospital so they were unable to benchmark their performance with other hospitals.
- There were 11 cases of unplanned inpatient transfer to another hospital in the reporting period (April 2015 to March 2016). This was not high in comparison with other independent acute hospitals. This represented 0.1 % of all the inpatient and day case attendances during the reporting period. The hospital had a service level agreement with a local trust to facilitate safe transfers of care and an admission and discharge policy; which identified that all unplanned and emergency transfers be followed up on a daily basis. All information would be kept up to date in the patient record until the patient was deemed 'safe' to return to the hospital.
- There were 18 cases of unplanned readmissions to the hospital during the reporting period (April 2015 to March 2016). This represented 0.2% of inpatient and day case admissions. This was not high in comparison to other independent providers.
- There were 38 cancelled operations in the twelve months prior to our inspection and 95% of these patients were offered another appointment within 28 days of the cancellation.

- There were 39 cases of unplanned return to theatres and this was not high in comparison with other independent providers. The hospital provided a breakdown of the reasons behind these and we could see clear documentation of discussions in the quality assurance group meeting minutes. Discussions during the quarterly clinical governance action plan identified no trends.
- The hospital provided information on the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) gap analysis for bariatric surgery. This audit looked at seven sets of records and found only 14% of patients had been referred to a clinical psychologist. This was in direct contrast to the cosmetic notes audit, which identified, out of 10 patients, every patient had been seen by a cosmetic nurse, counsellor or psychologist prior to surgery.

Competent staff

- There was a corporate policy in place, outlining the eligibility criteria, application and process for granting practicing privileges, the process for maintenance and review, management of performance concerns and the requirements of consultant appraisal. This policy was outlined within the consultant handbook.
- The hospital had processes in place, which were aligned to the policy, to monitor and maintain the practicing privileges in place. There was an electronic database, which was updated, monitored and maintained by a member of administrative staff, who worked closely with the matron/head of clinical services.
- We reviewed the records for 11 consultants engaged with practising privileges. Practising privileges were granted to medical practitioners by the hospital governing board subject to them providing certain evidence of their good character, qualifications, skills and experience and compliance with the terms and conditions of the practising privileges policy. We found:
  - Records of application for employment
  - Signed acceptance of the terms and conditions set out within the consultant handbook;
  - Disclosure and barring service (DBS) checks;
  - General medical council (GMC) licence;
  - Indemnity insurance details;
  - Details of the consultant's most recent appraisal and two references (one from the responsible officer for their appraisal and a professional colleague);
  - A document, which identified the scope of each consultant's practice, both within the hospital and within the NHS (where applicable);
  - All of the records had documentation that was in date within the specified timescales of the policy.
- The hospital carried out a biennial review of each consultant's performance, which included details of any incidents, complaints and any behaviour, which was not in line with the values of the organisation. The hospital used this as a review of the consultant's suitability to maintain their practising privileges. There was also a review of the consultant's scope of practise document.
- Processes were in place to ensure that consultants provided updates to required documentation, for example, their appraisal and updated indemnity insurance. We saw evidence in the medical advisory meeting minutes that the hospital made regular checks of the practising privileges report. This ensured that all checks were in place and the hospital and consultant addressed any outstanding actions. An electronic system generated a letter to the consultant a week before their documentation expired, a reminder two weeks later, and a further reminder followed this another two weeks later. If the consultant still did not present the appropriate documentation then their practice was suspended.
- Arrangements were in place to make sure that the local NHS trust was aware of any suspensions that may affect the staff working in their trust. The hospital gave us evidence of a recent example of this.
- We saw up to date information, which showed the practising privileges for all external first assistants in theatres. This included Nursing Midwifery Council (NMC) and GMC registration, Hepatitis B and C immunisation records, HIV status and indemnity certification.
- During the period January to December 2016, the hospital reported 100% of staff had an up to date appraisal.
- Nurses were encouraged to attend specialist training for areas that they were interested in, such as plastic and reconstructive surgery. The infection prevention control (IPC) lead nurse was currently undertaking a master's level qualification in IPC and the hospital was supporting this. The IPC lead nurse had strengthened relationships with the local NHS trust and shared knowledge by spending time with the VTE lead at the local trust.

- The ward was divided into areas for specific specialities; each area was co-ordinated by a team leader and this enabled the staff to build up their competence within a certain speciality. After a period, the staff were rotated into different teams and different specialities, ensuring good overall knowledge of the how the department ran. Staff we spoke with felt it gave them ownership and some team members told us they had been funded to complete education programmes.
- Staff on the wards and in the recovery area received in-house training by specialist nurses from the cardiac catheterisation suite. Whenever possible, patients were cared for on the ward by nurses who had previous cardiac experience and there was an experienced cardiac link nurse to join up the service.

Multidisciplinary working

- There was good multidisciplinary (MDT) working between all staff groups. Staff and teams worked together in a coordinated way to provide seamless care to patients.
- Staff we spoke with on the wards reported they had a good working relationship with the pharmacy department who had a visible presence on the ward. Visits were frequent throughout the day and staff were always able to help when advice was required.
- We witnessed excellent MDT working across all departments at the weekly resource meeting. The meeting was attended by the matron and representatives of departments, such as physiotherapy the booking team, catering, out patients and the pre-admission clinic. The MDT discussed any issues or risks identified at the pre-admission clinic and allocated the appropriate resources. Discrepancies between the booking team and the theatre lists could be identified and actioned. The meeting also enabled the theatre and ward teams to allocate staff appropriately for the planned lists. This meeting was an effective way for the MDT to identify any risk factors that might delay patient discharge.
- Effective MDT working could be seen at the pre-admission clinic, where physiotherapists for those patients undergoing joint replacements started preparing patients for what to expect post-operatively and when they got home. The physiotherapy teams identified those patients that might require social services referrals for support at home and would make these referrals after surgery if required. Communication with family or carers started at the pre-admission clinic and continued throughout the patient's stay in hospital.
- We saw evidence of external MDT working when a consultant referred an inpatient to a renal specialist who visited the patient at the hospital.

Seven-day services

- There was good provision of seven-day services across the hospital. The hospital carried out elective operations between Monday and Saturday with out of hour's provision for emergency returns to theatre. Physiotherapists offered services over the weekend and there was access to consultants at all times, in and out of hours. The hospital provided a pharmacy dispensing service five days a week. Medicine advice was available 24 hours per day via the on-call pharmacist. Staff gave us examples of phoning for advice when administering medicines they had not given before.

Access to information

- Not all consultant documentation was available in the patient's record. However, during our inspection the hospital was in the process of implementing the single patient record. This would improve patient safety by replacing the current system where records were held in several locations.
- Nursing assessments, medical and nursing care plans and theatre documentation were available in paper form and easily accessible on request.
- Test results including x-rays were available electronically and were accessible to medical staff.
- When patients were moved between the critical care unit and the ward an official handover took place and this was recorded in line with National Institute for Health and Care Excellence (NICE) clinical guideline 50.
- When a patient was transferred to the local trust in an emergency, a critical care transfer form was completed. This form was a concise handover of a patient's condition and included a checklist for staff to complete to facilitate a smooth transfer.
- The hospital sent electronic discharge summaries to GPs if they had access to the electronic system. If this was not possible, paper copies were sent to the GP instead. The pre-admission clinic staff told us that there was a GP follow up programme for patients with hypertension.

Good

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing staff understood the complexities of consent and decision making but not all consultants documented consent for medical photography.
- Patients identified at the pre-admission clinic as having language issues had their needs discussed at the weekly resource meeting and appropriate translation services were arranged so that there were no language barriers in to the process of obtaining informed consent. .
- Staff gave us an example of how, on the rare occasion that staff could not access translation services, a patient had their operation cancelled, as they were unable to give informed consent. The hospital rescheduled the operation.
- All the staff we spoke with had an understanding of the Mental Capacity Act (2005). Staff said they would always escalate any concerns to the ward sister, should a need arise. Staff could also identify that a deprivation of liberty could also occur for a short period, for example in post-operative delirium. They understood that a deprivation of liberty standard and best interests decisions would need to be considered in this instance and would seek advice and guidance from senior staff members.
- The hospital audited 10 sets of records for patients who had undergone cosmetic surgery and found that they were 100% compliant with requirements in relation to gaining consent for surgery and for medical photography. Outpatient appointments were scheduled 14 days prior to the surgery being offered and this allowed a 'cooling off' period, in line with the RCS Professional Standards for Cosmetic Surgery (2016). However, when we checked records for patients undergoing plastic surgery, there was no evidence of consent for photography. When we asked staff on the wards if this was a common occurrence, they told us that some consultants kept their own separate patient files in separate locations. This was not in line with the Royal College Surgeons (RCS) Professional Standards for Cosmetic Surgery (recommendation 24). This was also not in line with the hospital's policy on clinical photography, which states this is part of the patient's healthcare record.

Are surgery services caring?

Good

We rated this domain as good because:

- Results from patient satisfaction surveys were consistently high.
- The hospital had a dedicated concierge who greeted patients and relatives at the hospital reception. We observed how well this service worked and saw how it relieved patients and their relative's anxiety as they walked into the hospital. It was clear how this process facilitated a smooth admission from reception to the ward.
- Staff recognised how important relatives were to a patient's recovery.
- The hospital had identified the need for a breast care nurse and a clinical nurse specialist in cancer care. They were also providing the funding to train 'key workers'. These nurses would be able to offer emotional support to patients who had received bad news.

Compassionate care

- We saw how all of the hospital staff treated patients and their relatives with dignity, respect, compassion and professionalism.
- Patients spoke highly of the pre-admission assessment process and how well informed they were prior to their operation. An inpatient told us how they had told staff at their pre-admission assessment appointment that they were concerned about post-operative pain and staff eased their anxiety by explaining what would happen on the ward. The patient told us that when they needed pain relief it was administered effectively and staff had the time to explain if it was not effective, what the next step would be.
- One patient who had visited the pre-admission clinic told us how "enthused" they were with the "enthusiasm of the surgeon".
- The hospital asked all NHS patients to complete the friends and family test and asked all patients to complete a satisfaction survey. The 'friends and family test' response rates from October 2015 to March 2016 were above the England average and the scores were similar to the England average. In the month prior to the inspection results showed that, all patients were either extremely likely or likely to recommend the hospital.

The hospital analysed the results of the patient satisfaction survey on a monthly basis, identified trends and discussed these at the monthly senior management team (SMT), heads of departments (HODs), clinical governance committee and the discharge meetings. Staff discussed the survey results at team briefs and the hospital displayed them on boards throughout the hospital. Patients consistently rated the hospital at 98% or above.

- The hospital scored higher than the England average in the Patient Led Assessment of the Care Environment (PLACE) in the categories for dementia and privacy, dignity and wellbeing. Staff always closed bedroom doors when patients were having a physical or personal intervention or consultation. A light prompted staff to knock before entering or to return when the light was off and the door was open.
- Patient satisfaction survey scores were 97% and above for the category of treating patients with respect and dignity. Staff told us that the hospital would provide a chaperone for any patients undergoing an intimate examination or photograph and the hospital's policy corroborated this. The hospital had a chaperone competency framework and intranet training package for staff to complete.

Understanding and involvement of patients and those close to them

- Staff included carers and relatives in all discussions with patients when required. We saw an example of thoughtful and considerate discussions with a patient's family. The patient had very complex care requirements and staff worked with the patient's family members to formulate a plan to ensure the patient could have their operation as safely as possible.
- Relatives told us how staff had 'gone the extra mile' to help their relative recover from a significant surgical setback. They said that staff had encouraged the family to be a big part of the patient's recovery and they were always welcome to visit and stay with the patient, no matter what time. The patients relatives felt fully informed at all stages of their loved one's recovery.
- The hospital had a dedicated concierge who greeted patients and relatives at the hospital reception. We observed how well this service worked and saw how it relieved patients and their relative's anxiety as they walked into the hospital. It was clear how this process facilitated a smooth admission from reception to the ward.
- During the pre-admission assessment process if staff identified that a longer than average inpatient stay may be required, they would arrange for a member of the finance department to come and discus the extra financial costs with the private paying patient prior to admission the overall aim was to reduce anxiety.

Emotional support

- Staff understood the impact a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We saw how staff treated relatives of patients who had very debilitating conditions; staff recognised the pivotal role relatives had in the rehabilitation of patients in their care.
- The hospital had identified the need for a breast care nurse and a clinical nurse specialist in cancer care. They were also providing funding to train 'key workers'. These nurses would be able to offer emotional support to patients and their relatives who had received bad news. During our inspection, we saw staff talking to relatives in a quiet room that was reserved for private communications and breaking bad news.
- Results from the patient satisfaction survey showed that 87% said they found someone on the hospital staff to talk to about their worries and fears and 98% said they received excellent or very good care and attention from nurses.

Are surgery services responsive?

Good

We rated responsive as good because:

- There were excellent systems in place to facilitate the smooth access of patients on to the ward typically within 15 minutes and in line with the hospital admission and discharge policy.
- The hospital reviewed any cancellations at the quality assurance group and clinical governance meetings to identify any issues or trends.

- The hospital took steps to provide care to patients with complex needs, such as patients living with dementia, from pre-admission through to discharge.
- The multidisciplinary team's (MDT) weekly resource meeting discussed any patients identified in the pre-admission clinic with specific needs.
- The hospital had effective governance arrangements for handling complaints.

Service planning and delivery to meet the needs of local people

- The hospital planned and delivered services in line with the needs of the local population. For example they had responded to increased demand for cardiology services with the introduction of cardiology services and the catheter laboratory. This service offered radial (wrist) artery catheterization, which had a particular advantage for patients over femoral (groin) artery catheterization. This procedure reduced the risk of significant post-operative bleeding from the femoral artery and enabled the patient to mobilise and eat immediately after procedure.
- The weekly resource planning meeting discussed patients seen at the pre-admission clinic. Discussions included requirements for specialist equipment, patients with additional needs, such as bariatric patients, anxious patients or those who were at risk of falls. Beds could be booked in advance for the high dependency area. The multidisciplinary team identified any late additions to the theatre schedule and could discuss staff and bed availability.
- The hospital had identified the need for a clinical nurse specialist in cancer care, and was providing the funding to train 'key workers'. These nurses would be able to offer support to patients who had received bad news and be a source of information and onward referral.

Access and flow

- Patients received timely access to assessment, care and treatment. In the period April 2015 to March 2016, the hospital mostly achieved the target which required 90% of NHS patients to begin treatment within 18 weeks of referral. The target was not met in the months of December, January and February 2016.
- The hospital responded to the local population's needs by holding evening and weekend clinics ensuring easier access to consultant appointments.
- In the 12 months prior to our inspection, the provider cancelled 38 procedures for a number of reasons. Some cancellations were on the day of admission due to patients having coughs, colds, and others for non-clinical reasons. All but two patients accepted another appointment within 28 days (two patients changed their mind). The hospital reviewed all cancellations at the quality assurance group and clinical governance meetings to identify any issues or issues behind the cancelled operations. When the resource meeting identified previously cancelled patients the senior team discussed if further communications or apologies were appropriate.
- The hospital managed admission times in line with their admission and discharge policy. This maximised bed occupancy and allowed for better management of pre-operative fasting. Admission times were staggered throughout the day and reflected where the patient featured on the operating list. This also enabled the staff to manage the admissions on to the ward more smoothly.
- The discharge planning process scored consistently below the Spire average in the patient satisfaction survey and a discharge-working group was set up because of this feedback. We could see a consistent improvement in the survey results over the last year and the most recent data showed a 1% rise above the Spire average.
- There were excellent systems in place to facilitate the smooth access of patients on to the ward. The hospital employed a dedicated concierge who met all the patients at reception, then communicated with the ward to make sure the room was ready to receive a patient. The concierge brought patients up to the ward when the room was ready. We witnessed this happening, typically within 15 minutes of arrival and in line with the hospital admission and discharge policy.

Meeting people's individual needs

- The hospital delivered effective care to patients with complex needs such as patients living with dementia, from pre-admission through to discharge. A senior staff member was a 'dementia friend' champion and facilitated a training programme for clinical and non-clinical staff, we were not provided with the numbers of staff who had completed this training
- The multidisciplinary team weekly resource meeting discussed any patients identified in the pre-admission

clinic with specific or complex needs. We saw information added to the resource meeting folder regarding one patient who had a very complex physical disability and specific needs. This resource meeting allowed staff to assess and plan the care the patient may require in advance of their admission. Another pre-admission patient added to the resource folder had complex psychological issues, so staff wanted to know how to obtain psychiatric services, should they be required.

- Catering staff told us that they would cater for patients with religious, cultural and special dietary requirements. The resource meeting enabled catering staff to be alerted to patients' specific requirements so that they could contact external suppliers when necessary.
- Staff in the pre-admission clinic identified patients with diabetes and the resource meeting scheduled these patients first on theatre lists to minimise any risks from prolonged starvation prior to surgery.
- Staff encouraged patients to feel as normal as possible by encouraging them to mobilise early and not stay in bed. For those patients who were having joint replacements the physiotherapists in the pre-admission clinic explained how early mobilisation was important in their recovery so patients would be encouraged to take their meals out of bed and to get dressed as soon as possible. This helped patients and their relatives know what to expect post operatively and give them time to understand that a swift recovery did not happen if they stayed in bed.
- The hospital offered access to translation services for patients where English was not their first language. The hospital had cascaded a recent update to services to all the staff.
- All patients received a comprehensive discharge pack, which had all the information specifically and generically required to facilitate a safe discharge. Patients we spoke with felt well prepared for their discharge. Planning for this started at the pre-admission clinic. We saw excellent discussions with patients and their relatives around how to cope at home after a knee replacement. Advice was gratefully received such as having a thermos flask made up in the morning to reduce the risk of scalding whilst carrying hot drinks and using a rucksack to carry items around the home.
- The hospital respected patients' wishes if they did not want their GP to know the nature of their operation; therefore only the patient received the discharge summary. The hospital carried out an audit and found they were 100% compliant with patients' wishes regarding informing their GPs.

Learning from complaints and concerns

- The hospital listened, analysed and responded to complaints and concerns, in order to improve the delivery of care.
- Patients and relatives raised complaints through a number of routes such, as the hospital website, the CQC, patient feedback forms, the patient forum and NHS choices.
- There were 123 complaints for the whole of the hospital between April 2015 and March 2016 and two complaints made to the CQC during the same reporting period. This was higher than the rate of other similar independent acute hospitals. The hospital told us that they encouraged patients and their relatives to complain in writing so that feedback could be captured and improvements made. Complaints were discussed at senior level meetings where trends could be identified. We saw the minutes from a heads of department meeting that identified some patients had been confused over pricings and the hospital team were working on how they could increase the transparency of their pricing plans. No complaints had been referred to the Parliamentary and Health Service Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service.
- When a patient raised a concern whilst they were receiving care or a service within the hospital the most senior member of staff would speak with the patient and ask them to talk about their concerns. Patients who wished to make a formal complaint would be advised to do so by letter, email or online via the hospital website.
- The hospital had effective governance arrangements for handling complaints. The hospital matron, the operations manager and the relevant heads of department filtered all complaints and recorded them on to the hospital database. The hospital had a dedicated complaints handler who met weekly with the operations manager and matron to discuss individual complaints. When the hospital received a written complaint, they sent an acknowledgement letter and their complaints policy booklet within two days. The matron offered all complainants an opportunity to talk face-to-face. The hospital had processes in place to

keep a track on the timeliness of complaint responses and aimed for closure within 20 working days. The same time scales applied to complaints from private patients and NHS patients.

Are surgery services well-led?

Good

We rated well-led as good because:

- The senior management team had a clear vision and strategy and this was cascaded to all members of clinical and non-clinical staff.
- Managers motivated their teams and provided clear leadership.
- There were effective governance systems in place to support the delivery of good quality care.
- The hospital risk register identified all risks and clear action plans were developed and regularly updated.
- The hospital actively encouraged patients and the public to be involved in the future of the hospital.
- Staff said it was good place to work and we saw how proud staff were of their hospital.

However;

- There were 123 complaints for the whole of the hospital during the reporting period. This was higher than the rate of other independent acute hospitals.

Vision and strategy for this this core service

- The strong and clear vision and strategy was evident throughout all the departments.
- The senior management team (SMT) had a clear vision that they wanted their hospital to be the preferred choice of independent hospital for surgeons and their privately funded patients. The hospital had measured its services against other independent hospitals in the area to identify where they needed to improve in order to attract patients and a suitable workforce. The three-year strategy (2016 to 2019) clearly reflected this.
- The hospital held regular staff forums to discuss the strategy and the hospital newsletter regularly communicated this information.
- We could see clear discussion on hospital performance in the senior management team meetings. This was cascaded through the heads of departments meetings and into the individual departments, therefore, all staff were aware of the hospital's vision and strategy and all reiterated that they wanted to be the local hospital of choice.

Governance, risk management and quality measurement for this core service

- There were effective governance systems in place to support the delivery of good quality care. Information discussed at senior meetings was well documented and shared around the departments and we saw themes and issues such as the importance of the clear recording of fluids on patients charts clearly cascaded down throughout all the relevant departmental meeting minutes.
- The hospital medical advisory committee (MAC) was an integral part of the governance structure. The MAC consisted of the senior staff of the hospital such as the hospital director, matron and representatives from various specialist consultant groups. Recent changes to its structure ensured representation of all specialist groups who provided treatment and care in the hospital. The MAC had quarterly well attended meetings.
- A clinical scorecard was used to report and benchmark performance against key performance indicators (KPIs) across the whole of the Spire network. KPIs measure how well hospitals are performing against targets or expectations and measure performance by showing trends that demonstrate what improvements have or have not been made. The hospital displayed the clinical scorecard for all staff to see. This showed staff what the hospital target percentage should be, for example, in patients receiving an effective discharge and what the hospital's scores were in comparison to the whole of the Spire network.
- The clinical governance committee meetings and senior management team meetings discussed KPIs and when poor performance was identified, improvements and actions were cascaded through to all departments. We saw evidence in the minutes of the physiotherapy team meeting where certain areas of the scorecard were targeted and red or amber (below spire target) percentages were discussed.
- There was a clear strategy for continuous improvement in infection prevention and control (IPC). Audits took place to analyse infection rates in relation to individual surgeons. The IPC lead nurse informed us that four

surgeons with a higher rate of infection had been analysed over a two-year period and their results discussed regularly with a microbiologist to make sure that there were no concerns or trends identified.
- Local and national patient surveys, complaints, incidents reports and informal feedback all provided information on the effectiveness of admission and discharge arrangements at the hospital. These were all monitored in line with the requirements of the Spire Healthcare Clinical Governance and Quality Manual.
- The hospital risk register recorded different categories of risk, some department specific, some hospital-wide and some financial. It was not clear when risks were added to the register; however, we saw up to date action plans, for the introduction of the single patient record.
- Processes were in place to ensure that consultants and external first assistants provided updates to required documentation, for example, their appraisal and updated indemnity insurance in line with The Health Care and Associated Professions Order 2014. The electronic system generated a letter to the consultant a week prior to the expiration of documentation, followed by a reminder two weeks later, and a further reminder another two weeks later. The consultants practising privileges would be suspended if the documentation was not presented and this was clearly identified on the hospital wide risk register.
- There were processes in place to suspend or remove a consultant's practising privileges where there were concerns about their practice. The hospital provided evidence, which demonstrated a clear transparent approach within the governance processes and procedures of the hospital.
- Local and national patient surveys, complaints, incidents reports and informal feedback were all monitored in line with the requirements of the Spire Healthcare clinical governance and quality manual.
- At the time of our inspection, the hospital had no reported incidences of sepsis and so did not collect specific audit data on sepsis. In the audit plan a sepsis compliance audit was waiting 'to be advised' should an event occur.

Leadership / culture of service related to this core service

- There was clear and visible leadership at the hospital. All of the staff we spoke to regarded the senior management team as approachable and very visible around the hospital. Senior staff clearly operated an open door policy. During interviews with senior ward staff, it was clear there were no barriers to communicating with the matron and we saw evidence of phone calls made to obtain advice and support during our inspection.
- Staff morale was positive throughout the wards and theatres and staff we spoke to were overwhelmingly positive about working at the hospital. Sickness rates for theatre operating department practitioners (ODPs), ward nurses, healthcare assistants on the wards and in theatres were varied when compared to the average of other independent hospitals. Theatre nurse's sickness rates were lower than the average of other independent hospitals.
- The matron met quarterly with other Spire Matrons. These meetings were a forum for senior level staff to monitor and maintain the same standards across the Spire network.
- Heads of departments and senior teams told us how hard the staff at the hospital worked. One manager told us how proud they were of the theatre sterile services unit (TSSU) and how they went "above and beyond" to make sure that no operations were cancelled.
- Staff felt supported by senior staff members. During a comprehensive investigation into a serious incident, the hospital matron personally phoned staff to check on how they were managing and offered referral to a counselling service.
- The senior teams pro-actively managed their staff and monthly meetings tracked individual staff member's performance. Plans were put in place to manage staff who needed extra support, such as time management and help with prioritising workloads.
- Senior members of the theatre team had been given the time and support to attend study days on national safety standards for invasive procedures (NatSSIPs). They were able to plan the implementation of local NatSSIPs and a senior member of the theatre team had been given the time and support to lead this part of the service forward.

Public engagement

- The hospital invited patients to be part of improving services and they were involved with delivering the PLACE audits. These assessments involved local people known as patient assessors who visited the hospital as part of a team to assess how the environment supports

patient's privacy and dignity, food, cleanliness and general building maintenance assessing how the environment supported the provision of clinical care. The assessment focuses entirely on the care environment and does not coverclinical care provision or how well staff are doing their job. The yearly assessment results were reported publicly with the aim to help drive improvements in the care environment. The results show how hospitals are performing nationally and locally. The hospital performed well in these audits when compared with other services The scores were higher than the England average in for example cleanliness and dementia.

- The hospital asked all admitted patients to complete a two-page patient satisfaction questionnaire, which helped the hospital learn from patient feedback, driving quality improvement. The questionnaire covered all aspects of a hospital stay and included questions on pain relief, nutrition and hydration and staff competency.
- Patients were invited to complete a patient satisfaction survey the results were added into the clinical scorecard and could be seen displayed across the hospital. The results could be compared to the whole of the Spire network.
- The hospital displayed 'you said we did' posters in patient areas. Patients had identified concerns about the quality and standard of their rooms and the hospital had all rooms on one level refurbished. The public were invited to attend patient information events and the hospital had run two patient fertility events during November 2015.
- The hospital ran a patient forum, formed of senior management representatives and independent former-patients who provided a patient's perspective on how services were provided, what improvements could be made, and helped to shape the long term strategy of patient care.

Staff engagement

- The hospital recognised staff achievement and made staff feel valued for this. In 2015, the hospital presented 76 members of its staff with an 'Inspiring People' award for performance, which went 'above and beyond' the call of duty. Staff came from a wide range of clinical and non-clinical departments and this was an increase from 2014 where only 16 staff had received the award.
- Staff could attend a range of meetings, which clearly reflected the organisational structure. All departments had monthly meetings, such as the ward and the theatre department, the pathology quality meeting, discharge working group, quality assurance and specialities such as the resuscitation working group. The senior management team and the medical advisory committee oversaw these meetings, which clearly fed into each other.
- There was good communication with staff. The management team sent out a monthly newsletter and held regular staff forums. The newsletter had a matrons blog and introduced 'a day in the life of' where staff could understand how other team members and departments worked. This was aimed particularly at those members of the hospital with less visible roles.
- The latest staff survey results showed an increase in response rate from 71% to 87% this was an improvement but was still below the Spire group average of 88%.

Innovation, improvement and sustainability

- The hospital had identified risks for future sustainability and had considered the development of a cataract service. This was seen in the three-year plan and the risk register
- The endoscopy suite did not have Joint Advisory Group accreditation (JAG) and the hospital had plans to create a new endoscopy suite to gain this accreditation.
- Theatres received their human tissue grafting materials in dry ice from an external provider. The hospital had a service level agreement in place so if the material was not used on the day of surgery it was returned to the company for storage until it was needed. This saved the hospital the cost of holding a licence to store it themselves and minimise wastage of precious human tissue.
- The hospital had a very steep driveway and the engineering department secured funding to buy a tractor which would help clear away snow to make sure staff and patients could access the carpark safely.

Good

Critical care

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

Information about the service

The critical care service was a six bed facility, with three beds in the intensive care unit (ICU); three beds in the high dependency unit (HDU); and had the facilities to provide two further ICU beds within the post-anaesthesia care unit (PACU). The unit accepted a maximum of three level 3 patients and three level 2 patients at any one time. From April 2015 to March 2016 there was an occupancy rate of 19% for level 2 critical beds and 11% for level 3 critical care beds.

The hospital employed 18 critical care nurses, two team leaders and one nurse manager. There were eight bank staff who regularly worked on the unit. The average length of stay for patients in critical care was less than 24 hours.

Patients were admitted post-operatively, under the shared care between the admitting consultant and the consultant intensivist team, with the intensivist consultant supervising the day to day management of the patient and contributing to the admission and discharge of patients to the unit. Most admissions to the unit were planned. An outreach service was available to assess deteriorating patients in other areas of the hospital and those recently discharged from the critical care unit.

Level 3 (ICU) patients received one to one nursing care; and level 2 (HDU) patients had one nurse for every two patients.

The unit did not treat children.

We visited the unit over the course of two announced inspection days. We spent most of the time in the critical care unit as there were no patients in the high dependency unit for the two days we were on site.

During our inspection we spoke with eight members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the critical care leadership team and the senior staff nurse. We also spoke with two patients and one relative. We checked three patient records, the critical care environment and equipment. We also checked other hospital records such as policies and procedures.

Good

Critical care

Summary of findings

We rated critical care services overall as good because:

- There was a good culture of incident reporting and no serious incidents had occurred on the unit.
- The equipment and the unit appeared visibly clean.
- We observed and patients told us that staff complied with safe systems and processes to prevent and control infection, in line with hospital policy and national guidance.
- We saw effective multidisciplinary team working, including the outreach team who could treat patients who became acutely unwell.
- Nursing and medical staffing met the current guidelines, and all staff were experienced and had access to a wide range of training courses.
- The staff used evidence based practice and treatments.
- Patients were treated with dignity and respect and patient feedback was used to make improvements.
- There were effective governance systems in place to support the delivery of good quality care.

However,

- We found patient outcome data for their stay on the critical care unit was not routinely audited or monitored. Lack of full patient outcome monitoring in relation to their stay in critical care, in addition to the unit not participating in national benchmarking, made it difficult to fully assess performance.
- There was nowhere for critical care staff to have private conversations with relatives or carers within the unit.

Are critical care services safe?

Good

Overall, we rated critical care as good.

- We saw that there were no serious incidents on the unit and good levels of incident reporting with clear systems to feedback learning to staff. Staff were also aware of the hospital guidance regarding duty of candour and how to access this
- The equipment and the unit appeared visibly clean. We observed staff were always compliant with infection prevention and control processes, including being bare below the elbows and cleaning hands before giving intravenous medicines.
- The outreach team could improve the quality of care for patients who became acutely unwell, by undertaking daily ward rounds and supported staff who cared for patients identified at risk of becoming critically ill.
- Nursing and medical staffing met the guidelines outlined in the 2015 Intensive Care Society Core Standards for Intensive Care Provision.

Incidents

- See the Surgery section for main findings.
- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses, and to report them internally and externally. Staff were able to describe how they would report incidents and were encouraged to report so lessons could be learned and shared. Staff demonstrated that they had received training in using the incident reporting system. All pressure ulcers grade two or above were documented as a local clinical incident. Staff consistently reported incidents. We saw four incidents had been reported through the hospital incident reporting system from January to June 2016. Two incidents related to medication/drug incidents - one of which related to a controlled drug was found in a syringe on HDU, and the other was an administration error. One incident related to post-operative samples received in pathology from the critical care unit with no hospital numbers or date and time of collection. The final incident related to a patient who underwent a craniotomy and developed a haemorrhage.

- Feedback from incidents was discussed at the heads of department monthly meetings, and managers cascaded this to their staff. Staff also told us ad hoc meetings would be held for urgent feedback to staff. Lessons learned from complaints and incidents were sent out with staff pay slips.
- When things went wrong relating to ICU or HDU, thorough reviews or investigations were carried out. All relevant staff involved in the review and subsequent learning completed. An example of this was an incident which followed the unpreventable death of a patient. The coroner stated care and resuscitation attempts as 'exemplary'. The hospital organised a walk and talk through of an emergency procedure involved in this case for critical care staff to increase staff confidence. Staff talked about this positively. Learning was also shared with other Spire hospitals to highlight the importance of consistent and regular training.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation required the hospital to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff we spoke with were aware of this legislation and demonstrated good understanding of their responsibilities under this legislation. Serious incident reports showed this requirement had always been considered.
- Staff at all levels were able to describe what the duty of candour involved and the actions required. Staff were aware of the hospital guidance regarding duty of candour and how to access this.

Safety thermometer

- See the Surgery section for main findings.
- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. This data was not specifically reported and displayed within the critical care unit. Results of safety thermometers were not shared amongst staff or patients on the unit and data did not appear to be used. Staff told us they were aware of the safety thermometer data being collected but results were not shared back with the critical care team.

Cleanliness, infection control and hygiene

- The critical care service monitored the rates of infection occurring on the unit. The performance of the unit in relation to the following infections was noted: Clostridium-difficile, methicillin-resistant Staphylococcus aureus (MRSA), central venous catheter (CVC) related blood stream infections and ventilator associated complications including ventilator associated pneumonia (VAP). Audits showed no infections occurred within the critical care unit from October 2015 to September 2016.
- Staff were able to explain how standards of cleanliness and hygiene were maintained. We saw evidence of cleanliness and hygiene checks were regularly carried out, and monthly infection control audits were undertaken. Audit results showed the unit was 100% compliant in infection control for personal protective equipment (February and August 2016); and decontamination of patient care equipment (March and August 2016). Departmental waste was also audited. Results for critical care were included with theatres and results showed 86% compliance in June and 95% in July 2016.
- Reliable systems helped staff to prevent and protect people from a healthcare associated infection. The unit was cleaned every day. The unit was visibly clean and personal protective equipment (PPE) was available in wall mounted units in each of the areas in the unit. We observed staff using PPE during our inspection.
- We observed healthcare workers wash their hands immediately before and after every contact or care. The hospital undertook regular audits of hand sanitiser usage by weighing each bottle of sanitiser to monitor how much had been used. Results for the critical care unit formed part of the results for theatres which achieved 95%.
- Patients who needed a urinary catheter or needed a vascular access device had their risk of infection minimised because the staff followed specified procedures for insertion and removal complied with National Institute of Clinical Excellence (NICE) quality standard 61 for infection prevention and control.
- One patient told us they were impressed by the standard of cleanliness and the pleasant surroundings.

Environment and equipment

Good

Critical care

- Facilities and premises were designed in a way that kept people safe. Adult inpatient and clinical facilities were designed in keeping with the national standards of Health Building Notice (HBN04-02) which addresses the design of critical care units. There were three beds in the intensive care unit (ICU) and three further beds in the high dependency unit (HDU). Both areas were spacious, and had a good layout allowing staff good access to patients.
- Equipment was regularly and adequately maintained to keep people safe. An inventory of ICU, HDU and the post-anaesthesia care unit equipment was kept up to date. An equipment link nurse from critical care had one day per month to check all devices including service dates, including ventilators, humidifiers, and monitors. We were told engineers responded quickly to deal with faulty equipment, and old equipment was replaced through the capital replacement programme. Staff told us they had no problems with the equipment they were using, and felt empowered to raise an issue if they did. The unit had sufficient equipment.
- Staff used equipment safely. The equipment link nurse was responsible for ensuring all staff new how to use the equipment and were also responsible for training all new staff to use the equipment. They were also responsible for ensuring all staff were trained on new equipment. We were shown they had recently trained a cohort of staff on the new volumetric infusion pumps, which was then cascade to all other staff who used this equipment.
- There were safe systems for managing waste and clinical specimens including classification, segregation, storage, labelling, handling and treatment and disposal of waste. For example, sharps bins were used, dated and signed when full to ensure timely disposal, not overfilled, temporarily closed when not in use.
- Resuscitation equipment was readily available. This equipment was stored securely in tamper evident packs. We checked the resuscitation trolley during the inspection and it had been checked and signed every day in the previous month.
- There is an annual Capital Expenditure purse which is prioritised by SMT in terms of clinical need. Critical Care equipment forms part of this with recent purchases of volumetric pumps, haemofiltration equipment and a new balloon pump.

Medicines

- There were reliable systems for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines, medical gases and contrast media.
- Prescription forms were stored securely. Use of prescription forms was audited in accordance with the hospital policy.
- The processes for identifying out of date medication was effective. The systems for managing medicines were regularly audited for areas where medicines were stored. Controlled drugs audits were undertaken. The action plan following these audits showed the date and time of administration of medications were not recorded on 'a couple of occasions', and this had been addressed.
- When required action was always taken to address non-compliance with the policies. For example, a pharmacist told us all prescribing errors were logged on the hospital incident monitoring system and discussed with relevant members of staff and their managers.
- The systems for managing medicines were reliably communicated to staff. The hospital provided guidance to staff through the medicines management policy and standard operating procedures. Nursing staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council Standards for medicine management. We saw the controlled drugs register and clear instructions in the controlled drug cabinet of how to sign out drugs. Staff we spoke to were aware of the policy.
- Monthly audits were undertaken to ensure fridges containing medications were at correct temperatures. We saw in one audit a thermometer was not reset properly and was hand held which warmed up the thermometer. A new system was introduced and this issue was discussed at a staff meeting and an alert sent to all relevant staff by email.

Records

- The critical care unit used a paper based record system for recording patients' care and treatment.
- We reviewed three sets of inpatient records. Information was easy to access with each episode of care divided into separate sections to allow staff to access the most recent and relevant information about the patient.
- Patient's individual care records were stored securely. Records were accurate, complete, legible, and up to date. We reviewed three sets of patient records from

critical care. Admission notes were legibly documented. Nursing assessments conformed to nursing standards. The hospital undertook a full and comprehensive audit of all patients records, including critical care notes where the patient had stayed on the unit.

- There were systems for managing records and these were communicated to staff. These systems were monitored and improved when required. We saw minutes of meetings which showed the critical care chart was under review and all critical care staff were asked to contribute ideas for the new chart.
- Patient records showed evidence that specific critical care assessment proformas were in use. Staff also had access to the patients' surgical referral latter, preassessment clinic checklist, preoperative assessment undertaken by an anaesthetist, intraoperative anaesthetic record, and surgical notes. We saw venous thromboembolism, waterlow, fluid balance charts, and manual handling assessments had been completed.

Safeguarding

- There were systems, processes and practices to keep people safe. Safeguarding systems and processes were communicated to staff. All staff were able to explain these procedures. The hospital had a policy for safeguarding and staff could easily access this.
- All nursing staff in the unit had been trained in adult safeguarding to at least level 2, with four members of staff having level 4 training.
- None of the staff we spoke with had had to make a safeguarding referral but they were aware of the process and how to escalate concerns.

Mandatory training

- See surgery report for main findings.
- Staff received regular mandatory training updates in safety systems, processes and practices. Staff told us they had annual appraisals and regular one to one meetings with their managers where learning needs were identified. They told us they had protected time for learning and training, and received regular coaching and mentoring. A range of courses were available for staff to undertake.
- Training records were kept locally, and managers were aware of compliance levels for each member of staff.

Data received from the hospital indicated critical care staff had completed advanced life support (ALS) training to manage a cardiac arrest before the arrival of a cardiac arrest team.

Assessing and responding to patient risk

- There was a hospital wide standardised approach to the detection of the deteriorating patient, medical emergencies or challenging behaviour. This was provided by the critical care outreach team, which consisted of experienced critical care nurses, a consultant anaesthetist, and supported by the critical care sister. The aim of the team was to improve the quality of care for patients who became acutely unwell. The team did daily ward rounds.
- The team used the national early warning score system (NEWS), and supported staff who cared for patients identified at risk of becoming critically ill. Data provided by the hospital showed most patients were continually assessed using NEWS, with observations taken every five minutes, temperature taken every 15 minutes. They also followed up on all patients discharged from the critical care unit. There was a clearly documented escalation processes. The team also provided clinical support and guidance to ward nurses, reducing the number of adverse events, provide early intervention in the recognition and management of acutely ill patients, and reduce the number of clinically delayed discharges.
- Staff were aware of the hospital policy for sepsis management, which included early recognition, screening, escalation and management. All staff had access to the resuscitation care bundle for patients presenting with severe sepsis or septic shock.
- There were clear criteria for people who would and would not benefit from admission to the critical care unit. This was well communicated to other specialties. On admission to the critical care unit all patients had a treatment plan discussed with a consultant in intensive care medicine.
- The unit had plans for emergency transfers to a local NHS acute hospital if required, and there was a service level agreement in place for if a patient required an emergency blue light transfer to a local NHS trust. A checklist, based on National Institute of Clinical Excellence (NICE) 50 guidance (Acutely ill patients in hospital) included the decision made by a consultant, photocopies of the patient's notes including x-rays and test results, and infection status. A further checklist was

completed to help ensure the patient was stable before being transferred. A critical care nurse and anaesthetist would accompany a patient if they needed to be transferred to another hospital.

- The hospital had developed a sepsis management plan and an escalation policy for patients with sepsis who required immediate review. Risk assessments were undertaken for patients at risk from septicaemia. Staff were aware of the actions to take when patients were showing signs and symptoms of septicaemia.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so people received safe care and treatment at all times. The service used an acuity tool provided by the Core Standards for Intensive Care Units (2013) to consider the dependency of patients in each clinical area. Following the publication of the 2015 Intensive Care Society Core Standards for Intensive Care Provision, a gap analysis was undertaken to ensure the unit was compliant. Actions had been addressed to ensure the unit could provide a safe and effective service to critical care patients. Staffing in critical care was in line with the Intensive Care Society standards for staff competence and skill for level 2 and level 3 patients. The unit had an identified lead nurse who was formally recognised with overall responsibility for the nursing elements of the service.
- All staff received an induction to the critical care setting. A critical care nurse told us they had received an excellent induction over several weeks. This included mandatory training and e-learning, as well as face to face training including resuscitation, as per the induction policy. The unit had recently introduced the national competency framework for critical care nurses to build skill, knowledge and competencies of staff on the unit. For agency staff, a registered nurse completed induction checklists to ensure nurses were inducted to the unit so they may practice safely. Staff told us staffing levels were excellent and agency staff were rarely used.
- There were processes to keep patients safe at times of handover, shift changes and discharge. The unit had a standardised handover policy for medical, nursing and allied health professionals for patients discharged from the critical care unit. We saw a midday handover where staff discussed the patient together, then with the patient at their bedside. The handover was thorough and included a student nurse for education. We also observed a structured handover by an anaesthetist to critical care staff when a patient was admitted to the critical care unit – a verbal handover was followed by a written plan in the anaesthetic record. The anaesthetist then revisited the patients four hours later and updated instructions were noted on the critical care unit chart.
- All patients discharged from the unit received at least one follow up visit by the outreach service within 24 hours of discharge from the critical care unit.
- We saw that level 3 patients had one to one nursing provided by a registered general nurse with a critical care qualification to deliver direct care. Level 2 patients had one to two nursing provided by a registered general nurse to deliver direct care. A staffing review and gap analysis was undertaken in June 2015. The unit identified there were times when more than 20% of registered general nurses from bank and agency were employed on any one shift, which breached the nursing standards provided by the Core Standards for Intensive Care Units (2013). This was risk assessed as bank staff used by the unit were experienced Spire employees. When it was not possible to staff a night shift with contracted staff, a discussion and risk assessment was made by the senior critical care nurse to ensure the delivery of care was sufficient to ensure the safety of patients.

Medical staffing

- Staffing levels and skill mix were planned in accordance with standards set out in the guidelines for the provision of intensive care services 2015 by the Faculty of Intensive Care Medicine.
- The anaesthetic lead was a consultant who was affiliated to the Faculty of Intensive Care Medicine.
- Consultant work patterns delivered continuity of care. The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. There was no intensivist staff rota as each intensivist looked after their own patient and was responsible for finding their own cover if they were unavailable. Nursing staff told us this worked well and they were always able to contact an intensivist or the intensivist lead if they had any concerns about patients. Phone numbers of surgeons and intensivist were displayed on the white board in the critical care unit for any patients that had been admitted.

Good

Critical care

- The hospital employed four resident medical officers (RMOs) who had completed corporate mandatory training. All of the RMO's were qualified to specialty training level 3 (ST3). The Royal College of Surgeons (RCS) recommends in their publication Emergency surgery 2011, in case of emergency return to theatre an ST3 or someone with Membership of the Royal College of Surgeons (MRCS) and Advanced Trauma Life Support, (ATLS) must be able to see urgent patients within 30 minutes.
- The critical care nurses discussed all admissions to critical care unit with a consultant, who reviewed all patients within 12 hours of admission.

Major incident awareness and training

- Senior staff told us the hospital kept a copy of the major incident and lockdown plan in a file in the hospital management offices, with a copy at the main headquarters.
- The hospital had a business continuity plan to respond to potential major incidents, such as bomb explosion, wide spread fire or flood, or prolonged loss of power to ensure normal business could continue or be managed. These scenarios ranged from a fire, loss of the telephone system, through to loss of the operating theatres or a local major incident. The plan included transferring patients to another critical care unit through existing transfer arrangements with local healthcare providers or the critical care network, or for wards to transfer patients to the critical care unit.
- There were escalation plans if a consultant could not be contacted in an emergency with alternative contact numbers available.

Are critical care services effective?

Good

We rated effective as good because:

- We saw evidence-based practice and treatments were well established in the unit.
- We saw good multidisciplinary working.
- The unit had created a pain ladder - a guideline for the use of drugs in the management of pain. Nursing staff used this to assess acute pain and chronic pain, and ensure that patients received the correct type of medication and managed the expectations of patients.
- Staff on the unit were experienced and trained. There were reliable arrangements for supporting and managing staff, and a reliable system of staff supervision.

However:

- Information about the outcomes of patient's care and treatment was not routinely collected and monitored. Some patient outcomes, such as average length of stay, were not formally monitored and the unit did not contribute to a national benchmarking database, making it difficult to assess performance directly with other similar units.
- The critical care unit was not submitting data to the Intensive Care National Audit and Research Centre (ICNARC) at the time of inspection, although there were considerations of corporate plans to do this in 2017.

Evidence-based care and treatment

- The critical care unit service incorporated relevant and current evidence-based best practice guidance and standards, to develop how services, care and treatment were delivered. Guidance documents were available and easy to access on the critical care unit. These included NICE quality standard 66 for intravenous fluid therapy and Quality Standard 3 for treatment of thromboembolism. We saw these documents were up-to-date.
- A care bundle is a set of interventions, when used together, significantly improve patient outcomes such as patients with sepsis or urinary tract infection. Staff were aware of the care bundles and could explain how they were used to support and treat patients.
- The critical care team collected audit data to inform the hospital audit programme. Data was presented at clinical governance and head of department meetings, and minutes of these meetings were shared. Team briefings were based on the output of these meetings.

Pain relief

- Anaesthetists prescribed post-operative patient relief for patients and were contacted if effective pain control was not achieved. The resident medical officer could also be contacted to prescribe additional or alternative pain relief.
- Staff demonstrated a good understanding of methods available to them for management of patients' pain. The level of pain in patients was assessed using a locally

created pain ladder which was a guideline for the use of drugs in the management of pain. Nursing staff used this to assess acute pain and chronic pain, and ensure that patients received the correct type of medication and managed the expectations of patients. This tool was also used to train new staff and student nurses.

- The critical care service also had access to a specialist pain team, and staff told us the pain team would respond quickly and as necessary. The pain team included a critical care nurse, a pharmacist and a physiotherapist. The pain team responded to patients flagged by the outreach team, as well as providing training for new staff as part of the induction process. The critical nurse was able to give us examples of how patients were helped to manage their pain from the pre-operative assessment. They also told us they felt they had a duty of care until patients were discharged and was proud to be able to help.

Nutrition and hydration

- Staff demonstrated a good understanding of the importance of assessing nutrition and hydration needs. Patients' nutrition and hydration needs were adequately met. Nursing staff told us that nutrition and hydration needs were identified at preoperative assessments, and that the hospital used the malnutrition universal screening tool (MUST). This is a five- step-screening tool to identify possible risks of malnutrition.
- Patients were offered a range of meals. Specific dietary needs were identified at preassessment and catered for.
- The Patient-led assessment of the care environment (PLACE) audit from February to June 2016 showed that 98% score for the quality of food at the hospital, compared to an England average of 93%.

Patient outcomes

- The hospital provided evidence that there were no high risk sepsis admissions, unit acquired infections in blood, out of hours discharges to the ward, non-clinical transfers or unplanned readmissions to the unit within 48 hours. However, information about the outcomes of people's care and treatment within critical care was not routinely collected and monitored in a way which allowed the unit to compare its outcomes with other units. We did not see any evidence of how the critical care unit performance was monitored or benchmarked against others (either externally or against other units within the Spire group) and there were no tools in place to provide feedback about the quality of patient care or outcomes to those who work in critical care.
- The Guidelines for the Provision of Intensive Care Services, 2015 recommend that critical care units should collect standardised national data through a recognised national clinical audit, such as the Intensive Care National Audit and Research Centre's (ICNARC) case mix programme to promote local and national quality improvement. These analyses should be reviewed on a regular basis for local action. We were told that Spire Healthcare was considering submitting data to ICNARC which would provide information and feedback about the quality of care patients receive to those who work in critical care. Staff had also requested support for auditing against their critical care framework in September 2016.
- Staff were involved in the collation of audit data regarding patient outcomes for the whole of the patients stay (such as infection prevention audits and use of catheter and central lines) and a representative from the department attended the clinical effectiveness meetings where results are discussed and learning shared with the wider hospital. Feedback from these meetings was also shared in the departmental meetings or more informally given the small size of the team.

Competent staff

- All staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, when they took on new responsibilities and on a continual basis. Nursing staff in charge of patient care in the critical care unit had a prescribed set of competencies as outlined in the national competency framework for critical care nurses. The critical care unit ensured professional or national standards for intensive care nursing were met as outlined in the professional standards. This was monitored by the critical care lead nurse.
- Staff had specialist critical care training and were able to access additional training. A staffing review and gap analysis was undertaken in June 2015. Following this review an experienced nurse was appointed to oversee, plan and deliver additional intensive care training and updates to nurses in critical care.

Good

Critical care

- All nursing staff appointed to the critical care unit were allocated a period of supernumerary practice and have a thorough induction programme.
- There were reliable arrangements for supporting and managing staff, and a reliable system of staff supervision. These included an induction process, where new staff work with a mentor in a supernumerary capacity for three weeks, and further support of their first months. Progress was reviewed and objectives and goals agreed. Training needs were also identified and an action plan completed.
- The learning needs of staff were identified during regular one to one meetings with managers and at annual appraisals. Staff told us they had access to good quality training. Poor or variable staff performance was identified and managed. The nurse lead told us staff were supported to improve through a variety of methods including one to one coaching and supervision. We saw most staff had an annual appraisal during 2015/16, with the exception of staff who were on long term sickness absence.
- Clinical pharmacists providing a service to critical care were competent. The hospital pharmacist had a post graduate clinical diploma (which included a module covering Intensive Care and Surgery) and access to support from the superintendent pharmacist and bank pharmacists, as well as a service level agreement with the local NHS trust. The pharmacists provided an on call service.

Multi-disciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment.
- All staff worked together to assess and plan ongoing care and treatment in a timely way. This included when people were due to move between teams or services, including referral, discharge and transition. There were clear pathways for referral between specialties in the hospital and for referral to other organisations
- Staff told us the multidisciplinary team worked well together, and nursing staff told us the anaesthetists and resident medical officers were supportive.
- When patients were discharged from the critical care unit, this was done at an appropriate time of day, when clinically ready and appropriate to allow them to be settled at their destination ward. When a patient was discharged, relevant teams were informed. A discharge protocol and summary form was completed for each patient. This included the patient's condition and nursing requirements at time of discharge, and was signed by both the discharging critical care nurse and the admitting ward nurse.
- No patients were discharged out of hours; staff told us it was unsafe to move patients out of hours.
- All team members were aware of who had overall responsibility for each patients care. There was clear identification of the consultant responsible for providing specialist care for patients. The critical care unit used the objectives of The Academy of Royal Colleges guidance for taking responsibility: accountable clinicians and informed patients to identify and implement best practice.
- The critical care unit had access to an experienced physiotherapist who could help construct a suitable weaning plan for complex patients, or long stay patients in conjunction with the wider multi-disciplinary team. The physiotherapist would visit each patient pre and postoperatively, and a care plan was written up for each patient.

Seven-day services

- There was seven-day services across the hospital. The hospital carried out elective operations between Monday and Saturday. Physiotherapists offered services over the weekend and there was access to consultants at all times, in and out of hours. The hospital provided a pharmacy dispensing service five days a week. Medicine supply and advice was available 24 hours per day via the on-call pharmacist.
- Consultant cover at the weekend was provided by the anaesthetists responsible for patients on the unit. Consultants were on call 24 hours a day for patients in their care, and were responsible for identifying medical cover if they were not available.
- There was 24 hour medical cover from the resident medical officer in the hospital to provide clinical support to surgeons, staff and patients.
- The critical care unit met NHS seven days a week priority standards for diagnostics. Critical care patients had access to seven-day access to diagnostic services such as x-ray, computerised tomography (CT), and magnetic resonance imaging (MRI).

Access to information

Good

Critical care

- The information needed to deliver effective care and treatment was available to staff in a timely and accessible way. For example, critical care staff had access to care and risk assessments, care plans, case notes and test results.
- When patients moved between teams and services, including at referral, discharge, transfer and transition, the information needed for their ongoing care was shared and in a timely way. There was evidence of use of a formal handover document for people being stepped down from the critical care unit to a ward. This included what procedure the patient had undergone and what their current observations were. This was in line with National Institute for Health and Care Excellence (NICE) clinical guideline 50.
- Policies and guidelines were available to critical care staff in folders in an office and policies could be accessed on the hospital intranet. Staff could show us how they would access these policies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated understanding of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. Staff told us patients could only give consent if they could understand, weigh up, retain and communicate information. Critical nursing staff demonstrated an understanding of Deprivation of Liberty Safeguards, and talked through process of where they would or would not use the Mental Capacity Act.
- Nurses understood the difference between lawful and unlawful restraint practices and were aware how to seek authorisation for a deprivation of liberty. Staff told us about physical and chemical restraint methods could be used within critical care but had not applied these to any patients.
- Nursing staff told us if a patient did not have capacity to consent to treatment (as outlined in the Mental Capacity Act 2005) they would speak to the safeguarding lead for the hospital to ensure that consent processes were properly followed. They understood they needed to ensure patients understood questions and would ask patients to tell them what they understood. Where appropriate they would have discussion with carers and families.
- The unit had a safe sedation policy for patients over 16 years of age. It was reviewed by the Spire Healthcare chief nursing officer.

Are critical care services caring?

Good

We rated caring as good because:

- Patients were treated with dignity and respect, and were complimentary about the friendly and supportive staff, who were always aware of maintaining patient comfort.
- Staff involved patients and their relatives in decisions about their care, giving explanations and allowing opportunities to ask questions
- Patients felt able to ask questions and the staff to patient ratio on the unit meant staff had time to attend to any needs their patients may have.

Compassionate care

- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner. Patients told us they were very happy with all aspects of their care and the facility. One patient told us they were very happy with their care and would recommend the hospital to their family and friends. They told us that they were happy with the pleasant surroundings of the critical care unit and all the staff, and that their pain had been well managed.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. We saw staff introducing themselves and checking pain and discomfort levels with patients and responding in a compassionate and timely manner. We saw patients were treated with kindness and compassion and were kept informed throughout their stay.
- Staff made sure people's privacy and dignity was respected, including during physical or intimate care. Curtains were pulled around patients during check-ups, and conversations were sensitively handled so other patients would not overhear. We saw that staff spoke quietly during the patient handover from the night shift staff to the day shift staff, in a way that was inclusive with the patient, but could not be overheard by the other patient on the unit.

Good

Critical care

Understanding and involvement of patients and those close to them

- Staff always communicated with patients so they understood their care, treatment and condition. For example staff made sure patients and those close to them were able to find further information and ask questions about their care and treatment. We spoke to two patients who told us they were fully informed of the procedure they had undergone and what to expect next.
- We saw patients had their post-operative care explained to them in a way they could understand and were offered the opportunity to ask questions about their care or stay in the critical care unit.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment. Staff enabled patients to access this support, such as providing an opportunity of patients to visit the critical unit as part of their pre-assessment appointment.
- Information regarding safeguarding from abuse was displayed on noticeboards within the unit where patients, family members and carers would see it.
- In June 2016, six critical care staff had training on approaching relatives in regard to organ donation. Staff told us they would liaise with the specialist nurse for organ donation within the hospital and NHS Blood and Transplant if required.

Emotional support

- Staff understood the impact a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. Patients had their physical needs regularly assessed and addressed. This included nutrition, hydration, and pain relief. Although, psychological assessments for anxiety or depression were not routinely undertaken, staff told us how they would treat anxious patients with claustrophobia, stress, or delirium. The critical care unit also had access to psychiatric support for patients who required support. Staff told us they were able to refer patients to a psychiatric team within the hospital. We were told nursing staff ensured they sat down and talked to each patient no matter how busy the unit was.
- Patients were given timely support and information to cope emotionally with their care, treatment or condition. This included emotional support such as allowing carers to stay overnight at the hospital if the patient was vulnerable, emotional or confused. We were also told the hospital used translators for patients whose first language was not English, whilst they were recovering from surgery. This was to provide reassurance to patients.

Are critical care services responsive?

Good

We rated responsive as good because:

- There was good access to critical care beds. Elective procedures took place on time and patients were not transferred off the unit out of hours.
- The unit was responsive to the needs of individuals.
- The unit was available for patients when required and additional staff could be obtained at short notice.
- Individual needs were identified at pre-assessment to allow planning of the patient's care prior to admission.

However

- There was no information available on the unit advising patients and relatives of how to make a complaint about care and treatment.
- There was nowhere for critical care staff to have private conversations with relatives or carers within the unit.

Service planning and delivery to meet the needs of local people

- The hospital planned services to meet the needs of private and NHS patients. A resource meeting was held every week to identify the needs of each patient and the resources the hospital would require. This included where patients would or may require intensive care or high dependency care.
- A multidisciplinary daily early morning meeting also took place to discuss any particular needs of patients, including any patients who may require critical care.
- The hospital ensured enough critical care staff could be available should an unplanned admission to the critical care unit occur.

Meeting people's individual needs

- The critical care unit was planned and delivered to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy, and maternity status, race,

religion or belief and sexual orientation. We were given an example of how staff were able to respond to a patient's religious and cultural needs to provide care by discussion with the patient and researching on the internet. Staff ensured that women were nursed by female staff if requested. Staff also told us some patients had asked to ensure their relatives and carers would not see them without their wigs or teeth, and the staff ensured their wishes were accommodated.

- Translation services were readily available, and all staff we spoke to knew how to access these services. Staff had access to a list of contacts within the hospital who were able to interpret for patients. Staff also had access to a translation service who could arrange a telephone or face-to-face translator if required. Staff understood professional translators must be used if a patient requires any form of translation to give consent.
- Patients were provided with information leaflets or written information to explain their treatment plan in advance of their procedures. This allowed them to make informed decisions about their care. We saw staff patiently explaining the relevant stage of the care plan in the unit to patients and ensuring patients understood by asking them to summarise what they had been told.
- There was nowhere on the critical care unit for nursing staff to have private conversation with relatives. We were told when conversations needed to take place these happened at the end of a corridor outside the unit. There was a small table and chairs available, but conversations could be overheard and other hospital staff, patients and members of the public would be able to overhear conversations. When we raised this with hospital management we were told a room could be made available, but this was not known by critical care staff at the time of inspection.

Access and flow

- Patients who may require intensive or high dependency care were identified at pre-assessment.
- The critical care unit prioritised care and treatment for people with the most urgent needs through the flexible use of critical care beds. The maximum number of ventilated patients was limited by the number of IT standard ventilators (three). Patients were not transferred to other critical care units for non-clinical reasons.
- The service managed booked beds for post-elective level 2 and 3 critical care by ensuring scheduling elective surgery matched the level of critical care booked for the patient's needs, ensuring beds and staff were available. If the three beds in the intensive care unit were not in use for level 3 patients, they could be used for high dependency level 2 patients, or by level 1 patients were a surgeon or anaesthetist had requested extra monitoring of patients. This might include bariatric patients or patients with sleep apnoea.
- Care and treatment was only cancelled or delayed when absolutely necessary, and staff told us there were no instances where surgery was cancelled because critical care beds were unavailable.
- The nurse lead told us transfers from the critical care unit to the general ward did not happen outside of core hours, from 7am to 6pm, whenever possible.

Learning from complaints and concerns

- Patients told us they did not know how to make a formal complaint or raise concerns, and there was no information on the unit advising how to complain or provide feedback about the service. However, patients told us they felt confident to speak up about concerns. We saw that patients were provided information on making a complaint as part of their preadmission pack, and staff told us that they could provide this information upon request. However if a patient or their family wished to raise concerns they may not feel comfortable asking staffing caring for them for the information on how to make a complaint.
- The lead nurse told us no formal complaints had been received during the previous year. However, we were given examples of where the unit had responded to informal complaints such as replacing the noisy metal bins with plastic bins. We were also told about a patient who complained about the lights being on during the night which meant they were finding it difficult to sleep. The lead nurse then bought eye masks for the patients to use during the night. She fed this back to the patient who had complained and, although they had left the unit, they were pleased they had been listened to.

Are critical care services well-led?

Good

We rated well led as good because:

Good

Critical care

- The unit had a clear vision and set of values and all critical care staff were aware of this.
- There were effective governance systems in place to support the delivery of good quality care.
- Management were visible and approachable, and staff told us there was an open and positive culture.
- Results from the Friends and Family Test results for August 2016 showed the hospital consistently performed better than other independent hospitals.
- Staff were encouraged to use their initiative and staff ideas were encouraged and adopted.

Vision and strategy for this service

- The critical care unit had adopted a clear vision and set of values, with quality and safety as the top priorities. The operational policy for critical care at the hospital was in line with the key service characteristics outlined in Comprehensive Critical Care (Department of Health 2000) and Core Standards for Intensive Care Units (Intensive Care Society). The aims included providing the highest possible standard of care for level 3 and level 2 critically ill patients within the unit and support level 1 patients through the provision of a critical care outreach team.
- The unit philosophy was that the team of critical care nurses would work collaboratively with the inter-professional team, with each patient having the right to receive care based on their personal preference and clinical need. The philosophy stated "Patients must be cared for with an appreciation of his or her wholeness, integrity, and relation to family and environment. The nurses plan, coordinate and implement care with the health care team to meet the physical, psychosocial, cultural and spiritual needs of the patient and family. Our nurses must balance the need for the highly technological environment with the need for safety, privacy, dignity and comfort". The unit aim was to provide exceptional, empathetic and optimal holistic care the patients deserve and staff could be proud of.

Governance, risk management and quality measurement

- There was a governance framework to support the delivery of the strategy and good quality care. Clinical governance meetings were held bimonthly, and critical care was represented by the theatre manager.
- The governance framework and management systems were regularly reviewed. The governance action plan had not identified any issues related to the critical care unit.
- There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The critical care unit risks were included on the hospital risk register. This identified the following risks: failure to comply with the Core Standards for ITU (2005); and the care of the deteriorating patient. Actions taken to address these risks included: ensuring specialist critical care trained staff were available as necessary; availability of a resident medical officer and consultants; patients having clear treatment plans; and assessments of patients rehabilitation needs made within 24 hours of admission to the unit. The risks identified on the risk register were aligned to those staff identified as their main concerns.
- However, outcome data was not collected for critical care, although Spire Healthcare was considering collection of data through ICNARC in 2017.
- Managers had ensured there was a plan to develop local safety standards for invasive procedures using the national safety standards for invasive procedures. Managers had assessed the need for these standards against all invasive procedures carried out. A central venous access device (CVAD) insertion checklist was used by an observer when lines were inserted into patients. Staff told us the observer must stop the procedure if they observed a significant breach of aseptic technique. Policies were available for staff for to minimise blood stream infections when inserting central lines, arterial lines, and the emergency insertion of central lines,
- The hospital director ensured consultants holding practising privileges had a level of valid professional indemnity insurance. For example, arrangements to ensure those staff working under practising privileges hold indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014. The hospital medical advisory committee (MAC) monitored consultant's practice to ensure consistency with their stated specialty or sub-specialty, and compliance with the consultant's handbook. This included assessment of reports relating to clinical performance of individual consultants at the request of the clinical governance committee and/or the hospital director.

Good

Critical care

Leadership of service

- The unit had an identifiable anaesthetic lead and nurse lead for critical care. The lead nurse was formally recognised with overall responsibility for the nursing elements of the service. An identifiable supernumerary clinical co-ordinator was available on every shift.
- Senior managers of the critical care unit had all the skills, knowledge, experience they needed to do their jobs, and they had the capacity, capability, and experience to lead effectively. The lead nurse had undertaken management training in a previous role at another hospital outside the Spire group. They were booked on a management fundamentals course to take place in January 2017.
- Critical care staff told us the unit and hospital leadership team were friendly and approachable. They told us they were able to make suggestions about service improvements. We saw good leadership behaviours between senior and junior nursing staff with clear communication throughout. An anaesthetist told us 'the line of communications in ITU is great here'.

Culture within the service

- There was a strong emphasis on promoting the safety and wellbeing of staff, such as a rewards and benefits programme. Staff told us they had access to a counselling service, and fortnightly access to an occupational health service to get necessary injections, help with injuries at work, and to help staff who were on long term sick. Staff told us they felt respected and valued, and the unit had an open learning culture where they could ask any questions and be supported.
- We saw staff and teams worked collaboratively. Action was taken to address behaviour and performance was inconsistent with the vision and values, regardless of seniority. We were told of a medication error which had occurred in the month prior to the inspection. Nursing staff told us the incident was entered onto the hospital incident system, and felt empowered to discuss the issue with the anaesthetist involved. Staff told us it was an open and friendly unit to work in with high morale. One nurse told us the multidisciplinary team worked well together

Public and staff engagement

- Patients were encouraged to provide feedback through the hospital's inpatient satisfaction survey. The Friends and Family Test results for August 2016 showed 99% of patients were likely or extremely likely to recommend the hospital to their family and friends.
- Due to the size of the critical care unit there was not a forum for listening to the views and experiences of the patients in order to shape and improve the culture and the care in the unit. However, they did listen to feedback from patients, relatives and carers to shape the delivery of the service, and shaping the culture.
- Staff told us their views were reflected in the planning and delivery of services and in shaping the culture. For instance when staff had ideas or raised concerns, leaders recognised the importance of this and acted upon the ideas and concerns. For example, one nurse wanted to create a local pain assessment, treatment and management tool that identified which drugs should be used to treat patients' pain levels. They were empowered to research and create a new pain ladder which is now used across the hospital to assess pain.

Innovation, improvement and sustainability

- The critical care team developed a new pain ladder to help identify patients' pain levels and help staff use medication to help treat patients' pain.
- The critical care staff had the equipment and experience to care for more complex cases if the hospital chose to undertake more major surgery.
- The critical care manager was a member of the South West Critical Care Network and the Spire Critical Care Network. They are a member of the Intensive Care Society and attended the national conference annually.

Good

Services for children and young people

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

Information about the service

The service had been established for a significant number of years and provides a limited range of specialty care: mainly ear, nose and throat (ENT), but also urology, orthopaedics and some general surgery.

The number of children treated had increased over the years with a total of 357 paediatric admissions during 2015 representing 3.6 % of overall admissions to the hospital.

Children from birth to 18 years of age were provided outpatient care and treatment. In the reporting period between April 2015 and March 2016, Spire Bristol Hospital saw 1,976 children aged between three and 15 years old and 842 children aged between 16 and 17 years old.

Treatment for children under three years of age includes inoculations. The hospital only carried out surgical procedures on children aged three years or above.

Children were cared for in a 12 bed secure wing of the hospital which provided secure swipe access entry. There is a paediatric bay specifically designated and designed for children in the post anaesthetic care unit (PACU). They also carry out surgical procedures on young people for scoliosis correction which requires 1:1 or 1:2 staffing ratios for 48 hours. This care is delivered by the paediatric team.

We visited all areas where children and young people were cared for. This included the ward, theatres, recovery, outpatients department, and diagnostic imaging. We spoke with two children and eight parents, two registered children's nurses, two anaesthetists, three doctors, three senior hospital managers, four registered general nurses and two support staff. We also reviewed 10 patient records, observed care, and analysed data which we requested from the hospital.

Nursing staff with experience and qualifications to care for children and young people are employed by the hospital. Consultants authorised to practice at the hospital offered services that mirrored their NHS practice.

Good

Services for children and young people

Summary of findings

We rated children and young people's services as good overall because:

- The "Ispire" children's booklet, which included child friendly information about the hospital and its service, was effective to support children to be involved in, and understand, their care.
- There was a clear service vision and strategy in place and feedback from staff about the culture within the service was very positive.
- Staff worked effectively as a team, were dedicated and very passionate about children and young people' services.
- Feedback received from children and their parents was positive. Parents said that staff were kind and went above and beyond to support them and their child.
- Parents said they felt involved in their child's care and treatment and understood the plan of care in place.
- The use of the Spire paediatric scorecard, much like that of the NHS safety thermometer was placed in the hospital as a visual promotion of how well the hospital was providing care for children. Parents we spoke to said they liked the open approach that this demonstrated the hospital had.
- Patient outcomes were monitored through the paediatric safety thermometer and feedback from families and children
- Staff provided information for parents and for children in suitable formats.
- Governance systems oversaw standards of care and ensured appropriately trained staff cared for children and young people.
- All hospital staff were aware of when they would need support from registered children's nurses or a paediatrician and how to access them.

However:

- At the time of our inspection the Wi-Fi offered was unsecured and graphic images and content not suitable for children were easily accessible.
- While there was no dedicated children's waiting area in the outpatients department, there were suitable toys that children could play with and children were in sight of staff.
- We found missing clinician signatures within patients notes.

Good

Services for children and young people

Are services for children and young people safe?

Good

We rated services as good for protecting children and young people from avoidable harm because:

- Comprehensive safeguarding processes were in place.
- Staffing levels met the Royal College of Nursing (RCN) guidelines for provision of children and young people services.
- Reported incidents were low in number, but staff knew how to report and felt lessons were learned from hospital wide reporting.
- The children's ward was clean and tidy with toys available for smaller children.
- The children's ward had ligature safe blinds and the rooms were equipped with window restrictor to stop windows being opened fully.

Incidents

- Spire Bristol used an electronic system for reporting incidents.
- There had been two incidents recorded involving children in the reporting period. We found evidence of these incidents being reviewed and changes implemented as a result.
- We were initially told by paediatric staff that there had been no incidents for children or young people in the last 12 months. However we found two incidents within other departments that had been assimilated into department wide numbers rather than specifically children and young people.
- No never events reported that involved young people. Never events are serious, largely preventable patient safety incidents that that should not occur if the available preventative measures have been implemented.
- Staff we spoke with were able to explain how to report incidents and gave theoretical examples of ones they would report. Incidents were very low for children and young people.
- National patient safety alerts that would affect the children and young people service at the hospital were reviewed at the medical advisory committee (MAC) and shared with the lead paediatric nurse and relevant departments within the hospital.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Staff we spoke to about the regulation all knew it was about being open and honest. Staff gave us examples of when it should be applied

Cleanliness, infection control and hygiene

- See surgery report for main findings.
- In the dedicated children's ward all areas inspected were visibly clean and tidy.
- Rooms which required cleaning and decontamination were locked off to prevent children entering potentially contaminated rooms; a sign was hung from the door with 'TBC' (to be cleaned) written on it. This ensured housekeeping staff could identify the room and get it cleaned and fit for purpose before the next child used the room.
- We observed nurses in outpatients and wards using hand cleaning gel frequently and washing their hands before and after seeing patients. Staff were also seen to be bare below the elbow to reduce the risk of cross infection. This we saw across all departments that were involved with children and young people.
- Children were encouraged to wash their hands and were awarded a certificate and sticker when they regularly washed their hands during their stay. We observed staff making a show of hand washing when engaging children and demonstrating its importance.
- The hospital did not audit hand hygiene but used a method of weighing the hand sanitizer gel to monitor usage as a way of auditing compliance. Information was entered into a computer audit tool which calculated the number of shots taken per day. A benchmark of over 18

shots per room per day was set across Spire network. The results showed that the hospital scored 18 in quarter one and two of 2016, which was below the spire average of 21 shots per room per day.
- The service worked well with the parents of children regarding infection control and literature was written in a child friendly way to help them care for wounds when at home to prevent infection.
- Children and young people were screened for infection before admission to the hospital if they were to have an invasive procedure.

Environment and equipment

- While there was no dedicated children's waiting area in the outpatients department, there were suitable toys that children could play with and children were in sight of staff.
- In the recovery area in theatres, a bay was screened off and made suitable for children but was not separate from the main recovery area. We observed the privacy and dignity for one child was respected and promoted in the recovery department. Staff kept curtains closed and clinical staff announced their arrival before gaining entry to the bed area.
- Resuscitation trolleys were inspected and contained specialist equipment specifically for children. These were security tagged and checked daily. Once a month two members of staff date checked and ensured all equipment was ready for use. All equipment was in date.
- Access to the dedicated children's ward was card controlled and the door remained closed when the ward was in use. Although this area was dedicated for use when children were admitted to the hospital, it was not solely used for children and as such was decorated so that it could be used for adults and children. Staff told us that when a child had a surgical procedure which required 1:1 care in the high dependency unit, all of the children who were admitted for surgery on that day were cared for in rooms near to the high dependency unit, which was not in the dedicated children's area, but on one of the main wards in the hospital.
- Risk assessments were carried out for rooms and areas where children and young people were to be admitted, to ensure that any environmental risks were mitigated and managed. We looked at patient records, inspected rooms, and found that these assessments had been carried out and were suitable and sufficient.
- Security for children and young people was good. Reception knew who would be visiting children at any given time, any unexpected visitors were challenged.
- All portable electrical equipment we inspected had current electrical safety certificates in place.

Medicines

- The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Departments visited had suitable cupboards to store controlled drugs. The pharmacy team audited controlled drug processes once every three months and the departments conducted daily stock checks. We saw actions identified from the audits, which helped to keep processes safe.
- The hospital provided a pharmacy dispensing service five days a week. Medicine supply and advice was available 24 hours per day via the on-call pharmacist.
- The hospital had an organisational structure to manage medicine safety. Staff regularly reported medicine incidents and the hospital conducted investigations to try to prevent recurrence of errors.
- We saw that children and young people's charts had information on known allergies and the child's weight clearly indicated.
- Separate antimicrobial prescription sheets were implemented if required
- If pain relief was required the hospital used the Wong Baker system on smaller children that depicts faces in varying expressions of discomfort. Older children who were able to express pain were assessed on a scale of 1-10, 1 being no pain, 10 being worst ever pain.

Records

- Spire Bristol Hospital had systems in place to securely store and manage sensitive patient data.
- We looked at 10 sets of children's notes that were legible and concise

- Numerous risk assessments had been carried out before surgery for children and young people. These assessments included moving and handling, pain, skin integrity and medical history.
- Spire Bristol had an information lifecycle management and patient records policy that gave guidance to staff on completing and storing records responsibly and securely.

Safeguarding

- Safeguarding level 2 training was mandatory for all staff. The lead registered children's nurse (RN – child branch) had completed level 4 safeguarding training.
- All staff who were directly involved in the risk assessment and/or care of children admitted to the hospital had all completed level 3 safeguarding training. All surgeons who treated children under 18 were trained to level 3. All anaesthetists who delivered anaesthetics or sedation to children less than 18 years old were trained to level 2. We saw evidence of this in their training files.
- Spire Bristol Hospital took measures to protect children and young people at risk from female genital mutilation (FGM). Spire healthcare had provided staff with a policy which outlined how staff should make a safeguarding referral to Bristol Safeguarding Children's Board if FGM were suspected.
- The hospital had a clear procedure to follow if a child was abducted or missing. The written procedure advised staff on the action to take in a given time frame and which responsible individuals and external support to contact.
- During our inspection we found the Wi-Fi offered to children and young people was unmonitored and there was a risk that children could access websites which were unsuitable for their age. The hospital took immediate action to rectify this and password protection was implemented the following day.
- Out of hours and escalated safeguarding issues were handled jointly with an external safeguarding specialist team. This local authority organisation assisted the hospital and helped manage cases in line with local protocols.
- There had been no incidence of reported safeguarding concerns within the 12 months prior to our inspection, but staff we spoke with were able to describe how they would recognise children at risk of harm and how they would report it.
- Staff we spoke with were aware of the chaperone policy, we saw literature around the hospital offering and informing patients how to request one.

Mandatory training

- Please see the main surgery report for main findings.
- Mandatory training was reported within the clinical scorecard, an auditable system of progressive training, and progress tracked monthly by the administration manager.
- Of all the hospital staff, 83 held a paediatric basic life support (BLS) or immediate life support (PILS) or equivalent. This was above the target for compliance. In addition 14 staff held an advanced paediatric life support (APLS) or equivalent, this met the compliance target for the reporting period.
- All paediatric clinical staff were up to date with their safeguarding training. All directly employed hospital staff that worked with children and young people were working towards completing level 3 safeguarding training.
- The children's nursing team received mandatory training to keep children safe. The children's nurses were up to date with all aspects of their training. The children's lead nurse attended Spire Group networking days to enhance her knowledge
- Spire Bristol Hospital had built strong relationships with a local acute NHS trust and used their simulation suite for training to ensure staff competencies were kept up to date with paediatric emergency procedures.

Assessing and responding to patient risk

- The hospital managed the risk of a deteriorating child after an operation. The use of a paediatric early warning system (PEWS) was included in the child's patient notes. A flowchart and observation guidelines helped staff identify trigger points that prompted staff to take action at various levels of risk. The ensured a child was well monitored and treated accordingly and transferred out to an acute NHS hospital if necessary.
- If a child remained with a high PEWS score, had breathing, heart problems or excessive blood loss they would be transferred to the local NHS children's hospital for urgent care. A service level agreement was in place and a detailed local procedure on child transfer and the circumstances when this would be used.

- The registered medical officer was also EPLS trained and could seek out of hours support if required from the on call team.
- As of September 2016 the competencies for paediatric nursing staff were being reviewed to ensure ongoing appropriate levels of skill these competencies also met those nursing staff that were dual qualified for children's and adult care.
- Enhanced training on sepsis in children was provided as part of the hospital's advanced paediatric life support package in line with the resuscitation council's guidelines.
- The hospital used the Spire corporate policy regarding the fixed criteria for admitting children for both day case and overnight stays. It stated there should be five days' notice to parents of pre-assessment checks and that the pre- assessment check should take place at least two weeks before surgery, Clinical risk assessments were conducted at the same time as pre-assessment. As far as possible children had their operations as part of a children only list. These arrangements were mostly in line with Royal College of Nursing (RCN) guidance, except that the children's recovery area was partitioned off rather than completely separate. Staff told us that pre-assessment took place on a Sunday, so that children and young people could be shown around all areas of the hospital including the theatres and recovery room, whilst there were no operations ongoing. This also ensured that children and young people did not have to miss school.
- Children and young people were assessed as being suitable for treatment according to hospital policy before being accepted for any procedure. This assessment would identify children and young people who were unsuitable for treatment at the hospital. For example, a child or young person with epilepsy or cardiac conditions would not be accepted for any surgical procedure at the hospital.
- We witnessed the completion of the World Health Organisation's checklist for safer surgery for the children we saw having surgery. All were fully completed. A hospital Audit for WHO checklist completion showed a result of 97% compliance in completion of the forms.
- The hospital had no critical care facilities for children or young people. They had a service level agreement with the local NHS trust if a child needed stabilisation of their condition.
- Parents we spoke with were given a number to call at any time, if there were any worries when their child had returned home. The nursing staff could contact the paediatrician or anaesthetist if further advice was needed.

Nursing staffing

- There were sufficient staff to meeting the needs of children and young people. The children and young people's service was staffed by a children lead nurse and a children's recovery nurse.
- The children's services had not used agency staff. The service had access to a hospital based bank of staff to provide support when there were gaps in the nursing rotas. Three members of the bank staffing regularly worked at the hospital to ensure consistency in care and familiarisation of hospital procedures. One of the bank staff had recently become a full time member of nursing staff at the hospital.
- Staffing rotas showed us that when children were having surgical procedures a registered children's nurse was on duty until the child was discharged.

Medical staffing

- There were sufficient medical staff to meet the needs of children and young people. All children were cared for by a named consultant at all times. A named consultant paediatrician was available for advice and immediate cover when a child was admitted.
- The hospital employed three resident medical officers (RMOs) and two bank RMO's who had completed the Spire mandatory training on line. They were up-to-date with European paediatric life support (EPLS) and advanced life support (ALS) and had completed 100% of their annual mandatory training to date.
- Staff we spoke with knew how to contact surgeons out of hours. Staff told us they felt comfortable to phone consultants out of hours.
- The RMO was always on site and an out of hours team on standby for any medical emergencies.

Major incident awareness and training

- Staff we spoke with were clear on the roles and responsibilities during a major incident.
- The hospital had a backup uninterrupted power supply generator which would cover essential services in the event of a power outage. There was a regular test and servicing schedule in place.

Good

Services for children and young people

Are services for children and young people effective?

Good

We rated services for children and young people as good for effective because:

- Multi-disciplinary team working resulted in positive outcomes for children.
- There was good partnership working with other organisations, for example, on patient transfer.
- Parents we spoke with were very pleased with the outcomes for their children.
- Food for children was appetising and tailored to their needs.
- The service had access to x-rays and pharmacy for children 24 hours a day and seven days a week.
- There were clear arrangements for parents and children to consent to operations and treatment.
- The service benefitted from the NHS experience of its consultants and from networking with other Spire hospitals.

Evidence-based care and treatment

- The lead children's nurse networked regularly with other Spire hospitals with larger and more established children's services. This network produced corporate policies such as the 'Procedure for the care of children'.
- We found good compliance from staff to local policies and procedures, in one instance we observed staff referring to local procedure on the intranet for infection control.
- We reviewed three policies, which related to children and young people's services. All policies checked were based on up-to-date national guidance. The majority of policies and procedures were developed nationally by the Spire group. They were available to staff electronically via the intranet and in clinical areas.
- When policies are updated this information is passed on to staff via electronic alerts and through the paediatric working group.

Pain relief

- We saw staff assessed pain experienced by children post-operatively using recognised age specific assessment tools.
- Topical anaesthetic cream was used for children who needed intravenous cannulation to numb the area and prevent pain. Nurses called it "magic cream" to alleviate anxieties in children and make the process more engaging.
- All parents told us they felt that their child's pain was controlled well by the hospital and nurses.

Nutrition and hydration

- The hospital provided suitable meals for children and young people which could be tailored to a child's needs.
- The hospital had clear pre-operation fasting guidelines which were listed in the 'Procedure for Children and Young People.' Parents told us that they were given clear instructions at the pre-admission meeting with consultants. This information contained details such as the fasting period prior to the procedure and contact details for any questions that may crop up before the admission.
- There was no onsite dietician but one could be involved if required.

Patient outcomes

- The hospital used a tool called the Paediatric Clinical Scorecard to monitor safety and performance. Within this auditable tool were areas such as return to theatre, readmissions, pain management, medicines management and patient satisfaction. The results of this were displayed around the hospital. Parents of children we spoke with liked this as it gave them an idea of the quality of the care for their child.
- The results from the 2016 scorecard showed that all assessed areas were within the green score area of 90% and above. The ratings were scored red for poor, amber moderate and green for good.
- Parent we spoke with were pleased with the outcome for their child and spoke of better quality of life after having tonsillectomy,(removal of the child's tonsils) and pinnaplasties, (pinning back of the ears).

Competent staff

- There where systems in place to ensure all staff were competent in their role and had relevant, up to date knowledge, skills and experience to provide effective care for children and young people.

Good

Services for children and young people

- Practising privileges for consultants (authorisation from the hospital director for consultants to practise at their hospital) were monitored by the medical advisory committee MAC.
- Consultant's appraisals were carried out and were up to date. The information was shared between the local NHS trust and Spire about a consultant's procedures and practices that were relevant to their role. The hospital carried out a biennial review of the care provided by each consultant and this included a review of their ongoing practice in the NHS and whether the consultant had carried out a suitable number of surgical procedures on children and young people within their practice to remain competent. Those undertaking lower numbers of procedures were monitored through this system to ensure that no occasional practice occurred at the hospital.
- Trauma and medical emergency simulations were carried out at Spire and at a local NHS hospital simulation suite to ensure paediatric staff were well practiced in common and not so common conditions relating to children and young people. Staff we spoke with told us how valuable they found these sessions.
- Nurses told us they had appraisals. These meetings took place at the beginning, middle and end of every year. They considered the meetings to be useful and they discussed hospital values, personal and organisational objectives and training needs
- All the nurses treating children and young people were registered children's nurses, or dual qualified in adult and children nursing.

Multidisciplinary working (in relation to this core service)

- Team meetings were held and information was shared with registered children's nurses, physiotherapists and ward staff.
- The hospital had service level agreements with outside agencies such as a retrieval service for critically ill children and the local NHS hospital if a patient transfer was needed.
- Safeguarding organisations were accessed for training, advice and information sharing

Seven-day services

- Children and young people were able to attend outpatient and physiotherapy appointments in the evenings which would allow them to avoid missing school.
- The physiotherapy were also trialling weekend appointments at the time of our inspection to enable patients to attend at convenient times for them.
- The hospital provided a pharmacy dispensing service five days a week. Medicine supply and advice was available 24 hours per day via the on-call pharmacist.

Access to information

- We found that discharge forms were informative and timely. Clinicians sent care summaries to a child's GP, usually within 24 hours, to ensure that children continued to be cared for in the community.
- Information was available for staff to ensure continuity of care to children and young people. Consultants arranged for records to be available in the hospital and records were stored on site for any follow up procedures.
- Medical records were kept securely on the ward but were easily accessible for relevant staff.
- Nursing records began during the pre-assessment clinic. This recorded initial observations, such as the child's heart rate and blood pressure. It recorded any other clinical needs the nursing staff would need to be aware of such as allergies. These records followed the patient to the ward, theatre and continued post-operatively. Nursing records were kept in the room post-operatively for staff to access, monitor and record further observations.

Consent

- Staff understood arrangements for consent and the relevant legislation. The hospital had different rules for children and young people at different ages. The hospital's policies and procedures made the patient's best interests central to the process. If a young person was under 16 years of age and wished to consent to their own treatment, the treating doctor assessed whether the young person would have the maturity and intelligence (known as Gillick Competence) to understand the nature of treatments. They would give the young person time to consider all the options.
- Consent forms were easy for patients for follow. The parental agreement to investigation or treatment was in plain English and explained parental responsibility and

who could give consent. The child or young person could also add their signature to this form. There was also a 'confirmation of consent' box for the clinician to sign. We reviewed these forms which were correctly completed.

Are services for children and young people caring?

Good

We rated services for children and young people as being caring because:

- Parents we spoke with said they felt they had received compassionate care and were involved with their child care and decisions about their procedures. Child friendly information was available explaining what will happen during their stay in the hospital
- Nursing staff offered emotional support to both children and parents when required. The hospital planned the care of children taking into account such elements as spiritual, mental, social and physical needs.
- A video called "the little big sleep" was produced by the hospital to engage and inform children on what to expect during their stay.
- In one instance a nurse who found a mobile phone left by a young patient was hand delivered to their home the same day.
- Older children had the opportunity to speak with staff alone at their discretion without the parents being present.
- Other parents spoke of the confidence they felt in the nursing staff, that their children would be safe in their care.

Compassionate care

- We observed nursing staff and consultants engaging and working with children in a caring and gentle manner. For example we saw at pre assessment a child was given a tour of the hospital and where they would be staying and who they would most likely see during their stay. Staff were able to win the trust of the child and formed an effective bond for the duration of their stay.
- Staff went the extra mile to ensure that care was provided compassionately. For example, we observed recovery nurses bandaged up a child's cuddly toys before the child came around from the anaesthetic which gave the child a familiarity helping to soothe an anxious child.
- We observed that staff throughout the hospital treated children, young people and their parents with privacy and dignity. For example, nurses and consultants announced their arrival prior to entering the recovery cubicle so as not to startle the child.
- Feedback from parents was continually positive about the care provided to their children. Parents spoke of how caring they found the staff and took strength from seeing the interactions between nurses and children. For example. We saw nurses asking children which of their favourite soft toys they would like to take into theatre with them.

Understanding and involvement of patients and those close to them

- Small children received a bright pictorial patient survey which was easy to follow and tailored to them. Older children received the adult survey. Children and young people responded that they were happy with the service.
- Older children could talk to a clinician without their parent(s) present. The hospital had a clear policy on consent at different age ranges, and that 16 to 17 year olds were entitled to withhold consent. The treating doctor would have to decide whether the young person had the competence to make their own decision.

Emotional support

- Staff provided emotional support. Children came to the hospital on pre-operative familiarisation visits where they met nurses, clinicians and the anaesthetist. This was important in reducing their anxiety when they were away from home. One of the paediatric nurses was on hand to play with children who were scared or upset. We heard from parents how the paediatric lead nurse supported and reassured them at sensitive times, for example if their child was slow to recover from anaesthetic.
- Parents we spoke with said often the nurses knew that that the parents were more worried than their children and nursing staff sat and explained the procedures again to worried mums and dads to ensure they understand and calm nerves.

Good

Services for children and young people

Are services for children and young people responsive?

Good

We rated services for children and young people as being responsive because:

- The children's and young people service provided at Spire Bristol was responsive to patient's needs.
- They provided appointments at times that suited the children and their parents. The physiotherapy department had allocated more after school appointment times to allow children to remain in lessons and attend appointments outside of school times.
- The service introduced children in a sensitive way to the hospital environment through a visit and pre assessment appointment to allow the child to be familiar with the faces and places within the hospital.

However

- The hospital lacked a dedicated child's waiting area in outpatients.

Service planning and delivery to meet the needs of local people

- The service was planned and delivered to meet the needs of local people. As far a practicable the children's surgery list was planned around local school holidays and at times that would lessen the impact on child's education or planned family holidays.
- Nurses encouraged children and young people to keep in touch with friends and family. Parents told us that they helped children plug in their electronic devices and access Wi-Fi to help keep families in touch. Staff also encouraged parents to stay overnight on a temporary bed in the same room as their child to reduce anxiety, and would provide a meal if needed.
- The hospital had planned its activities around the needs of the local population. They accepted referrals from the NHS via the choose and book system, from GPs and patients and/or parents could self-refer.
- Children were screened to ensure the hospital had suitable facilities to treat them. Processes were in place to deal with unexpected outcomes. Service level agreements had been arranged between the local NHS hospital and a critical care retrieval team to ensure patients could be cared for if their condition deteriorated and required more specialist care.
- For scoliosis corrections there was a small three bed high dependency unit for the care period when recovering from the procedure.

Access and flow

- The hospital offered good access for children's routine operations. Outpatient clinics were available in the evening as well as during the day. Children could choose to have operations during the school holidays.
- The paediatric service did not routinely measure how long children waited for their operations. Parents told us that waiting times for operations were tailored to their needs. For example, they would schedule an operation during the school holidays if this was more convenient. If a child needed an urgent operation, the service had the flexibility to do this. Although the service aimed for children-only theatre lists, children could also be prioritised to have their operations first, ahead of an adult theatre list.
- The paediatric lead nurse was aware of all children and young people attending for a procedure at Spire Bristol. All planned paediatric admissions were reviewed to ensure appropriate staffing was in place for the children due in.

Meeting people's individual needs

- Pre-admission assessment was required for all children and young people undergoing invasive procedures. When patients were unable to attend in extreme circumstances a telephone assessment was offered. This informed staff of any issues or special requirements the patient may have.
- Nursing staff had two different coloured uniforms, bright pink or blue, and would ask older patients how they would like to be treated, as a child, teenager or adult and would therefore change their nursing uniforms to suit the patient.
- Play and recreational needs were accommodated in a small room and there were toys and books available on the ward. Older children were encouraged to bring in their tablets, iPod, or laptops to keep connected with friends and families via the internet; the internet was free and fast enough to enable streaming of music and movies and was available in individual rooms.

Good

Services for children and young people

- A package of information was provided on discharge for patients and their parents. These varied in format to make them suitable for their age and understanding. The type of information included how they might expect to feel and what to do if they were worried about anything.
- Information and support was provided in a child-friendly format to help children make decisions about their own care, including an attractive set of leaflets for children about surgical procedures. Staff would engage the children with interactive puzzles and colouring in sections to help embed an understanding of what would happen.

Learning from complaints and concerns

- The service used the Spire corporate complaints policy. The complaints process was clear and parents said that they would have no difficulty giving feedback.
- The lead paediatric nurse was informed of any complaints involving children and young people. These were presented at senior management and MAC meetings.
- There had been one formal complaint raised within the reporting period (April 2015 to March 2016). Concerns had been raised by a parent of a child this and we saw that this was investigated and action was taken as a result.

Are services for children and young people well-led?

Good

We rated services for children and young people as being well led because:

- The service had clear aims for the future which it shared with children's nurses and staff. There was a positive culture and staff showed clear motivation to do their best for children and young people.
- There was a good risk management structure and children's nurses worked well with consultants to develop policies and plan services.
- The governance structure helped deliver good quality care.
- Senior managers recognised that the lead children's nurse provided good care to children and had represented the service well within the Spire group.
- The service ensured they were using the skills and experience of organisations and specialists who were independent of the hospital.
- When Spires's attention was brought to the unsecured Wi-Fi they promptly secured this with a password to lower the likelihood of children accessing inappropriate images or information.

Vision and strategy for this this core service

- Spire Bristol Hospital had a strategy to drive the safety of children through the paediatric working group.
- Staff we spoke with were clear they wanted to increase the numbers of children seen and achieve excellence in their service. They spoke animatedly on how it would benefit patients who needed scoliosis corrections and to access a high quality, child focussed service more locally.

Governance, risk management and quality measurement for this core service

- All staff we spoke with knew how to access support from paediatric leads and were clear about their role and responsibilities.
- The lead paediatric nurse identified risks and took steps to mitigate them with improving equipment, additional training and sharing information to departments.
- A paediatric working group was in place to help steer and develop the quality of care for children and young people. We could see from minutes where areas such as the safety of children, safeguarding and training were discussed and actioned.
- Consultants at the hospital were engaged to work in the hospital via a process of practising privileges. Practising privileges may be granted to medical practitioners by the Medical Advisory Committee (MAC) to allow them to provide patient care and treatment within that hospital, subject to them providing certain evidence of their good character, qualifications, skills and experience and compliance with the terms and conditions of the practising privileges policy

Good

Services for children and young people

- There was a corporate policy in place which outlined the eligibility criteria, application and process for granting practicing privileges including the process for maintenance and review, management of performance concerns and the requirements of consultant appraisal.
- The hospital had procedures in place which were matched to the policy to monitor and maintain the practicing privileges in place. There was an electronic data base which was updated, monitored and maintained by administrative staff, who worked closely with matron.
- Processes were in place to ensure that consultants provided updates to required documentation. For example, appraisal and updated indemnity insurance. The electronic system generated a letter to the consultant a week prior to the documentation expiring. Should the documentation not be presented two weeks prior to expiry the consultant's practice was suspended until they had produced the documentation.
- For those consultants who provided care and treatment for children and young people, there were additional requirements detailed within the paediatric admitting rights documentation. The number of children and young people they saw in outpatient clinics each year and also the types of surgical procedure they performed on children and young people and numbers of cases each year. This was monitored as part of the biennial review.
- The matron/head of clinical services was aware of which consultants carried out lower numbers of procedures on children and young people, and as part of the biennial review monitored whether this constituted occasional practise, and how consultants maintained their competence.
- There were processes in place to suspend or remove a consultant's practising privileges where there were concerns about their practice. We were provided with evidence which demonstrated a clear transparent approach.
- There was a medical advisory committee (MAC) at the hospital, which was an integral part of the governance structure. Changes had been made to ensure that there was representation of specialist groups who provide treatment and care in the hospital.

Leadership / culture of service

- There was a positive "can do" culture within Spire Hospital Bristol and staff felt they were well respected and valued.
- Senior management were visible and maintained an open door policy and all staff we spoke with felt they could speak with management about anything at any time.
- The hospital had a clear management structure led by the hospital director with matron leading all clinical services.
- Staff we spoke with knew who the lead paediatric nurse was and the children and young people wider staff team, all were deemed approachable and professional by their peers.
- Staff we spoke with said they felt listened too and felt they could approach all department heads with any concerns.

Public and staff engagement

- Staff spoke of how they felt involved with the planning of children's services.
- When the hospital had received a complaint, the complainant had been invited to attend a face to face meeting which gave a more personal and engaged response from the hospital.
- Staff were offered study days to help bolster team and individual skills
- Spire held social events which we were told were always well attended by staff and appreciated.
- Small children received a bright pictorial patient survey which was easy to follow and tailored to them. Older children received the adult survey. Children and young people responded that they were happy with the service. This data is collected as part of the paediatric scorecard and used corporately for improvements and displayed for patients to see how the hospital is performing for children and young people.
- One child we spoke with said they enjoyed the way nursing staff spoke with them and said they were "nice".

Innovation, improvement and sustainability

- Spire Hospital Bristol was the first of the Spire group to have a critical care outreach team developed to support all departments. They are on call 24 hours a day seven days a week and provide support to staff when required.

Good

Services for children and young people

- The paediatric scorecard is continually being updated and improved to gather a wider range of data for children and young people. This information will go towards improving overall children's services.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient services at the Spire Bristol Hospital covered a wide range of specialities. These included Ear Nose and Throat (ENT), orthopaedics, cardiology, dermatology, gastroenterology and general surgery. The physiotherapy department provided services to patients who were both inpatients and outpatients. The diagnostic imaging department provided an extensive range of diagnostic services. These included x-rays, CT (Computed Tomography), PET (Positron Emission Tomography), DEXA (Dual-energy x-ray absorptiometry) and MRI (Magnetic Resonance Imaging) scans, ultrasound, mammography and dental x-rays.

The outpatient department had 26 consultation rooms together with three separate treatment rooms. The physiotherapy department had three consultation rooms and a well-equipped gym.

From April 2015 to March 2016 the outpatients department saw 77,312 patients of all ages, including children. Patients that were referred under the NHS accounted for 16% of the total number of patients seen in outpatients. Those patients that were self-funding or via their insurance accounted for 84% of the total number of patients seen within outpatients.

During our inspection, we visited the outpatients, physiotherapy and diagnostic imaging departments. We spoke with 19 staff including nurses, physiotherapists, managers, healthcare assistants, receptionists and medical staff, 10 patients and one relative. We reviewed patient records and staff training records. We observed care and reviewed the hospitals performance and quality information that was provided to us before, during and after our inspection.

Summary of findings

We rated outpatient and diagnostic services overall as good because:

- Clear systems were in place for incident reporting, investigation and learning from incidents.
- All departments were visibly clean and tidy and all equipment had been tested and serviced in line with manufacturer's instructions to make sure it was safe to use.
- Up to date and appropriate risk assessments were in place across outpatients, physiotherapy and diagnostic imaging.
- There was good evidence of multidisciplinary team working practices.
- Staff were competent and well trained. Enabling Excellence (appraisal and professional development) files were available for all staff to demonstrate their individual competencies.
- A new induction programme had been developed in conjunction with staff. This provided an induction that met the needs of each individual member of staff to orientate themselves to the hospital and department.
- There were sufficient staff to meet the needs of the patients.
- The patients we spoke with were overwhelmingly complimentary about the hospital, staff and the care they had received.
- Staff were able to give examples of where they had made a difference to individual patients' experience and their journey through the outpatients department.

Good

Outpatients and diagnostic imaging

- Staff were aware of their patient's emotional needs and gave examples of where staff had been able to reduce patient anxieties. Additional support was available from specialist and link nurses.
- Staff were experienced in recognising patients individual needs and gave examples of where this had improved the patient experience.
- The leadership, governance and culture promoted the delivery of person centred care. There were clear governance structures and systems in place with defined accountabilities for assurance.
- Managers provided clear leadership and motivation to their teams.
- Staff were overwhelmingly complimentary about their immediate line managers and the overall hospital management teams.
- There was an open and transparent culture within outpatients, physiotherapy and the diagnostic imaging departments. Staff told us they felt proud to work in the departments and for the hospital.
- The departments regularly engaged with patients and staff in the development of the service.
- One member of staff summed up what all the staff we spoke with felt. "We have time to listen, time to talk and time to care".

However:

- It was not clearly documented that all women of child bearing age were asked about the possibility of them being pregnant before radiological procedures taking place.
- WHO checklists for interventional radiology were not always fully completed. Referral forms for radiological procedures were not always fully completed. Swift action was taken by the hospital to rectify this prior to the unannounced visit.

Are outpatients and diagnostic imaging services safe?

Good

Overall we have rated safety as good because:

- Clear systems were in place for incident reporting, investigation and learning from incidents.
- Staff were aware of and when to apply the duty of candour.
- All departments were visibly clean and tidy.
- All equipment had been tested and serviced in line with manufacturer's instructions to make sure it was safe to use.
- Up to date risk assessments were in place across outpatients, physiotherapy and diagnostic imaging.
- Medicines were stored, recorded and administered in line with hospital policy and best practice.
- All staff were up to date with their mandatory training.
- There were sufficient staff to meet the needs of the patients.

However:

- It was not clearly documented that all women of child bearing age were asked about the possibility of them being pregnant before radiological procedures taking place.
- WHO checklists for interventional radiology were not always fully completed. Referral forms for radiological procedures were not always fully completed. Swift action was taken by the hospital to rectify this prior to the unannounced visit.

Incidents

- Staff within the outpatients, physiotherapy and diagnostic imaging departments were aware of their responsibilities to report incidents. Staff told us they felt comfortable to report, knew how to report incidents and had no hesitation in doing so. Staff gave us examples of where they had raised incidents. For example, the medicines used to be stored in the treatment room which meant patients undergoing treatments were sometimes interrupted by staff needed to obtain medicines.
- The outpatients and diagnostic imaging departments reported 88 clinical and 36 non-clinical incidents

between April 2015 and the end of March 2016. The numbers of clinical incidents reported at the hospital was lower than other independent hospitals and for non-clinical incidents the numbers were similar to those from other independent hospitals.

- Incidents were documented on an electronic risk management system. All incidents that took place within outpatients, physiotherapy and diagnostic imagine departments were seen and investigated by the respective managers. This meant that the head of the department had an overview of issues that happened within their department.
- We saw evidence of learning from incidents. For example, specialist nasal scopes were previously kept together whether they were clean or dirty. Following an incident where a dirty scope was used, the processes were reviewed and changed. We saw evidence that once a scope had been used it was placed separately ready for cleaning. We also observed that the clean scopes were double wrapped with green 'I am clean' tabs to make it visibly clear to staff that the scopes were clean and ready to use. All the staff we spoke with in the outpatient department were aware of the incident and the actions that had followed, which meant systems were in place to communicate incidents throughout the department.
- The diagnostic imaging department had clear processes for reporting incidents about Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Staff followed the hospital procedures to report incidents. There had been one incident that had been reported under these regulations. The incident had been investigated and measures put in place to prevent it happening again. The root cause was that the radiographer being distracted by other staff whilst carrying out a procedure. The actions taken were to prevent other staff from being present in the control booth to prevent distraction.
- Trends and themes of incidents were monitored at the monthly clinical governance meetings. This identified a problem with the labelling of specimen bottles sent to the laboratories. Discussions were held with staff and the laboratories to identify how to improve the process of labelling and reduce the errors. The resulting actions included new pens suitable to labelling specimen bottles that were issued to all the staff. Additional training was provided with staff spending time in the laboratories to physically see the importance of correct labelling. When mistakes occurred, the member of staff concerned also was responsible for contacting the patient to ask them to return for repeat specimens. This made sure staff were aware of the impact of the error had on the patient and to help them learn from their mistake. At the time of our inspection, the manager told us that they had seen a reduction in the amount of labelling errors that had been made.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Staff were aware of when to apply duty of candour and the hospital was open and transparent and apologised to people when things went wrong.

Cleanliness, infection control and hygiene

- All the outpatient and diagnostic imaging areas we visited during our inspection were visibly clean and tidy. Cleaning schedules were in place and signed off when completed. In the patient led assessment of the care environment (PLACE) audit completed in February 2016, cleanliness in the outpatient and diagnostic imaging departments was rated at 100%, which was above the England average of 98%.
- Staff were complimentary about the housekeeping staff who maintained the cleanliness of the department. The patients we spoke with during the inspection were also complimentary about the cleanliness of the departments. In the yearly physiotherapy patient satisfaction survey, 100% of patients said the cleanliness in the physiotherapy department was either excellent or good.
- We observed good hand washing practices from both nursing and medical staff as well as staff using alcohol gel in line with hospital policy. Staff were also seen to be observing the hospital policy of being bare below the elbows.
- Personal protective equipment (PPE) such as gloves and aprons was available for staff in the outpatient and diagnostic imaging departments. We observed staff using the PPE in line with best practice and hospital policy.

Good

Outpatients and diagnostic imaging

- Domestic and clinical waste was disposed of correctly. There were special bins and bags available for disposal of clinical waste and sharps (needles) in the departments. All the sharps bins were assembled correctly, signed on assembly and staff made sure they were not overfilled.
- The outpatient department was carpeted in the non-clinical areas and in the seated areas in consultation rooms. Flooring in treatment rooms and beneath examination couches in consultation rooms were not carpeted. The furniture was all able to be wiped clean which meant they could be kept clean effectively. The carpets and chairs were all visibly clean with no signs of staining. We were informed that the whole of the outpatient area was due for complete refurbishment during 2017 during which the carpet would be removed.
- All equipment we looked at was visibly clean and the departments used 'I am clean' tape to identify that the item had been clean and was ready for use.
- There had been no reported cases of healthcare-associated infections such as methicillin resistant Staphylococcus aureus (MRSA), Clostridium difficile (C.diff) or, methicillin sensitive Staphylococcus aureus (MSSA) for the outpatients, physiotherapy or diagnostic imaging departments.
- Seating in the waiting areas was visibly clean and able to be kept clean to prevent the spread of infection.

Environment and equipment

- The hospital had a main reception area at the main entrance. Patients attending for an outpatient appointment were either directed to wait in the main reception area or directed to the secondary reception in the outpatient department. There were several waiting areas within the outpatient department. All the main waiting areas were bright and clean with newspapers, magazines, refreshments and toilet facilities.
- The PLACE (patient-led assessments of the care environment) audits for February 2015 to June 2016 showed a 100% score for the condition, appearance and maintenance of the departments within the hospitals. At the time of our inspection, we were informed that the outpatient department was due for a complete refurbishment during 2017.
- All the equipment we saw within the outpatient department had been tested to make sure it was safe to use and had been serviced in line with the manufacturer's instructions. We looked at service records and invoices that confirmed this.

Medicines

- Medicines in the outpatients and diagnostic imaging departments were stored, managed, administered and recorded safely and in line with legislation and hospital policy.
- Prescription pads were used by the medical staff so that patients could obtain the necessary medicines via the hospital pharmacy to take home. Each prescription pad had a corresponding record sheet for consultants to document the prescription number that had been used and the nursing staff checked these at the end of each day. An audit into these prescription sheets in July 2016 showed that they were not always 100% compliant (compliance averaged 82% across the 21 areas audited) in staff completing the record sheets to account for the prescription sheets. Following this audit, prescription pads were no longer put into every consultation room. Some consultants then had to request the prescription pads when then needed them. This made it easier to monitor compliance. At the time of our inspection, we looked at two random prescription pads and found them to have been completed in line with hospital policy.
- Systems were in place within the outpatient department to store medicines securely and safely. Medicines were stored in locked cabinets or fridges and only the nursing staff had access to these. Where medicines needed to be kept at particular temperatures, these were monitored daily and recorded. Normal temperature ranges were also documented so that staff knew what was abnormal and when to report any problems.
- During our inspection we did a random spot check of the medicines within the outpatient department and did not find any medicines that were out of date or stored incorrectly.
- We saw systems in place that medicines were checked each month and those due to expire within the following three months were noted. This showed that staff were aware of their stock levels, which medicines had expired and when. Any expired medicines were returned to the pharmacy for disposal.

- Patient group directions (PGD) were in place for different medicines within outpatients and diagnostic imaging. PGDs provide a legal framework that allows registered health care professionals who have completed appropriate training to administer a specific medicine to a pre-defined group of patients without them having to see a doctor. Each PGD was in date and the details of the staff who had been assessed as competent to administer the medicine was recorded.

Records

- Medical records in the outpatients department were paper based. We looked at five sets of outpatient records completed by the nursing staff. We found them all clear and concise, dated, timed and signed in accordance with professional and hospital policies and guidance. Treatment plans were detailed and this reduced the risk of confusing or conflicting information being given to patients.
- Information provided to us before our inspection showed that in the three months preceding our inspection, staff had access to the medical records for all patients attending their outpatient appointment. This meant staff had all the relevant patient information available during their consultation and treatments.
- Records were kept on site for three months before being sent to a secure off site archive facility. When notes were needed from this facility, daily deliveries made sure they arrived in a timely way ready for an appointment or admission.
- At the time of our inspection the hospital was working towards a single clinical record for each patient. This would incorporate the inpatient notes with the outpatient notes.
- Any patients attending the hospital for the first time were asked to bring their referral letter. Following their initial appointment, the consultant's secretary and the records department made up the hospital records for all future attendances. If the patient had been seen before in the hospital, their existing notes were retrieved ready for their appointment.
- During clinic times, patient records were kept with the consultant in the consulting rooms or returned to the secure store that only staff had access to.

Safeguarding

- There were policies, systems and processes for safeguarding both adults and children. These were corporate policies that applied to all the hospitals in the Spire group. The hospital had their own local safeguarding leads who were aware of the local authority safeguarding guidance and the corporate policies.
- All staff we spoke with were aware of when and how to raise a safeguarding concern. They were aware of the various forms of abuse and when to seek advice from the hospitals safeguarding leads.

Mandatory training

- See surgery report for main findings.
- New staff were able to complete their mandatory training whilst on their induction. Mandatory training was completed using an on-line learning package. The training included information governance, infection prevention and control, manual handling and fire management.
- We saw evidence that showed all the staff (100%) within the outpatients and diagnostic imaging departments had completed their mandatory training. All the staff we spoke with confirmed this.

Assessing and responding to patient risk

- Resuscitation equipment for both adults and children was available in the outpatient department. This included a defibrillator, oxygen and separate medicine boxes for adults and children. All the equipment was in date and had been checked regularly by staff and regularly maintained according the manufacturer's instructions. Tamper proof security tags were in place and these were checked daily to make sure they were in tack and the equipment had not been tampered with. Once a month the full contents of the resuscitation trolleys and bags were opened and checked. We saw evidence that this was done consistently every month.
- Within both the outpatient and diagnostic imaging department, emergency bells were situated in all clinical areas for staff to summon help in an emergency. This was an automated system that notified the resuscitation team and automatically directed them to the correct location in the hospital. The staff we spoke with told us that the response to any emergency calls was very fast.
- The Royal College of Radiologists (RCR) states that all females aged 12-50 who are having radiography to areas between the knees and diaphragm should be asked about the possibility of their being pregnant. In addition

the RCR states that this should happen 100% of the time. There was a radiology system used within the diagnostic imaging department which would not let staff proceed with examination unless the question had been asked to all women of child bearing age. It was not clearly documented within paper records that this check had been undertaken.

- In February 2010 the National Patient Safety Agency implemented guidance on the use of the WHO (World Health Organisation) Surgical Safety Checklist across all healthcare organisations. In December 2010 the Royal College of Radiologists issued its standards for implementing an amended checklist for radiological interventions. It is expected that the checklist is completed 100% of the time for any interventional radiological procedure.
- Between February and March 2016, an audit was undertaken at the hospital looking at the records of 305 patients who had received an interventional radiology procedure to check compliance with the WHO surgical safety checklist. This audit found that 65% of patient's notes did not have a WHO surgical safety checklist fully completed when the patient had received an interventional radiology procedure. A re-audit was completed in September 2016, reviewing only 10 sets of patient records and found 100% compliance with completion of the WHO surgical safety checklist. During our inspection we randomly selected 10 records to check for compliance with the WHO surgical safety checklist. We found only three (30%) checklist forms that were completed correctly. We raised this with the senior managers who confirmed the original audit results and the actions they had taken in response. Swift action was taken by the hospital as a result of our findings. The diagnostic imaging manager told us of the additional measures that had been put in place to make sure staff were fully completing the checklist. These included: paper scanning equipment being installed in each imaging room; responsibility for the completion and recording of the WHO surgical safety checklist being given to the individual radiographer; and additional monitoring processes on a weekly basis to ensure full completion. We randomly selected a further 10 patient medical records that had received interventional radiology following our initial feedback. We found that all 10 WHO checklists had been fully completed.
- When referrals for a diagnostic image were made, the referral form had to be completed by the clinician and was required to include specific criteria in order to meet the Ionising Radiation (Medical Exposure) Regulations 2005 (IR(ME)R) legal requirements. These were not always completed correctly by clinicians. However, cross checks were made by the diagnostic imaging staff to ensure the forms were returned to the referrer for correction when omissions were identified. This occurred prior to the image or scan being performed on the patient.
- We saw that risk assessments were in place across the outpatients and diagnostic imaging departments. These assessments were reviewed regularly and were up to date. Examples of the range of risk assessments included, children's toys left out in the outpatient areas through to checking and labelling specimen bottles. COSHH (Control of Substances Hazardous to Health) risk assessments were also in place for the wide variety of solutions and cleaning materials used within the outpatient and diagnostic imaging departments. Staff were aware of the risks within the department. For example, when once children had finished playing with the toys, a member of staff would make sure they were cleaned and returned to their storage area so they didn't present a hazard to other patients.
- There were arrangements in case of a radiation or radioactive incident. The hospital had access to a radiation protection advisor from the local NHS acute hospital, who was able to provide specialist advice and support.

Nursing / Radiography staffing

- There were sufficient nursing staff levels to safely meet the needs of patients. Staffing was planned by the head of the department according to the needs of the department and the skills of staff.
- At the time of our admission there were 5.8 whole time equivalent (WTE) health care assistants and 9.7 WTE qualified nursing staff working within the outpatients department.
- Bank staff were used to cover gaps in the staff rota such as sickness or annual leave. These bank staff had experience of the departments to maintain consistency for patients. Agency staff were not used in the outpatients or diagnostic imaging departments.

Good

Outpatients and diagnostic imaging

- There had been a successful recruitment drive in the outpatients department. This meant that at the time of our inspection there were two part time vacancies out to advert which when filled would make the outpatient staffing at full compliment.
- Within the diagnostic imaging department there were 14 radiographers supported by a team of four administration staff. A clinical practitioner was also available for chaperoning and to do ultrasound lists.
- There was a staff handover at the beginning of each shift and we attended a handover in the outpatient department. Clinical activity for the upcoming shift and designation of staff to each area was discussed to ensure people received the care and treatment they required.

Medical staffing

- The hospital had 366 consultants who had practising privileges to work within the hospital, of which 31 were radiologists. The number of radiologists were sufficient to meet the needs of their patients.
- There were no concerns raised about the levels of medical staffing during our inspection. There were sufficient consultants to meet the service needs and cover outpatient clinics. Clinics were consultant led and appointments were booked when they were available.
- The hospital had a resident medical officer (RMO) available 24 hours a day to attend any emergencies in the outpatient, physiotherapy and diagnostic imaging departments. We observed this in practice during an incident that took place during our inspection. The RMO responded immediately at the request of clinic staff.
- Consultants at the hospital were engaged to work in the hospital via a process of practising privileges. This is sometimes known as admitting rights.
- There was a corporate policy in place, outlining the eligibility criteria, application and process for granting practicing privileges, the process for maintenance and review, management of performance concerns and the requirements of consultant appraisal. This policy was outlined within the consultant handbook.
- There were processes in place to suspend or remove a consultant's practising privileges where there were concerns about their practice. We were provided with evidence which demonstrated a clear transparent approach, within the governance processes and procedures of the hospital.

Major incident awareness and training

- The hospital had a business continuity plan in place. This detailed what staff needed to do in response to a variety of scenarios that could affect the operation of the hospital. These scenarios ranged from a fire, loss of the telephone system through to loss of the operating theatres or a local major incident. The plan included mutual aid that could be called upon from other Spire hospitals. Mutual aid meant services at other Spire hospitals that could be utilised following discussions with senior managers. For example if the diagnostic imaging department was unavailable, the imaging services at the next nearest Spire hospital could be used.

Are outpatients and diagnostic imaging services effective?

Good

The effectiveness of outpatients and diagnostic services was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

- There was evidence to show that NICE guidelines were being followed in physiotherapy, outpatients and diagnostic imaging. For example within cancer care and breast care.
- There was good evidence of multidisciplinary team working practices.
- Diagnostic imaging and physiotherapy provided 24 hour services to inpatients within the hospital.
- Audit plans were in place, and action plans implemented when necessary
- Staff were competent and well trained. Enabling Excellence (the appraisal and professional development system within Spire Healthcare) files were available for all staff to demonstrate their individual competencies.
- A new comprehensive induction programme had been developed in conjunction with staff.

Evidence-based care and treatment

- We saw that the patient group directions were developed in line with guidelines from professional bodies such as the Nursing Midwifery Council and national organisations such as the National Institute for

Health and Care Excellence (NICE). These allowed staff who had received additional specialist training to administer a range of medicines to a pre-defined group of patients.

- Policies were referenced to confirm they were developed in line with national recommendations and best practice. For example, one policy for the cleaning of a specialist scope had been developed in line with guidelines from the British Society of Gastroenterology, and the Department of Health.
- Staff were kept up-to-date with changes in policies. We saw evidence that staff had read the updated policies and signed to show they had read them.
- The cancer standards used within the hospital were based on Macmillan quality standards, Health & Safety guidance and NICE guidelines.
- Within the diagnostic imaging department, we observed evidence based care. In one particular area (cardiac MRI scans) the staff performing these scans regularly visited other NHS acute hospitals to teach the NHS staff how to perform these specialist scans.
- There was a local audit plan in place which detailed which audits would be carried out each month over the course of a year. We saw evidence that the outpatient had 100% compliance in the following audits: Use of personal protective equipment (PPE) in February 2016, environment (were the departments clean) in March 2016, decontamination of equipment (had equipment been cleaned in line with hospital policy) in April 2016, departmental waste (had clinical and non-clinical waste been disposed of in line with hospital policy) in June 2016, linen handling (had dirty linen been handled in line with hospital policy) in August 2016, bare below the elbow (were staff practising bare below the elbow in line with hospital policy) in September 2016.

Pain relief

- Pain relief was available in all departments. Staff told us that if a patient informed them they were in pain, they could be assessed by the resident medical officer or in the outpatient department by the consultant they were due to see. Prescriptions for pain relief medication could be obtained from the hospital pharmacy department.

Patient outcomes

- We saw evidence that systems were in place when a consultant wanted to introduce a new procedure into the outpatients department. For example, at the time of our inspection a consultant who wanted to introduce a new procedure had put together a research paper to support their procedure which was to be presented to the Medical Advisory Committee (MAC). The committee would then decide whether the proposal was based upon the latest evidence and good practice, whether staff and consultants were competent to perform the procedure and make recommendations to the hospital management.
- The diagnostic imaging department had also achieved 100% compliance in the audits with the exception of cleanliness (environment). The areas within the diagnostic imaging department scored between 79% (x-ray) and 100% (CT) for cleanliness. Following actions taken to improve the cleanliness, the re-audit showed 100% compliance for the diagnostic imaging department.
- Within diagnostic imaging the department aimed to make sure that the time from referral to report did not exceed 48 hours for x-rays, CT and Ultrasound and three to four days for MRI scans. We saw evidence that the diagnostic imaging department was meeting these timescales for the year prior to our inspection.
- The local clinical commissioning group were no longer commissioning physiotherapy treatments at the hospital for NHS patients. As a result NHS patients having surgery at the hospital requiring follow-up physiotherapy had to be referred back to NHS physiotherapy services. The physiotherapy manager at the hospital kept track of these patients to make sure they didn't fall through the net.

Competent staff

- The hospital had processes in place which were aligned to the policy to monitor and maintain the practicing privileges in place. There was an electronic data base which was updated, monitored and maintained by a member of administrative staff, who worked closely with the matron/head of clinical services.
- In addition, the hospital carried out a biennial review of each consultant's performance, which included details of any incidents, complaints and any behaviour which was not in line with the values of the organisation. This was documented and used as a review of the consultant's suitability to maintain their practising privileges. Alongside this there was also a review of the consultant's scope of practice document.

Good

Outpatients and diagnostic imaging

- Processes were in place to ensure that consultants provided updates to required documentation, for example, their appraisal, updated indemnity insurance etc. The electronic system, generated a letter to the consultant a week prior to the documentation expiring, followed by a reminder two weeks later, and a further reminder another two weeks later. Should the documentation not be presented at that point the consultant's practise is suspended until such point as they produce the documentation.
- All staff (100%) within the outpatients department had received their appraisals both for this current year (2016) and the previous year (2015). Each member of staff within the diagnostic imaging department had their own 'EE (Enabling Excellence)' file which detailed their competencies, six monthly and yearly appraisals.
- A new induction for outpatient staff had been developed in conjunction with staff involvement. New staff to the department spent the first four weeks on induction which included spending time in all the other departments across the hospital. The induction programme was tailored to suit each individual member of staff. For example, if a nurse had come from a ward environment, then their time on the ward would be reduced because they already had experience of this. We spoke with two staff that had been through the new induction programme. They told us that it had been worthwhile and had given them all the relevant information to start their new role. Following successful completion of the induction programme, new staff were given a mentor who supported and worked with them to achieve the required competencies for their role.
- The staff told us that there were lots of opportunities for further learning within the department. For example, some staff had completed courses in cancer care, identifying a deteriorating patient and enhanced communications with patients. Staff told us that their immediate line mangers and hospital senior managers were always very supportive with training requests and encouraged staff to continually develop their skills and knowledge.
- All staff administering radiation were qualified to do so and we saw evidence that they were regularly assessed for their competency. This was in accordance with the legislation set out under the Ionising Radiation (Medical Exposure) Regulations 2000.
- The physiotherapy department held regular in-service training for staff each month. We saw the training programme for the year which included topics such as manual handling, pain management and feedback from specific courses staff had attended. Specific update days were held for bank staff working within the physiotherapy department to make sure their skills and knowledge were kept up to date.
- The hospital had a system in place to make sure registered nurses and allied health care professionals maintained their registration and were able to meet revalidation requirements.
- The specialist breast care and cancer link nurses had all received additional training in their specialist areas to enable them to perform their roles effectively.
- Systems within outpatients, physiotherapy and diagnostic imaging ensured all staff were trained and competencies were completed. Competency frameworks were in place for specific therapies used within physiotherapy, operating specific machines within diagnostic imaging through to removing clips and stitches from healed wounds within outpatients. This meant that staff would receive additional training to perform these tasks and would be assessed using the competency framework to make sure they were able to perform each task safely.

Multidisciplinary working

- The multidisciplinary teams within the hospital worked well to support the planning and delivery of care in the outpatient, physiotherapy and diagnostic imaging departments. Meetings took place each week to look at the individual needs of each patient being admitted into the hospital.
- The physiotherapy team led the hospital's multidisciplinary discharge working group. This brought together staff from the booking, reception, planning and management teams along with nursing and physiotherapy staff to look at effective discharge planning.
- We observed good communication between the medical and nursing staff. This communication was open and encouraged effective multidisciplinary team work.
- Staff told us how the profile of the outpatient department had been raised throughout the hospital so that other staff had an understanding of the department. This had improved communication between outpatients and other departments in the hospital.

Good

Outpatients and diagnostic imaging

- Monthly multidisciplinary meetings took place. For example, heads of departments meetings. These meetings were held to share good practice and enable learning across the hospital teams.
- Service level agreements were in place where necessary. For example, arrangements were in place with a local NHS acute hospital to provide expert radiation advice to the diagnostic imaging department.
- Staff told us how important it was to work together, draw on each other's experience and knowledge and have shared learning across the hospital. This reflected how well different teams worked together.

Seven-day services

- The diagnostic imaging and physiotherapy departments provided a 24 hour service to inpatients within the hospital via an on-call service.
- Evening and Saturday clinics were provided by the outpatient, physiotherapy and diagnostic imaging departments.
- Physiotherapy services were provided to both inpatient and outpatients. For inpatients the service runs from 8am to 8pm Monday to Friday within an on-call service for outside of these hours. For outpatients clinics were provided from 8am to 8pm four days a week and 8am to 6.30pm one day a week. Saturday morning clinics were provided for three out of four Saturdays.

Access to information

- All pathology and diagnostic imaging results were available via the hospitals electronic system and the patient's medical notes.
- The hospital contacted GPs by letter to keep them informed of treatment patients had received.
- We saw an example of when a patient had attended the outpatients department and subsequently admitted to the inpatient ward. Copies of the outpatient records accompanied the patient to the ward so that a complete picture of the patient's treatment was available. At the time of our inspection the hospital had separate inpatient and outpatient notes. However, a project was underway to create a single patient record across all departments in the hospital.
- The information needed to deliver effective care and treatment was always available to staff. Records for NHS patients were requested before a consultation. When notes arrived in the outpatient department, they were kept in locked room that only staff had access to.
- Staff were able to access information on their local intranet which included policies and guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff told us that they always obtained verbal and/or written consent from patients prior to any treatment. Staff also told us that they would request a capacity assessment if they were concerned that a patient lacked capacity.
- We observed staff asking patients for their consent before providing any treatments such as a change of dressing. We also saw that written consent had been taken for more invasive procedures.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

Overall we rated caring as outstanding because:

- The patients we spoke with were overwhelmingly complimentary about the hospital, staff and the care they had received.
- The friends and family patient satisfaction scores consistently showed high levels of satisfaction.
- We observed good communication between staff and their patients.
- Staff were able to give examples of where they had made a difference to individual patients and their journey through the outpatients department.
- Staff were aware of their patients emotional needs and gave examples of where staff had been able to reduce patient anxieties.
- Additional support was available from specialist and link nurses.
- We observed caring and compassionate staff and saw that patients were treated with dignity and respect.
- Patients told us they were involved in decision making and that they understood the care and treatment choices available to them.

Compassionate care

Good

Outpatients and diagnostic imaging

- Patients were all complimentary about the hospital and the staff. Comments included: “the staff have all be friendly and helpful”; “I have already recommended this hospital to my friends”; “I am always impressed by the care and services here”; “The staff are fantastic and always look after me very well”; and “I can’t praise them enough, nothing is too much trouble”.
- Staff recognised when patients needed extra support with their care and treatment. This was provided in a friendly and compassionate way. For example where a patient had been diagnosed with cancer, the specialist and link nurses would provide additional support to the patient and their families.
- All the patients told us they would recommend the hospital to their family and friends.
- The Friends and Family test showed that 98% of 126 patients (NHS, insured and self-pay patients) during August 2016 thought the care provided by the outpatient staff was good, very good or excellent. For those patients who used the diagnostic imaging department, 95% of 97 patients (NHS, insured and self-pay patients) during August 2016 thought the care provided in the department was good, very good or excellent. For patients who used the physiotherapy department, 95% of 97 patients during August 2016 thought the care provided was good, very good or excellent. Trends in the patient satisfaction scores from June 2015 to June 2016 showed a consistent high score for both the outpatient and diagnostic imaging departments. The outpatients department scored on average 97% whilst the diagnostic imaging department averaged 96% across the time period.
- Chaperones were available at all times and we observed patients being offered a chaperone when they attended for their appointment.
- Patients told us that their privacy and dignity were respected by the staff.
- Staff we spoke with consistently told us how much they enjoyed having the time patients needed to give good care to each patient.
- The patient was constantly at the heart of everything the staff did. Staff told us that they wanted to make the patient’s experience as best as it could possibly be.

Understanding and involvement of patients and those close to them

- Staff always communicated with patients so they understood their care, treatment and condition. All patients we spoke with told us that staff clearly explained procedures and checked the patients understanding before continuing.
- Staff recognised when a patient and those close to them needed additional support to help them understand and be involved in their own care. This was done in person and via the telephone when patients called in. For example, if a patient needed additional reassurance about their wound.
- Patients told us that they felt actively involved in their treatment plans and decision making about their own care. Patients told us they were always kept informed of waiting times.
- We observed staff using clear communication and giving patients time to ask any questions. For example one member of staff explained an upcoming procedure to a patient, and answered the questions raised by the patient and their family.
- We saw evidence that follow-up calls were made as necessary to check on the welfare of patients. The decision on which patients were call were based on staff judgement and their knowledge of the patient and how much support they needed. Documentation of the follow up calls showed patients were appreciative of this aftercare.
- Staff in the outpatient department were able to give us examples of where they had made a difference to a patients care and treatment. For example, one patient was seen in the department and was very quiet and withdrawn. The staff were told the patient had communication difficulties. However, the staff took the time to talk to the patient before their treatment and ascertained the patient loved singing. The staff told us how at that moment, the patient’s mood just lifted and was ‘glowing’ because they had taken the time to get to know that individual patient to make their experience in outpatients as good as it could possibly be.

Emotional support

- Staff demonstrated an understanding of the impact a person’s care, treatment or condition might have on their well-being. They explained how different treatment options were discussed with patients and their relatives

so that they had the information to make their own decisions. For example the breast care nurse specialist was able to explain the various treatment options open to a women after diagnosis with breast cancer.

- Staff and patients told us were staff went out of their way to reduce a patient's anxiety. For example, one patient had attended for a procedure the day before their holiday. The patient was anxious to receive their results so that if they were positive they could enjoy their holiday. The hospital made arrangements to get the results to the patients GP later that day. However, later that evening the patient contacted the hospital because the GP had not passed on the results. The staff arranged for a consultant to call the patient to put their mind at ease prior to their holiday.
- In another example, staff in the outpatient department told us when they were able to provide extensive emotional support to a patient who was extremely anxious about their treatment. One nurse was able to see the patient over a number of appointments to maintain continuity and was able to build a good relationship with that patient as a result. This allowed the nurse to be able to answer all the patient's questions and concerns and reduce their anxiety.
- Staff told us that if they had to break bad news to a patient, quiet rooms would be used.
- During our visit we observed staff giving reassurance to patients and their relatives. When patients were anxious, additional support was provided by staff. For example one patient was particularly anxious about a procedure. The same nurse was able to see the patient and the nurse had already built a good professional relationship with the patient and was able to provide reassurance on the procedure.
- Additional emotional support was provided by the specialist nurses and cancer link nurses. For example they would make sure they were available to complete a pre-assessment visit and would then visit them on the ward and attend consultations. This provided a level of continuity for patients so could feel comfortable in asking questions or asking for help and support.

Are outpatients and diagnostic imaging services responsive?

Good

Overall we rated responsive as good because.

- Services were planned and delivered to meet the needs of the patients.
- Chaperone signs were displayed across outpatient, physiotherapy and diagnostic imaging waiting areas and staff routinely asked patients if they wanted a chaperone.
- Information on how to raise complaints, concerns or compliments were readily available in the waiting areas.
- The diagnostic imaging department reported x-rays, ultrasound and CT scans within 48 hours from the referral and report MRI scans three to four days from the referral.
- Staff were experienced in recognising patients individual needs and gave examples of where this had improved the patient experience.
- Breast care specialist and cancer link nurses were available to support patients through their care and treatment journey.
- Interpreting services were available to patients whose first language was not English. Staff knew how to access these services when necessary.
- There were examples where lessons had been learnt from complaints.

Service planning and delivery to meet the needs of local people

- The hospital held 'resource' meetings on a weekly basis to discuss the needs of patients attending the hospital the following week. These meetings were attended by administration and clinical staff to make sure all the patients' needs were met and to ensure that any clinical risks were identified. For example, one patient needed special arrangements to support their communication and another patient was very anxious about their admission so staff knew to provide additional reassurance.

Good

Outpatients and diagnostic imaging

- Patients told us that the waiting areas were comfortable. There was a variety of refreshments, magazines and newspapers available for patients in the waiting area. Wi-Fi was available for patients to use and a television was also available in the waiting areas.
- Car parking at the hospital was free to patients, but at times the car park became full. The hospital told us that they were already aware of the shortfalls in car parking spaces and told us of their plans to seek planning permission to build a multi-storey car park to increase the number of spaces offered.
- We observed patients arriving for their appointments at the main reception. The majority of patients knew where they were going, and for those that didn't the reception staff directed patients or escorted them personally. Diagnostic imaging had a separate reception desk in the main entrance to book people in for their procedures.
- At the time of our inspection the hospital was undergoing a refurbishment plan. The outpatients department was due to be completely refurbished during 2017.

Access and flow

- The hospital had a target set by the clinical commissioning group to see 92% of the patients referred under the NHS within 18 weeks of referral. Information supplied to us before our inspection showed that the provider consistently achieved between 98 – 100% from April 2015 to March 2016.
- Within diagnostic imaging, no patient waited longer than national target six weeks from their referral for their diagnostic imaging procedure. For x-rays, ultrasounds and CT scans the time was 48 hours from referral to report. For MRI scans it was three to four days from referral to report.
- The outpatient department saw patients from a wide range of specialities such as Dermatology, Paediatrics, ENT (Ear, Nose and Throat) and Orthopaedics.
- During our inspection we observed patients arriving for their appointments and the consultants calling them through at their appointment time. The nursing staff were aware when clinics were running late and kept patients informed. Written signs were on display asking patients to speak to staff if they had been waiting longer than 15 minutes. Patients told us that they very rarely waited to see the consultant or nurse because their appointments had been on time.
- Before outpatient clinics started in the morning, the staff met with the nurse in charge to review which consultants were holding clinics, the rooms they were in and patients who were attending for treatments such as a change of dressings. This allowed staff to know what was happening in the department and keep the clinics running to time. The staff also met again at the lunchtime shift changeover.
- Within the diagnostic imaging department the waiting times from referral to report was typically 48 hours. We saw evidence that patients referred for x-ray, CT and ultrasound procedures were all seen and reports provided within this 48 hour timescale. For MRI scans, the waiting time from referral to report was approximately three to four days.
- Appointments for outpatients and diagnostic imaging were offered between Monday and Friday from 8am to 8pm and on Saturday mornings to make them as convenient as possible for patients. Patients told us that they were able to change their appointment time if needed.

Meeting people's individual needs

- The outpatient, physiotherapy and diagnostic imaging departments planned and delivered services to meet people's individual needs. For example, longer clinic appointments were provided to people where they needed to have additional time to ask questions or receive additional information or reassurance from staff.
- The outpatient department offered outpatient appointments until 8pm each evening Monday to Friday and on Saturday morning. The physiotherapy team also offered appointments during these times which were particularly useful to those finishing work or children finishing school.
- One relative told us how easy it had been to get an appointment. They told us that it had all been arranged via email which they found useful because of their work commitments.
- Through audit, patient and staff observations, the hospital recognised that whilst they didn't see many patients living with dementia, when they did their stay wasn't managed as well as it could have been. As a result a member of staff had been appointed as the dementia lead for the hospital. The dementia lead received additional 'champion' training from the Alzheimer's Society and met with their counterparts at the local NHS acute hospitals. In March 2016 the

dementia lead established dementia training for all staff within the hospital. Any needs that a patient might have were identified during the pre-assessment appointment and relayed to staff accordingly. Some staff within the hospital had received additional training in dementia awareness and wore badges showing that they were Dementia Friends. Longer clinic times were also provided for patients of 75 years of age and over. At the time of our inspection, a draft pathway was in place for patients living with dementia, which was being trialled before being approved.

- All staff were aware of how to access the interpreting services should their patients need it. Staff told us that occasionally in emergencies or at the patients request a relative would be used to interpret, although all staff confirmed that children would never be asked to interpret. Staff also told us that where any issues of consent arose, they would always use the interpreting services company.
- The hospital had good disabled access and two separate entrances to prevent patients from walking the steep hill if they were unable to do so.
- Patients told us that they had received information from the hospital in a timely way and had been informed about how they would receive any results.
- Cancer link nurses were available for staff to refer patients to. Once a referral had been received, the link nurse would call the patient and introduce themselves and explain how they could help and support. The patient could choose not to receive their help, in which case they were invited to contact them at any time if the patient changed their mind. The link nurses were available to complete the patients pre-assessment and visit them on the ward if they were coming in for surgery. They liaised with other healthcare professionals involved in the patient's treatment to make sure the patients were receiving consistent information and continuity of care.
- Staff gave us examples of how they adapted individual appointments based on their individual needs. For example, one patient with learning difficulties attended the department with their carers. Staff had been informed beforehand that the patient was scared of fire extinguishers. Staff removed the fire extinguishers from the patient's sight during their journey through the outpatient department and replaced them once the patient had left the department or that particular area. This made sure the patient was able to visit the department without experiencing additional anxieties.
- The breast care nurse specialist was based within the outpatients department. Their role was to support all women from start to finish with their diagnosis and treatment. They attended multidisciplinary meetings with the local NHS acute hospital and liaised with other health care professionals as required. Good working relationships had been developed with the local acute hospital oncology team which meant the nurse was kept informed of their patient's treatment journey away from the hospital. The nurse told us how they worked around the needs of the patient rather than the other way around. For example, one patient didn't want their children to know about their diagnosis and treatment, so appointments were scheduled when their children were out. During this time, it also allowed the nurse to provide additional support to the patient to help prepare them to talk to their children about their diagnosis and treatment.
- One member of staff summed up what all the staff we spoke with felt. "We have time to listen, time to talk and time to care".

Learning from complaints and concerns

- From April 2015 to the end of March 2016, the hospital received 123 complaints.
- We saw evidence where actions had been taken in the outpatient department in response to concerns raised by patients and staff. For example, the medicine cabinet was located in one of the treatment rooms. This meant that patients undergoing treatments such as change of dressings were interrupted by other staff needing to get medicines. As a result of concerns raised by both patients and staff the medicines cabinet was moved into a room where only staff had access.
- Patients told us that they knew how to raise a complaint. They told us they felt confident about speaking to staff about any problems they encountered and felt that the staff would listen and act when necessary. We saw leaflets informing patients how to complain in the waiting areas together with leaflets encouraging people to share their feedback with the hospital.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Good

Overall we rated well-led as good because:

- The leadership, governance and culture promoted the delivery of person centred care. There were clear governance structures and systems in place with defined accountabilities for assurance.
- Managers provided clear leadership and motivation to their teams.
- Staff were overwhelmingly complimentary about their immediate line managers and the hospital management team.
- There was an open and transparent culture within outpatients, physiotherapy and the diagnostic imaging departments. Staff told us they felt proud to work in the departments and for the hospital.
- The departments regularly engaged with patients and staff in the development of the service.

Vision and strategy for this this core service

- At the time of our inspection the outpatient manager had been in post for just a few months and had not had a chance to develop a long term vision for the department. However, they felt it was important to consolidate all the changes that had occurred since taking up the role and involving staff in decisions affecting the department.
- Staff told us about the vision of the corporate provider and that of the hospital. Staff felt they contributed to the overall corporate vision in their day to day work.

Governance, risk management and quality measurement for this core service

- There were clear governance and risk management structures in place. This included staff being able to raise concerns and to receive information from the hospital management but also in learning so that they were always striving to provide the best possible service.
- There were various meetings for senior staff including clinical governance group, head of departments meetings and clinical leaders group. Minutes of these meetings showed that a wide range of issues were discussed including incidents, complaints and any areas of risk or concern. The minutes of these meetings were made available to staff to read within the outpatient department and the highlights were fed back to staff via their monthly team brief.
- There was a medical advisory committee at the hospital, which was an integral part of the governance structure. Changes had been made to ensure that there was representation of specialist groups who provide treatment and care in the hospital.
- We were provided with a copy of the hospital wide risk register. The risks were generic and could apply to any Spire hospital and included subjects such as 'over exposure to radiation' or 'a patient's health deteriorates in the outpatient department'.
- Staff were aware of the risks within their departments and told us they knew of incidents that took place elsewhere in the hospital because the information was cascaded to them via team brief.
- The outpatients, diagnostic imaging and physiotherapy departments produced a team brief each month for its staff. This included information that needed to be cascaded about the hospital in general in addition to specific information relating to each department. Complaints and incidents were discussed. Changes to policies were also discussed to make sure staff were aware of them.

Leadership / culture of service

- The department managers told us how proud they were of their staff and the care they provided to patients. For example one manager told us about the compliments they received from patients and gave an example of where staff came together during a period of sickness to make sure no clinics were cancelled and no patients were adversely affected.
- All the staff in the outpatients department told us they had previously felt undervalued and morale had been low, but this had changed with the introduction of a new outpatients manager. The staff had nothing but praise for their manager and the matron. They also commented on how the manager had been able to turn the department around by valuing staff and including staff in the development of the service. Staff told us it was now a place in which they felt proud to work.
- There was a clearly defined and visible leadership within the outpatients, physiotherapy and diagnostic imaging departments. Staff told us how they felt supported and listened to by their managers. Staff said that senior

managers were visible on a daily basis and knew each member of staff by name. Several staff told us how much they liked working for the hospital because it was like being part of a family. Other staff said it was a community working at the hospital, with one member of staff commenting "everyone is so friendly and says hello to each other". Staff told us that the manager of outpatients was very visible in the department and available when staff needed support. Staff told us that the matron visited daily, knew each staff member's name and always checked if there were any problems or concerns.

- Staff told us that both immediate line managers and hospital managers were all very approachable, encouraged staff to put forward suggestions and listened to staff when suggestions were made. Staff also said that when concerns were raised, they found the managers to be very responsive.
- All the staff we spoke with told us that there was a learning culture within the hospital rather than a blame culture. As a result, staff were not afraid to report incidents or learn from mistakes.

Public and staff engagement

- Patients attending the hospital were asked to complete a satisfaction survey. The results were collated each month and the hospital consistency achieved a higher response rate than other independent hospitals. The Friends and Family Test showed that of 196 patients who completed the survey in August 2016, 99% would be likely or extremely likely to recommend the hospital to friends and family.
- In all the waiting areas and public areas we saw leaflets 'your views matter' encouraging people to share their views with the hospital. We also saw that 'you said, we did' boards so that people could see the actions taken. For example, one 'you said, we did' was for hot chocolate to be available in the vending machines. The response from the hospital was to ensure that all beverage stations had these back on the menu.
- The physiotherapy department conducted their own yearly patient satisfaction survey with patients who had attended the department three times or more. The results were very positive with 100% of respondents saying they would recommend the department to others.

Innovation, improvement and sustainability

- All staff focused on continually improving the quality of care patients received.
- The staff had identified that no-one in the hospital followed the cancer patients through on their care and treatment journey, this meant that these patients received no support or continuity. As a result, cancer link nurses were established (one based on the ward and two based in outpatients). These nurses received additional training to be able to support cancer patients. Their role was to provide continuity of care for the patients and to liaise with other professionals to make sure the patient received the best possible care. Staff told us that the hospital management had been very supportive in getting these nurses in post.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The inspection of the termination of pregnancy services at the hospital was conducted using the Care Quality Commission's new methodology for services of this type. We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The report is limited as there was insufficient evidence and a very small number of procedures carried out at the hospital.

The hospital had been registered with the Care Quality Commission to provide termination of pregnancy services since 13 October 2010. Surgical terminations under general anaesthetic were the only method available for pregnancies up to 12 weeks gestation.

At the time of this inspection surgical termination of pregnancy was available only to private patients aged above 18 years old. All care and treatment was consultant led. Two consultant gynaecologists had been granted practicing privileges to provide termination of pregnancy procedures at Spire Bristol hospital. The last five patients had been treated by the same (one) consultant.

The rate of terminations was low. From April 2014 to March 2015 there had been four, between March 2015 and April 2016 there had been five. No termination of pregnancy procedure had been completed during 2016 (1 January to 31 August). The date of the last surgical termination procedure at the hospital was in December 2015.

The hospital had been granted a licence from the Secretary of State to provide a termination of pregnancy service at this location. We saw this licence was in date at time of our inspection. A condition of the licence was that the service should be compliant with a range of Required Standard Operating Procedures (Department of Health, 2014). There was evidence that compliance had not been met with a number of the Required Standard Operating Procedures. The senior management team were informed of our findings during the inspection and took prompt actions in response to deregister and cease the provision of the termination of pregnancy services.

During this inspection we spoke with one consultant gynaecologist, the hospital matron, the clinical nurse manger, the theatre manager, one senior nurse (sister) and one registered nurse. We reviewed the medical records of the last five patients who had received termination of pregnancy treatment and care. We looked at information, policies and procedures before and during our inspection. No patients had attended Spire Bristol hospital for termination of pregnancy services at the time of our inspection or for the preceding eight months.

Termination of pregnancy

Summary of findings

- At the hospital the termination of pregnancy service was not provided as a distinct service but was facilitated through the general outpatient department and surgical services.
- There was evidence that compliance had not been met with a number of the Required Standard Operating Procedures. This was necessary to maintain the licence from the Secretary of State to provide a termination of pregnancy service at the hospital. The senior management team were informed of our findings during the inspection and they took immediate actions to deregister and cease the termination of pregnancy service.
- We received written confirmation that applications had been made to the Care Quality Commission to remove the condition of registration that the regulated activity termination of pregnancy be carried out at Spire Bristol Hospital. An application had also been made to the Department of Health to remove the Secretary of State licence. Written confirmation of the intent to cancel was received on 15 September 2016. The senior team at the hospital notified us that all relevant staff had been informed of these changes. Termination of pregnancy information was also removed from the Spire Bristol website.
- Between April 2015 and March 2016 there had been no reported incidents or hospital acquired infections.
- Patient records showed risks had been assessed and relevant actions taken. Written information confirmed the legal requirements for a termination had been followed.
- Care records were stored safely. However medical records were not accessible to all staff. These were maintained by the consultants and stored off site.
- The majority of staff had in date mandatory training, including safeguarding vulnerable adults and children.
- Records documented compliance with abortion law and regulations.
- The provider's clinical guidance and policy had limited reference to national guidance and standard. There was no audit plan in place to monitor standards, care and practice for termination of pregnancy patients' treatment and care.
- We were told there had been no complications for the last five termination procedures completed.
- Consent was documented as checked and pain assessments were completed and appropriate actions taken.

Termination of pregnancy

Are termination of pregnancy services safe?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The report is limited as there was insufficient evidence and a very small number of procedures carried out at the hospital.

- Between April 2015 and March 2016 there had been no reported incidents or hospital acquired infections.
- Patient records showed risks had been assessed and relevant actions taken. Written information confirmed the legal requirements for a termination had been followed.
- Care records were stored safely. However medical records were not accessible to all staff. These were maintained by the consultants and stored off site.
- The majority of staff had in date mandatory training, including safeguarding vulnerable adults and children.
- Care was consultant led and there was sufficient staff to provide safe patient treatment and care. Resident medical officers were available to respond to any clinical issues at all times in between consultant visits.

Incidents

- We spoke with the hospital matron who told us they reviewed all reported incidents. There had been no reported incidents relating to the termination of pregnancy service at the time of our inspection.

Cleanliness, infection control and hygiene

- The risk of patients contracting a hospital acquired infection was low. Between April 2015 and March 2016 there had been no reported incidents of Clostridium difficile (Cdiff), E.coli, methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-susceptible Staphylococcus aureus (MSSA).

Records

- The termination of pregnancy records were stored safely in locked cupboards. We reviewed five patient records and saw they included relevant, completed risk assessment personal details, observations, treatment and care action plans and consent.
- Not all of the patients' records were held in the medical file. Some of the clinical information and examination details such as scan results were held separately and stored at an external location by the consultant gynaecologist. The information held by the consultant gynaecologist was not known or accessible to other clinical staff at the hospital.
- There were systems in place to make sure the legal requirements relating to a termination of pregnancy were documented in records. We reviewed five patient records and saw each had been fully and appropriately documented as completed. This included two registered medical practitioners who were required to sign the HSA1 form. The form had to be fully completed following a patient consultation and before the termination could proceed.

Safeguarding

- National guidance (Intercollegiate Document, 2014) recommends staff should be trained to one of five levels of competency, depending upon role and interaction with young people. Records showed the majority of staff had in date safeguarding training.
- Safeguarding children and vulnerable adults training to level 3 had been completed by eight clinical staff and all the surgeons with practicing privileges at the hospital. All other staff, and all of the anaesthetists with practicing privileges had been trained to level 2.
- The hospital's paediatric lead nurse had been trained to level 4 and the matron who had overall accountability for safeguarding at the hospital was trained to level 3.

Mandatory training

- Records showed the majority of staff (between 86% and 96%) had completed mandatory training updates. This included: fire safety, health and safety, infection control, safeguarding children and vulnerable adults, manual handling, compassion in practice and equality and diversity.
- Staff compliance with mandatory training was tracked every month by the hospital administration manager and staff were prompted to book and complete mandatory training when required. We were told plans were in place for all staff to have completed mandatory training by December 2016.

Assessing and responding to patient risk

Termination of pregnancy

- Care was consultant led and there were resident medical officers available at all times to provide medical care if required until a consultant arrived.
- Each consultant gynaecologist was responsible for assessing the suitability of each patient for a surgical termination procedure.
- The provider confirmed all (100%) of the resident medical officers at the hospital had completed advanced life support training.
- Records showed between April 2015 and March 2016, 100% of patients admitted to the hospital had venous thromboembolism (VTE) risk assessments completed
- The five medical records we reviewed showed patients had been tested prior to procedure for rhesus disease in future pregnancies. Treatments were provided to patients who tested positive.
- Nursing staff confirmed the treating consultant assessed each patient after the termination procedure to ensure they could be safely discharged. Nursing staff told us patients were provided with the Spire Bristol contact numbers should they need further advice following discharge. If required, nurses would contact the treating consultant gynaecologist.

Nursing staffing

- The termination of pregnancy service did not have any dedicated nursing staff. There were 61.2 whole time equivalent registered nurses employed throughout the hospital which was sufficient to provide support with patient treatment and care from admission through to discharge.

Medical staffing

- Two consultant gynaecologists had been granted practicing privileges at the hospital to provide termination of pregnancy services.
- Three registered medical officers (RMOs) were employed who were available 24 hours per day, seven days per week. The RMO provided medical care where required in-between consultants attending the hospital.

Are termination of pregnancy services effective?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The report is limited as there was insufficient evidence and a very small number of procedures carried out at the hospital.

- Records documented compliance with abortion law and regulations.
- The provider's clinical guidance and policy had limited reference to national guidance and standard. There was no audit plan in place to monitor standards, care and practice for termination of pregnancy patients' treatment and care.
- We were told there had been no complications for the last five termination procedures completed.
- Consent was documented as checked and pain assessments were completed and appropriate actions taken.
- If patients requested counselling support they were referred to external services. However, staff were not familiar with the range or scope of these external services.

Evidence-based care and treatment

- We spoke with medical and nursing staff who assured us processes were followed to comply with the Abortion Act (1967) and Abortion Regulations (1991). This included a clinical assessment of each patient by medical staff, which was documented in patient records. However, there was a lack of evidence based policy on termination of pregnancy for staff to adhere to. For example: reference to some national standards was not included in the provider's clinical guidance or policy. This included: The Care of Women Requesting Induced Abortion (2011), for Termination of Pregnancy for Fetal Abnormality (RCOG, 2010) and for The Management of Tubal (ectopic) Pregnancies (RCOG, 2004).
- The Royal College of Obstetricians and Gynaecologists (RCOG) guidance for 'The Care of Women Requesting Induced Abortion' (2011) makes a range of good practice recommendations. These included: assessment and provision of contraception, screening for sexually transmitted infections and access to support and advice after procedures. The hospital could not provide evidence they had been consistently compliant with all of these recommendations.
- The hospital did not participate in any audit programmes related to termination of pregnancy. This

would have supported the service to evaluate if termination of pregnancy treatment and care was being provided in line with national standards and to identify improvement actions.

Pain relief

- The five patient records we reviewed included completed pain assessments. Pain relief had been prescribed and documented as provided.

Patient outcomes

- Only one termination procedure (vacuum aspiration) with a general anaesthetic was available at the hospital. The consultant who had performed the last five terminations told us there had been no complications associated with these, nor had any of the procedures failed.
- Department of Health policy (2014) is that women who are legally entitled to a termination should have access to the procedure as soon as possible. Evidence shows that the risk of complications increases the later the gestation (Evaluation of Early Medical Abortion, DH, 2008). Records showed the last five patients had their termination treatment when they were less than 13 weeks in gestation. This was the same as the national average, with 92% of terminations carried out at under 13 week's gestation (Abortion Statistics, England and Wales: 2014, published June 2015).
- The five medical records we reviewed documented that each patient had been advised of what actions to take if they had health concerns post discharge

Competent staff

- Each doctor's practising privileges, including annual appraisal and revalidation were evaluated on an annual basis. We reviewed the two consultants files and saw evidence to demonstrate this.
- Nursing and health care assistant staff had an annual appraisal of their performance and learning needs each year. Records showed all of these staff had an in date annual appraisal.
- There was no specific staff training available at the hospital to update the clinical skills of staff regarding termination of pregnancy patient care.

Seven-day services

- The hospital was open 24 hours a day, seven days per week.
- The contact details of each patient's consultant surgeon, anaesthetist and any consultant cover were available to all staff and recorded within the on call folder.
- Senior nursing staff told us patients were provided with the contact details of alternative (external) services regarding advice or counselling prior to and following termination procedures. Staff were not familiar with the range or scope of what these external services were able to offer.

Access to information

- Systems were not in place to enable information to be shared appropriately and promptly between all staff. Upon referral to the service, each patient had a record of personal and medical information started and stored by the hospital. The consultant gynaecologist also maintained their own medical record, including investigative tests. The consultant records were stored off site. This prevented the full patient care details being accessible to all staff involved with each patients termination of pregnancy treatment and care.
- The Department of Health Required Standard Operating Procedures state that it is good practice for two certifying doctors to see a patient who has requested a termination of pregnancy, although it is not a legal requirement. In the five patient records we reviewed, the HSA1 form had been completed and filed in each patient's hospital medical record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Procedures to gain consent were documented in the five medical records we reviewed. All five consent forms had all been fully completed.
- Each patient was asked for consent before any information was shared with others. This included the patient's GP, even if they had made the referral to the service. In the five medical records we reviewed, decisions were documented as discussed and patient choice had been followed.

Are termination of pregnancy services caring?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal

Termination of pregnancy

duty to rate this type of service or the regulated activities which it provides. The report is limited as there was insufficient evidence and a very small number of procedures carried out at the hospital.

We were not able to speak with any patients as no termination of pregnancy procedures had been carried out since December 2015.

Are termination of pregnancy services responsive?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The report is limited as there was insufficient evidence and a very small number of procedures carried out at the hospital.

- A licence had been granted which granted legal permission to provide termination services. Attached to the licence were a number of required standard operating procedures. There was evidence that not all of these had been complied with.
- The provider took prompt action in response to deregister and cease the provision of termination of pregnancy services.

Service planning and delivery to meet the needs of local people

- The rate of terminations was low. From April 2014 to March 2015 there had been four, between March 2015 and April 2016 there had been five. No termination of pregnancy had been completed during 2016 (1 January to 31 August). The date of the last surgical termination procedure at Spire Bristol was December 2015.
- There was evidence that compliance had not been met with a number of the Required Standard Operating Procedures. These were necessary to maintain the licence from the Secretary of State to provide a termination of pregnancy service at the hospital. The senior management team were informed of our findings during the inspection and took prompt actions in response to deregister and cease the provision of the termination of pregnancy services.

Access and flow

- Royal College of Obstetricians and Gynaecologists guidance (2011) recommended patients should be offered an appointment within five working days of referral and then offered an appointment within five working days of the decision to proceed with treatment. Therefore the total time from initial contact to treatment should not have exceeded 10 working days, unless the patient chose to delay the treatment. We reviewed records of the last five terminations provided at Spire Hospital Bristol. Only one procedure had been provided in excess of 10 working days and the treating consultant confirmed this had been due to patient choice.

Meeting people's individual needs

- No patient feedback specific to termination of pregnancy services was collated.

Learning from complaints and concerns

- The matron oversaw all patient concerns and complaints. We were told that none had been received regarding the termination of pregnancy service.

Are termination of pregnancy services well-led?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The report is limited as there was insufficient evidence and a very small number of procedures carried out at the hospital.

- The termination of pregnancy service was provided within the general surgical services. There was no explicit vison or strategy.
- There were minimal governance and scrutiny processes in place to review and manage potential risks and quality issues.
- We were told the Department of Health were sent notifications of treatments as required in a timely matter.

Vision and strategy for this this core service

- There was no specific vision and strategy. The termination of pregnancy service had been provided as part of the wider surgical service.

Termination of pregnancy

Governance, risk management and quality measurement for this core service

- There was minimal governance and scrutiny processes in place to maintain oversight and management of any potential risks and quality measures for the termination of pregnancy services.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination had been met. We looked at five patient records and saw two doctors had reviewed the patient's history and grounds on which they were seeking a termination.
- An Abortion Notification (HSA4 Form) was forwarded as required to the Department of Health (DH) as was legally required and in a timely way. We were told by a senior nurse that the last five HSA1 forms had been completed and sent to the Department of Health as required.

Outstanding practice and areas for improvement

Outstanding practice

- The weekly multidisciplinary resource meetings, which involved managing patient risk, staffing and proactive planning for admission and discharge to ensure effective use of resources.
- The provider had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Senior leadership approach to engaging and empowering staff was outstanding. As was the leadership focus on patients and the quality of care delivered. Both staff and the senior management team were resoundingly complimentary of each other's practices, commitment and ethos towards a shared goal.
- The physiotherapy team consistently went above and beyond their responsibilities in making sure NHS patients did not suffer adverse recovery due to a delay in receiving NHS physiotherapy.
- A new induction for outpatient staff had been developed in conjunction with staff and was tailored to suit their individual needs.
- In the children and young people's service, nursing staff had two different coloured uniforms, bright pink or blue, and would ask older patients how they would like to be treated, as a child, teenager or adult and would therefore change their nursing uniforms to suit the patient.

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that all patient records are accurate and fully completed records and ensure all surgeons record consent for medical photography and keep copies of photographs in the single patient record. The hospital must continue with its project to create a single clinical record across the hospital and reduce the need for separate inpatient and outpatient medical notes as quickly as possible.
- The diagnostic imaging department must make sure that the WHO surgical safety checklists for interventional radiology are fully completed for every patient and every procedure.

Action the provider SHOULD take to improve

- The hospital should consider implementing audit work in sepsis recognition and treatment.
- The hospital should consider the removal of the carpets in corridors where patients and staff have access.
- The hospital should ensure systems are in place to benchmark and compare patient outcomes with other similar critical care units.
- The hospital should take steps to ensure the internet provided has suitable measures in place to protect children and young people accessing inappropriate content.
- The diagnostic imaging department should ensure that they clearly document asking women of child bearing age about the possibility of them being pregnant before radiological procedures taking place.
- The diagnostic imaging department should work closely with the consultant staff to improve the compliance with the proper completion of imaging request forms.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— A. assessing the risks to the health and safety of service users of receiving the care or treatment; B. doing all that is reasonably practicable to mitigate any such risks; **The hospital did not have a single clinical record across inpatient and outpatients.** **The diagnostic imaging department could not evidence that the World Health Organisation surgical safety checklists for interventional radiology were being fully completed for every patient and every procedure.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Regulation 17 Good** **Governance** **17(1).Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** **17(2).Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—**

This section is primarily information for the provider

Requirement notices

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

Patients' records were not always complete so we could not be assured that assessments, care and treatment had taken place. Consent for and storage of medical photography did not always support the confidentiality of the people using the service and we could not be assured they were held securely.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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