Spire Manchester Hospital

Quality Report

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Date of inspection visit: 13 to 14 September 2016
Date of publication: 22/03/2017

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Manchester Hospital is operated by Spire Healthcare Plc. and originally opened in June 1981 as Bupa Manchester. The hospital was renamed in 2007 when the hospital arm of Bupa was sold to Spire Healthcare. The Spire Manchester Hospital treats both NHS funded patients and patients who wish to pay for their own treatment.

The Hospital is located in Whalley Range, Manchester and it has 49 patient bedrooms, four theatres (two of which are laminar flow), a separate endoscopy room and a CE (European conformity) accredited Sterile Services department.

There are imaging facilities on site, which include a 16 slice computed tomography (CT) scanner, 1.5T Magnetic resonance imaging (MRI) scanner, a Fluoroscopy room, ultrasound and mammography. There is also a physiotherapy department, a complete patient gym with rehabilitation equipment, including an anti-gravity treadmill. The outpatient department has 18 consulting rooms in the main hospital, minor treatment rooms and two specially adapted consulting areas for bariatric patients. The hospital is also an International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) accredited weight loss centre.

Specialities undertaken at the hospital include: Cardiology and Chest medicine, Cosmetic Surgery, Dermatology, ENT, Endocrinology, Gastroenterology, General Medicine, General Surgery, Gynaecology, Neurology, Ophthalmology, Oral and Maxillofacial surgery, Orthopaedics, Paediatric Medicine and Surgery, Pain Management, Plastic/Cosmetic Surgery, Psychiatry, Rheumatology, Urology and Weight Loss Surgery. The hospital also has a satellite clinic in Hale, with four consulting rooms and a minor treatment room.

Chris Chadwick became registered manager in November 2012 and the accountable officer for controlled drugs for the Spire Manchester Hospital is Dawn Davies.

The majority of the consultants are from local NHS trust and have all been given practice and privilege rights at the hospital. The hospitals main activity comes from general surgical procedures and outpatient diagnostics imaging services. The hospital reported 6,470 inpatient and day case episodes of care in the reporting period (April 2015 to March 2016); of these 33% were NHS funded and 67% were funded privately. The hospital operates Monday to Saturday, also offering evening appointments.

We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out an announced inspection visit on 13 and 14 September 2016 and an unannounced inspection on 26 September 2016.

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

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

Spire Manchester Hospital has previously been inspected by the Care Quality Commission on 22 May 2014. The Care Quality Commission inspected against five core standards and found the hospital to be compliant.

Spire Manchester Hospital is operated by Spire Healthcare Limited, Spire Manchester Hospital is registered to provide the following regulated activities:

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

Summary of findings

We inspected the core services of Surgery, Services for Children and Young People and the Outpatients and Diagnostics service.

We rated this hospital/service as requires Improvement overall. Our key findings were as follows:

- Equipment was maintained and appropriately checked, but in some areas was not always visibly clean.
- In theatres, there were inconsistencies in the recording of the administration and destruction of controlled drugs in all of the controlled drug registers we reviewed.
- We found there were numerous missing signatures and times for administration of controlled drugs were not, or not accurately, recorded. Failures to record the amount of the medication administered or destroyed, indicated that these medications were unaccounted for.
- Medications, including controlled drugs, were observed being drawn up prior to the operation and prior to the patient arriving in the anaesthetic room.
- Staffing levels were sufficient to meet patients' needs and staff assessed and responded to patient risks in theatres and the outpatients and imaging department. However, care and treatment was not always provided by suitably trained, competent staff. For example nurses caring for children did not have the appropriate paediatric competencies.
- Patients did not always receive care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges. Surgery services participated in national audits.
- There were governance structures in place, which included a risk register. We saw that not all risks had been identified and actions were not always taken to mitigate the risks in a number of areas that included controlled drugs in theatres.

However

- The hospital had systems in place for reporting risk and safeguarding patients from abuse.
- Medical equipment was checked and maintained by an independent company. We saw records to confirm that electrical equipment had been tested across all areas.
- There was sufficient capacity in the ward and theatres, so patients could be seen promptly and receive the right level of care before and after surgery.
- Patients were given information about how to make a complaint. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- Staff treated patients with dignity and respect and patients were kept involved in their care. Patients and their relatives we spoke with told us they were supported by staff. We observed staff deliver care in a caring, compassionate and supportive way.
- All staff were dedicated to delivering good, compassionate care and were motivated to work at the hospital.
- Patient records were stored securely at the hospital and access was limited to those individuals who needed to use them. This ensured that patient confidentiality was maintained at all times.
- Patients had a choice of appointments available to them through the 'Choose and Book' service. This meant that patients were able to attend appointments at a time best suited to their needs.
- Robust systems were in place to ensure that consultants holding practising privileges were valid to practice. We saw there were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).
- Staff that worked at the hospital felt appreciated and valued, they discussed with us the different ways Spire recognised staff for their hard work.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with a requirement notice that affected surgical services and children and young people services. Details are at the end of the report.

Summary of findings

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	We rated surgery as requires improvement in the safe and well-led domains, although effectiveness, caring and responsive was good. • Staff assessed and responded to patient risks and used recognised assessments. However the surgical safety checklist was not always fully completed. • Staff did not always cleanse their hands after touching patient surroundings. Equipment stored on corridors in theatres, such as trolleys, was dusty, whilst this equipment was labelled with an '"I am clean" sign. Oxygen cylinders had been stored outside and dirt from the base of the cylinders had been transferred onto patient trolleys. • Incidents in relation to recording controlled drugs and omissions or errors were under reported in theatres. There were widespread omissions and poor recording of controlled drugs in record books in theatre. Staff reported that there was consultant resistance to complete the controlled drug registers. We found no evidence of actions taken to address this prior to the inspection; action was only taken when the inspection team raised concerns. This issue had not been raised at the medical advisory committee. • Medications, including controlled drugs, were observed being drawn up prior to the operation and prior to the patient arriving in the anaesthetic room and this practice was confirmed by theatre staff; we observed an anaesthetist drawing up controlled drugs and documenting this in the controlled drugs register prior to the patient's arrival in the anaesthetic room. However, when the order of the theatre list was changed, the entries in the controlled drugs register were crossed through and the name of the patient amended.

Summary of findings

- Audits to monitor patient safety did not always detail what actions were required to improve patient care and safety
- The most recent audit of the surgical safety checklist showed 88% compliance with documentation and 73% compliance on the observational audit. The outcome of the audit did not identify appropriate actions or sufficient measures to address the shortfall in compliance. There had been no previous audit of compliance with this checklist.
- We reviewed nine sets of records and saw that in all cases, documentation was incomplete and not in line with best practice for record keeping. In theatre records staff were identified by their first name only and there was no clear record of which staff member had undertaken what role during surgery.
- There was no locally agreed policy or risk assessment in place to support the use of scrub staff carrying out a dual role in theatre.
- Not all risks on the risk register had action due dates or details of who was responsible for completing the actions identified for wards and theatre departments. This meant that there was a risk of ineffective monitoring of actions taken to reduce risk.

However,

- There were systems in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.
- Staff were kind, caring and compassionate and high numbers of patients would recommend the hospital to their friends and family.
- Patients had access to treatment in a timely way. Staff recognised and understood the importance of individual patients' needs.
- Staff responded to patient risk appropriately. Early warning scores and risk assessments were completed and escalated in line with guidance. Clear systems were in place to manage the care of deteriorating patients. Staff had access to resident medical officers and consultants, 24 hours a day.

Summary of findings

- Patients received care from sufficient numbers of well-trained staff. There were sufficient numbers of suitably qualified staff to care for patients and they worked well as part of a team.
- Nursing staffing levels met the needs of patients. There was adequate access to a resident medical officer and access to consultant surgeons, physicians or intensivists if required.
- Systems were in place to ensure the competence and compliance of consultants operating under practising privileges. .
- Care and treatment was delivered in line with national guidance and best practice. Hospital policies and pathways reflected evidence based care and treatment.
- The hospital participated in a number of national audits of patient outcomes including patient reported outcome measures.
- Staff were supported to develop their skills through additional training. All clinical staff in surgical services had completed an annual appraisal.
- There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- The Medical Advisory Committee (MAC) provided clinical scrutiny in relation to evidence based care and treatment. If consultants wanted to introduce new treatment methods or procedures, the evidence and guidelines for these procedures were reviewed by the MAC and approved if this was appropriate. Minutes we reviewed showed that the MAC refused permission to carry out procedures where there was insufficient evidence to support the use of the procedures.
- There was a positive, open and honest culture. Staff described leaders as approachable and they were happy to work at the hospital. Staff and the public were involved in developments and service improvement initiatives.

Summary of findings

- The hospital's vision and values had been cascaded across the surgical services and staff had an understanding of what these involved. There was clearly visible leadership within the services.

Services for children and young people

We gave the services for children and young people at Spire Manchester Hospital an overall rating of requires Improvement. This was because:

- When incidents required more detailed investigation, which applied to 2/21 of the incidents that had occurred from September 2015 – August 2016, there was variability in the quality of the investigations. One case was appropriately investigated but the other did not identify all the issues that required addressing to ensure learning and prevention of further incidents.
- Nurse staffing did not fully meet national guidance. We found there was only one children's nurse on duty when children were taken to theatre, meaning that paediatric patients were left with adults' nurses who did not have the appropriate paediatric competencies.
- Not all theatre staff were trained in accordance with standards outlined in national guidance; 56.5% of theatre staff were not up to date with paediatric competencies and 33.3% of staff recovering children post-operatively had not completed their advanced paediatric life support (APLS) training.
- Paediatric records completion was not consistently in accordance with best practice. Audits had recently been introduced in the hospital, but action plans to address findings from audits were not embedded at the time of our inspection. The service measured some patient outcomes using the paediatric scorecard, which had been recently introduced at the hospital. However, there was no standard dataset across Spire hospitals for effective benchmarking within the Spire group. The service told us this was being developed corporately, but no implementation date was provided. There were no child-friendly

Requires improvement

Summary of findings

consulting rooms and limited provision for children in outpatients, for example toys and seating. In one of two pre-assessment clinics that were being undertaken, the patients were seen for their observations from the children's playroom for inpatients.

- Children waited alongside adults for their outpatient appointments and were nursed on adult wards.
- Risks that affected the paediatric service were not all recorded on the provider's risk register.
- Whilst a gap analysis had gone some way to assist the provider in achieving its strategy, the analysis undertaken was not comprehensive and omitted immediate risks to patients' safety.

However,

- Systems and processes were in place to safeguard children and young people.
- Duty of candour, a regulatory duty that relates to openness and transparency, was understood and correctly applied by staff.
- Policies and procedures were in place that were in accordance with best practice and national guidance. For example staff applied the "Child day-case/overnight stay care pathways" for children and young people undergoing elective surgery.
- The services available to children and young people were planned according to service demand. The hospital offered good access for children and young peoples' routine operations. Outpatient clinics were available in the evening, as well as during the day.
- Parents spoke very highly of the caring and compassionate nature of staff. Children and young people were involved in their care and were aware of their treatment options.
- We found that consultants holding practising privileges for children had been assessed as holding the relevant skills and experience.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging good overall. This was because:

Summary of findings

- There were systems in place for reporting risk and safeguarding patients from abuse. Staff were aware of how to report incidents that took place in the departments and we saw evidence of incidents being investigated and learning being shared within the team.
- From observations we saw that equipment was maintained, appropriately checked and visibly clean. Medical equipment was checked and maintained by an independent company.
- Clinical areas and waiting rooms were all visibly clean and tidy. Patient records were stored securely and were only accessible by those authorised to do so. This ensured that patient confidentiality was maintained at all times.
- The departments used evidence based guidance to inform their practice.
- Patients and their relatives we spoke with told us they were supported by staff that were caring, empathetic and helpful to their needs. Patients were positive about how they were treated by staff. Staff maintained patient privacy and dignity across the departments and provided emotional support to patients.
- Patients were kept well informed about the treatment they were receiving in the hospital.
- Services were planned and delivered to meet the needs of patients. The hospital offered a wide range of services, which were planned and delivered in a way which met the needs of local people. Patients told us there was good access to appointments and flexibility to attend appointments at times that suited their needs.
- All staff told us that managers of the service were available and supportive. Staff were positive about the culture within their departments and said the senior management team were visible and approachable.

However,

- The hospital did not hold a full medical record for insured and self-paying patients using the outpatient department. Although it did have a process for requesting all records needed.

Summary of findings

- Not every non-emergency patient having a CT scan involving an iodinated contrast agent had their kidney function tested prior to their scan, which is a recommendation of Royal College of Radiologist guidelines.
- On one occasion during the inspection we found patients standing in the waiting area as there were not enough seats in the outpatient department waiting area to always accommodate all of the patients waiting for appointments.

Summary of findings

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Requires improvement

Spire Manchester Hospital

Services we looked at

Surgery; Services for children and young people; Outpatients and diagnostic imaging; Diagnostic Imaging and Endoscopy Services

Summary of this inspection

Background to Spire Manchester Hospital

Spire Manchester Hospital is operated by Spire Healthcare Plc. and originally opened in June 1981 as Bupa Manchester. The hospital was renamed in 2007 when the hospital arm of Bupa was sold to Spire Healthcare. The Spire Manchester Hospital treats both NHS funded patients and patients who wish to pay for their own treatment.

The Hospital is located in Whalley Range, Manchester and it has 49 patient bedrooms, four theatres (two of which are laminar flow), a separate endoscopy room and a CE (European conformity) accredited Sterile Services department.

Chris Chadwick became registered manager in November 2012 and the accountable officer for controlled drugs for the Spire Manchester Hospital is Dawn Davies.

Specialities undertaken at the hospital include: Cardiology and Chest medicine, Cosmetic Surgery, Dermatology, ENT, Endocrinology, Gastroenterology, General Medicine, General Surgery, Gynaecology, Neurology, Ophthalmology, Oral and Maxillofacial surgery, Orthopaedics, Paediatric Medicine and Surgery, Pain Management, Plastic/Cosmetic Surgery, Psychiatry, Rheumatology, Urology and Weight Loss Surgery. The hospital also has a satellite clinic in Hale, with four consulting rooms and a minor treatment room.

Our inspection team

The inspection was led by CQC inspector, who lsupported by other CQC inspectors, a specialist advisor with expertise in governance, a theatre nurse, a senior nurse manager, a paediatric nurse and a diagnostic radiographer. The inspection team was overseen by Inspection Manager.

Why we carried out this inspection

We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out an announced inspection visit on 13 and 14 September 2016 and an unannounced inspection on 26 September 2016.

How we carried out this inspection

Before visiting the hospital, we reviewed a range of information we held about the hospital and

each core service. We carried out an announced inspection visit at the main hospital site on 13 and 14 September 2016 and an unannounced inspection on 26 September 2016. We did not visit the satellite clinic in Hale as it was not being used at the time of the inspection.

We spoke with a range of staff across the hospital, both individually and as part of a focus group, including the registered manager, nurses, consultants, administrative, ancillary and clerical staff.

During our inspection we reviewed services provided by Spire Manchester Hospital on the ward, operating theatres,Outpatients and imaging departments. We did not visit the satellite site in Hale because at the time of the inspection we were informed that the four consulting rooms were not being used.

Summary of this inspection

During our inspection we spoke with patients and staff, including a consultant surgeon who was chair of the Medical Advisory Committee [MAC]. We also spoke with family members/carers across 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. We also reviewed data provided by the hospital and local commissioners of the service.

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 Manchester Hospital

We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out an announced inspection visit on 13 and 14 September 2016 and an unannounced inspection on 26 September 2016.

Spire Manchester Hospital has previously been inspected by the Care Quality Commission on 22 May 2014. The Care Quality Commission inspected against five core standards and found the hospital to be compliant.

The Spire Manchester Hospital has onsite pathology unit, diagnostic imaging services and is accredited IFSO weight loss centre. The hospital reported 6,470 inpatient stays, of which 25% were overnight stays funded by the NHS and 33% were funded privately in the reporting period of April 2015 – March 2016. In the same reporting period there were 54,187 outpatient total attendances, of which 22% were NHS funded and 78% were other funded. The hospital reported that of all patient groups, 87% of patients who visited as an inpatient or outpatient were between the ages of 18-74 year olds. This was reported as their largest group of patients.

The main surgical procedures undertaken at the hospital include endoscopic resection of semilunar cartilage, injection of therapeutic substances into joint and cholecystectomy. Between the reporting period of January 2016 and March 2016 there were 1551 theatre visits.

Overall the hospital reported 484 clinical incidents between April 2015-March 2016; of which 82% related to surgery. There were no reported incidents of MRSA, MSSA or Cdiff bacteraemia between the same reporting period and one case of E-Coli bacteraemia was noted between October 2015-January 2016.

All patients are directly admitted and treated under a consultant. The medical care is supported 24 hours a day, seven days a week by an onsite resident medical officer (RMO.) Patients are cared for and supported by registered nurses, care assistants, allied health professionals, such as physiotherapists and pharmacists, who are all employed by the Spire Manchester hospital. Doctors have practising privileges and their individual activity is monitored.

Services accredited by a national body:

- Accredited MRI unit
- BUPA accredited breast centre
- CPA accredited pathology
- International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO)
- Registered Pharmacy
- Sterile Services ISO 13485 2003 EN 13485:2012.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- In theatres, there was a widespread inconsistency in the recording of the administration and destruction of controlled drugs, in all of the controlled drug registers we reviewed.
- We found there were numerous missing signatures in respect of the first practitioner's signature and the second witness' signature required for the appropriate administration and destruction of controlled drugs. Times for administration of controlled drugs were not, or not accurately, recorded. We also noted failures to record the amount of the medication administered or destroyed in the controlled drugs registers which meant that medications may be unaccounted for. Furthermore, we saw a number of other errors that included the absence of dates or recording of incorrect dates.
- Medications, including controlled drugs, were observed being drawn up prior to the operation and prior to the patient arriving in the anaesthetic room and this practice was confirmed by theatre staff. When the order of the theatre list was changed, the entries in the controlled drugs register were crossed through and the name of the patient amended.
- Staffing levels and skills mix was sufficient to meet patients' needs in theatres and outpatient department. We raised concerns regarding the competencies of adult nurses caring for paediatric patients during the pre-assessment appointment. We found that paediatric nurses did not have the right skills to perform some of the pre-assessment tests, for example paediatric nurses had not been trained in scoliosis lung function tests, ECG reading or venepuncture.

However,

- There were processes in place to report, investigate and monitor incidents. Staff had access to systems to keep people safe and knew what constituted as a clinical incident and safeguarding concern.
- Surgical procedures were performed by a team of consultant surgeons and anaesthetists, who were mainly employed by other organisations, such as the NHS. Surgeons and anaesthetists were in substantive posts and had practising privileges.
- All staff were aware of their responsibilities relating to the duty of candour legislation and were able to give us examples of

when this had been implemented. The hospital had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. The legislation was also incorporated in the complaints policy to ensure staff exercised their responsibility to inform patients of an incident.

- Staff used assessment tools to examine patients; they routinely assessed and responded to patients' risks.
- Equipment was maintained, appropriately checked and visibly clean across areas inspected, except for the theatres. Medical equipment was checked and maintained by an independent company.
- Patient records were stored securely and access was limited to those who needed to use them.
- Resident registered medical officers [RMOs] were employed to provide medical cover when the named consultant was not available. We reviewed documentation that confirmed the hospital checked that doctors were able to practice within scope.

Are services effective?

Good

We rated effective as good because:

- Staff delivered care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- Spire corporate policies, based on National Institute for Health and Care Excellence (NICE) and national and royal college guidelines were available to all staff on the intranet.
- Any new policies or amendments to existing policies were reviewed and signed off by the Medical Advisory Committee prior to implementation.
- Patients were offered appropriate pain relief post operatively.
- There was a system in place to review practising privileges. We saw there were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).
- Appropriate systems were in place to obtain consent from patients. Consent was sought from patients prior to delivering care and treatment across all areas we visited.
- Staff were aware of what actions to take if a patient lacked the capacity to make their own decisions.

However,

- Patient outcomes were generally routinely monitored through audits to ensure that practice was in line with current guidelines.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Patients and carers spoke positively about the care and treatment staff delivered. Staff treated patients with dignity and respect and kept them involved in their care plan.
- Feedback from patients who used the service was consistently positive about the way they were treated and cared for. In the 2015 patient survey, 99% of patients said they were treated with dignity and respect.
- All of the patients we spoke with during our visit told us that they had been treated exceptionally well by staff. This was also reported in the 2015 patient survey: 99% of patient said they received care and attention from nursing staff.
- We observed that staff were sensitive and understanding of the emotional impact of care and treatment. Staff told us that they put the needs of patients first.
- Patients we spoke with said that staff always introduced themselves and made them feel that they were involved.
- NHS patients were asked to complete the friends and family test: 99% of patients between October 2015 – March 2016 said they would recommend the hospital. The hospital achieved a 57% response rate both results are above the national England average.

Are services responsive?

Good

We rated responsive as good because:

- Patient needs were assessed to clearly identify the patient's treatment pathway.
- The service worked to clear inclusion and exclusion criteria and did not accept patients with certain underlying medical conditions. Daily planning by staff ensured patients were admitted and discharged in a timely manner.
- Patients were able to access services in a timely manner and the service was performing within the recommended target timeframe.
- If a patient had complex needs and was identified as high risk, they were referred to a local NHS trust to make sure all their needs were met appropriately.
- There was sufficient capacity in theatres, so patients could be seen promptly and receive the right level of care before and after surgery.

Summary of this inspection

- Cultural needs of patients were taken into account when planning and delivering services. For example, patients attending the wards were asked about their religious beliefs and dietary requirements, in case these affected their treatment options or meal preferences.
- Staff had access to translation services for those patients whose first language was not English and information was available to patients in differing formats if required.
- Systems were in place to support vulnerable patients. Patients were given information about how to complain and raise concerns and the service responded to complaints. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a corporate governance committee structure in place that captured and discussed identified risks. The framework also enabled the dissemination of learning and service improvements and a pathway for reporting and escalation to the Spire board.
- The hospital's vision and values had been cascaded across the services and staff had an understanding of what these involved.
- All staff were dedicated to delivering good, compassionate care and were motivated to work at the hospital.
- Staff across the departments spoke positively about the leaders and the culture within the services.
- There was clearly visible leadership within the services; staff spoke positively about the culture and the level of support they received.
- We observed well-defined leadership roles within the areas we visited; we noted that staff were supportive of each other and managers operated an open door policy. All the staff we spoke with spoke highly of the senior management team and colleagues.
- The Medical Advisory Committee (MAC) was well attended and was monitored by the hospital. The MAC provided advice to the hospital director on any matter relating to the proper safe, efficient and ethical medical and dental use of the hospital. This included any satellite site where members of the medical society were undertaking or supervising the delivery of healthcare services.

Summary of this inspection

- There was a system in place to review practising privileges. We reviewed employee information that showed the service had followed the 'fit and proper person' regulations.
- We observed NHS patients receive the same level of care as private, self-paying and insured patients.
- Prior to admission, the hospital sent information packs with appointment letters to patients, which gave clear instruction about cost and payment. Patients received costing information to make sure that patients were fully aware of any costs involved.

However,

- Although a quality assurance framework was in place, it failed to provide senior management with oversight of hospital activity. The hospital identified further refinements were required, for example with regards to drugs and therapeutic management.
- The hospital strategic direction was well described by the senior management team and it was clear that the management team were committed to improving governance processes, but systems were not yet embedded and further work was still required.
- The local governance arrangements did not ensure the identification, mitigation and monitoring of risks. We were not assured that the senior management team had a full understanding and grip of the potential risks within the service and the supporting clinical governance arrangements.
- We were not assured that the senior management team took sufficient actions to address shortfalls identified through audit. For example, a corporate controlled drugs (CD) quarterly audit showed significant issues in the management of CD's in the theatre areas for both quarter 1 and 2 of 2016. We found no evidence of action taken to address the gaps identified, despite a picture of worsening compliance in the theatre areas between quarter 1 and 2. We reviewed the governance meeting minutes held bimonthly and noted that the pharmacy manager did not attend this meeting for a number of months and there was no mention of the issues raised in the audits.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Requires improvement

Surgery

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

Summary of findings

We rated surgery as requires improvement in the safe and well-led domains, although effectiveness, caring and responsive was good.

- Staff assessed and responded to patient risks and used recognised assessments. However the surgical safety checklist was not always fully completed.
- Staff did not always cleanse their hands after touching patient surroundings. Equipment stored on corridors in theatres, such as trolleys, was dusty, whilst this equipment was labelled with an '"I am clean" sign. Oxygen cylinders had been stored outside and dirt from the base of the cylinders had been transferred onto patient trolleys.
- Incidents in relation to recording controlled drugs and omissions or errors were under reported in theatres. There were widespread omissions and poor recording of controlled drugs in record books in theatre. Staff reported that there was consultant resistance to complete the controlled drug registers. We found no evidence of actions taken to address this prior to the inspection; action was only taken when the inspection team raised concerns. This issue had not been raised at the medical advisory committee.
- Medications, including controlled drugs, were observed being drawn up prior to the operation and prior to the patient arriving in the anaesthetic room and this practice was confirmed by theatre staff; we observed an anaesthetist drawing up controlled drugs and documenting this in the controlled drugs register prior to the patient's arrival in the anaesthetic room. However, when the order of the theatre list was changed, the entries in the controlled drugs register were crossed through and the name of the patient amended.
- Audits to monitor patient safety did not always detail what actions were required to improve patient care and safety
- The most recent audit of the surgical safety checklist showed 88% compliance with documentation and 73% compliance on the observational audit. The outcome of the audit did not identify appropriate actions or sufficient measures to address the shortfall in compliance. There had been no previous audit of compliance with this checklist.
- We reviewed nine sets of records and saw that in all cases, documentation was incomplete and not in line with best practice for record keeping. In theatre records staff were identified by their first name only and there was no clear record of which staff member had undertaken what role during surgery.
- There was no locally agreed policy or risk assessment in place to support the use of scrub staff carrying out a dual role in theatre.
- Not all risks on the risk register had action due dates or details of who was responsible for completing the actions identified for wards and theatre departments. This meant that there was a risk of ineffective monitoring of actions taken to reduce risk.

However,

- There were systems in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.

Requires improvement

Surgery

- Staff were kind, caring and compassionate and high numbers of patients would recommend the hospital to their friends and family.
- Patients had access to treatment in a timely way. Staff recognised and understood the importance of individual patients' needs.
- Staff responded to patient risk appropriately. Early warning scores and risk assessments were completed and escalated in line with guidance. Clear systems were in place to manage the care of deteriorating patients. Staff had access to resident medical officers and consultants, 24 hours a day.
- Patients received care from sufficient numbers of well-trained staff. There were sufficient numbers of suitably qualified staff to care for patients and they worked well as part of a team.
- Nursing staffing levels met the needs of patients. There was adequate access to a resident medical officer and access to consultant surgeons, physicians or intensivists if required.
- Systems were in place to ensure the competence and compliance of consultants operating under practising privileges. .
- Care and treatment was delivered in line with national guidance and best practice. Hospital policies and pathways reflected evidence based care and treatment.
- The hospital participated in a number of national audits of patient outcomes including patient reported outcome measures.
- Staff were supported to develop their skills through additional training. All clinical staff in surgical services had completed an annual appraisal.
- There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- The Medical Advisory Committee (MAC) provided clinical scrutiny in relation to evidence based care and treatment. If consultants wanted to introduce new treatment methods or procedures, the evidence and guidelines for these procedures were reviewed by the MAC and approved if this was appropriate. Minutes we reviewed showed that the MAC refused permission to carry out procedures where there was insufficient evidence to support the use of the procedures.
- There was a positive, open and honest culture. Staff described leaders as approachable and they were happy to work at the hospital. Staff and the public were involved in developments and service improvement initiatives.
- The hospital's vision and values had been cascaded across the surgical services and staff had an understanding of what these involved. There was clearly visible leadership within the services.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- Incidents were reported electronically. There were 395 clinical incidents reported for surgery at the hospital between April 2015 and March 2016. This accounted for 82% of all incidents at the hospital. The rate of incidents for surgery is higher than other independent acute hospitals CQC hold this data for. However, the majority of incidents were graded as no or low harm, indicating a good reporting culture.
- There had been no never events at the hospital between April 2015 and March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented.
- There had been two deaths at the hospital between April 2015 and March 2016, one of which was unexpected although this was investigated found to be an unavoidable death.
- Staff felt able to use the incident reporting system and told us that they were confident in reporting any incidents.
- All staff told us that they received feedback from their line managers about incidents which they reported. Although not all could give us examples of incidents which they had learned from.
- Themes and trends in incidents were monitored by the ward managers, matron and hospital director. This information was collated and shared at team meetings and senior management briefings and reviews.
- During our inspection we found numerous incidents of unsafe practices in relation to documentation of controlled drugs and none of these had been reported through the incident reporting system. This meant there was a lost opportunity to monitor themes and trends in relation to medicines incidents.
- Serious incidents, including deaths were investigated using a root cause analysis (RCA) model. Staff told us they were involved in this process and felt comfortable with it. We saw that RCAs identified key actions required to prevent a similar incident occurring in the future. For example, following the death of a patient after transfer to an NHS hospital, there had been an update to the high dependency policy to improve processes for review by all medical specialities involved in the care of complex patients.
- A monthly safety and lessons learnt bulletin was issued corporately. The hospital had identified that sharing of learning from incidents could be better communicated and were actively looking at ways to improve this, for example increasing staff engagement in the preparation of materials to share learning.
- Most staff understood the duty of candour and were able to give examples of when they would apply this. We saw that the hospital had taken the appropriate steps as set out in the regulation following an incident of a patient death. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Some staff had not heard the term 'duty of candour' before, but understood the importance of being open and honest.

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

- The hospital used a safety thermometer to measure, monitor and analyse patient harm and 'harm free' care for NHS patients. The thermometer covered areas such as falls, venous thromboembolism (VTE) and catheter associated urinary tract infection. In the six months before our inspection, the inpatient ward had achieved 100% harm free care. Safety thermometer results were displayed on patient information screens.
- There had been one incident of a hospital acquired pressure ulcer, which had developed in theatre. A full root cause analysis investigation was undertaken and showed that despite all the available preventative measures being taken, such as a gel mat and spinal foam, the patient still developed a pressure ulcer.

Cleanliness, infection control and hygiene

- There had been eight surgical site infections at the hospital between April 2015 and March 2016. The rate of infections was above the average of NHS hospitals during this time period. There had been one incident of E-coli infection at the hospital between April 2015 and March 2016.

- During the inspection, we saw staff cleaning pieces of equipment in between patient contacts in theatre and on the ward. Equipment was then labelled with green 'I am clean' stickers on the wards, to enable staff to identify that equipment was ready for use.
- However, equipment stored on corridors in theatres, such as trolleys, was dusty, even though this equipment was labelled with printed "I am clean" signs. Oxygen cylinders had been stored outside and dirt from the base of the cylinders had been transferred onto patient trolleys, which were then transported through theatre. This was despite a theatre porters' daily checklist that expected trolleys to be cleaned underneath including oxygen cylinders. We raised our concerns about the cleanliness of trolleys in theatres during the inspection and saw that the hospital implemented a new checklist with additional prompts for the cleaning of theatre trolleys including oxygen cylinders.
- We saw that the crash trolley, defibrillator and anaphylaxis boxes on Malory Ward were dusty. Twenty patient rooms had carpeted floors. A risk assessment had been completed and plans were in place to reduce the risk of the spread of infection including scheduled three monthly and 'as required' deep cleans. All rooms in the new hospital were planned to have sealed vinyl flooring.
- There was no access to hand washing sinks for patients, visitors and staff when entering wards. Alcohol gel was available.
- The hospital carried out a six monthly audit of hand hygiene in all departments, by measuring how much hand sanitiser had been used. However, weighing hand sanitiser before and after the audit period did not demonstrate that staff were following hand hygiene principles. The hospital told us it was trialling an observational audit tool before the end of 2016.
- Patients were screened for the presence of infections such as methicillin resistant staphylococcus aureus (MRSA) and carbapenemase-producing enterobacteriaceae (CPE) during pre-operative assessments or on admission.
- Staff were aware of current infection prevention and control guidelines and were able to give us examples of how they would apply these principles. However, we saw that staff did not always cleanse their hands after touching patient surroundings. On one occasion, we observed a member of staff return a patient to the ward from theatre, put used theatre disposables in a clinical waste bin, leave the ward and returned back into theatre without washing their hands at any point.
- The number of staff with up to date infection prevention and control training was 83.3%. The hospital was on track to meet the target of 95% by the end of the mandatory training cycle.
- All staff followed 'bare below the elbow' guidance. Staff followed procedures for gowning and scrubbing in the theatre areas.
- Sharps containers were dated and signed when assembled, however, we saw that the temporary closure was not used when sharps containers were not in use.
- Personal protective equipment (PPE), such as gloves and aprons was stored inside patient rooms on Malory and Austin Wards. There was also a portable storage centre containing PPE that could be moved outside a patient room when barrier nursing was indicated, to ensure staff had access to this equipment before entering the room.
- We saw staff cleaning equipment in between patient contacts. Equipment was then labelled with green 'I am clean' stickers on the wards, to enable staff to identify that equipment was ready for use.
- The Patient Led Assessment of the Environment (PLACE) is a measure of the care environment in hospitals which provide NHS care. The assessments see local people visit the hospital and look at different aspects of the care environment. PLACE scores at Spire Manchester between February and June 2016 for cleanliness were 97.8% which was just below as the England average of 98.1% for independent acute hospitals.

Environment and equipment

- The environment in theatre and on the wards was tidy and clutter free. Staff told us they had easy access to the equipment they needed to care for patients. This included access to specialist bariatric equipment when required.
- Daily checks were undertaken of essential equipment such as defibrillators in all areas. The contents of adult crash trolleys and paediatric resuscitation bags was checked once per month and then sealed with numbered tags to allow staff to identify if the contents of the trolley had been tampered with. The tag number was checked daily.

- Electrical safety testing was up to date for all electrical equipment we reviewed. Equipment had been serviced and maintained.
- Used linen and bags of clinical waste were stored on the floor in the sluice on Malory Ward. This was both a fire risk and a risk to the spread of infection. We highlighted this to the provider and when we returned for our unannounced inspection we saw that this practice continued although there were fewer bags. The hospital told us a suitable trolley had been ordered and the porter's rounds to collect linen and waste bags had been increased.
- PLACE scores for privacy and dignity were higher than the England average for independent acute hospitals.

Medicines

- Prior to the inspection we had received information with regards to alleged mismanagement of controlled drugs within the hospital. These concerns related to alleged continued non-compliance by consultant anaesthetists in relation to signing, administration and destruction (SAD) record completion in the theatre controlled drug registers.
- During the inspection we reviewed one controlled drugs (CD) record book in theatre areas. This book showed wide spread omissions and issues with the recording of controlled drugs. As a result of this finding, we reviewed a total of eight CD record books across the ward areas and theatre areas. All reviews of the CD record books in theatre areas highlighted a similar picture of widespread omissions and very poor recording of controlled drugs.
- We also found errors in recording of controlled drugs on Malory Ward. However, these were historical and were reported as incidents immediately.
- When we raised our findings with the senior management team for the provider, they advised us that a number of measures would be immediately implemented to ensure correct completion of the CD books and maintain patient safety.
- We also observed on one occasion that controlled drugs were being signed out of the record book as administered before the patient had entered the anaesthetic room and had received the medication.
- We reviewed 206 entries in total across the theatre and recovery areas. We found that in 174 of these entries, there was no recorded time of administration. In 111 of 206 cases we found there was no signature present to confirm administration. In 44 cases we found that the destruction of controlled drugs was not documented or witnessed. In a further 115 entries there was no signature to state that the drug had been supplied.
- The corporate provider required that quarterly CD audits be completed. We reviewed the results of these audits, which showed a high rate of non-compliance in theatres for quarter one and two of 2016. They also showed a worsening rate of non-compliance, specifically in the administration and destruction signature areas.
- The hospital was unable to provide us with any evidence of actions taken as a result of these audits and there was no evidence in the minutes of the clinical effectiveness or governance meetings that these audit results had been discussed. Additionally, these audits had not been seen by the controlled drugs accountable officer.
- As a result of the issues we identified, the hospital senior management team formulated an action plan and took immediate remedial action. When we returned for the unannounced inspection we found that these issues had been resolved. The hospital management team had issued all doctors working in the hospital with a letter outlining the need to follow Spire processes and provided them with a copy of this policy. The hospital management team had also initiated a daily audit of all controlled drugs books and addressed any issue of noncompliance immediately. We found that 50 out 50 entries we reviewed contained all the relevant information and signatures.
- We noted that an audit of anti-biotic prescribing showed that of 50 patient records audited, 47 did not show compliance with Spire antibiotic prescribing guidelines and did not document the reason for this. The audit action plan was not robust and did not detail actions to be taken, with deadlines for completion and follow up audit. The hospital later provider us with an updated document detailing actions to be taken and plans for a follow up audit.
- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. There were appropriate arrangements in place for the destruction of unwanted and expired medicines.
- Emergency medicines and equipment were readily available and there was a procedure in place to ensure they were fit for use.

- Medicines fridges were secured and maximum and minimum temperatures had been recorded, in accordance with national guidance.
- Controlled drugs were stored appropriately in locked cupboards in line with legislation on the management of controlled drugs.
- There were appropriate processes in place for ordering medications and stock reconciliation for medications with the exception of controlled drugs.
- We observed nurses administering medications to patients and they undertook appropriate checks, including checking the patient's name, date of birth and allergy status. Allergy status was appropriately documented on the prescription chart.
- Discharge medications and prescriptions were managed well. Prescriptions for these medications were completed legibly and records for take home medications were amended accordingly. Pre-labelled take home medications were available on Malory Ward. These medications were checked by a nurse and the registered medical officer (RMO) before being dispensed to a patient. This system offered the hospital more flexibility with discharge times.

Records

- Consultant outpatient records did not form part of the hospital medical record for private patients although staff could request access to these notes in line with Spire policy. The hospital and medical advisory committee (MAC) had agreed that there should be one contemporaneous medical record, rather than an individual record held by a consultant and there was a task group working on this.
- Records audits were completed three monthly and the most recent audit in quarter two showed a high level of compliance of between 95 and 100% with documentation of VTE assessment, pain scores, early warning score and consultant documentation.
- However, we reviewed nine sets of records and saw that in all cases documentation was incomplete and not in line with best practice for record keeping. These issues included failures to document names, times, staff designation and incomplete records of care. In theatre records, staff and their role allocation were identified by first name only. In all records we reviewed, operation notes did not identify key staff members and the roles they had undertaken. In one patient record, there was no documentation of any care by the anaesthetic practitioner.
- Risk assessments were completed by nursing staff during pre-operative assessments or on admission and were included in the hospital medical record.

Safeguarding

- Staff understood their responsibilities in relation to adult safeguarding and an awareness of specific issues such as female genital mutilation (FGM). At the time of our inspection 81.9% of staff had completed level one and level two safeguarding adults. Safeguarding children level one and level two had been completed by80.4% of staff. The hospital was on target to achieve the target of 95% by the end of the cycle in December 2016.
- Staff knew how to raise a safeguarding concern and there was a folder in each area with information about how to manage safeguarding issues. They told us they were able to access the ward managers and the matron for advice on any safeguarding issues.
- There was a named nurse for adult safeguarding, who was trained to level three adult safeguarding, and represented the hospital on the local safeguarding committee. The hospital was also the representative for the independent health sector on the Greater Manchester adult safeguarding board.

Mandatory training

- Mandatory training was a mixture of face to face sessions and e-learning and covered topics such as fire safety, manual handling and safeguarding. The mandatory training cycle ran from January to December each year.
- Mandatory training rates varied by subject but were around 83.3% for ward and theatre staff. The hospital was on track to achieve the target by the end of the cycle in December 2016. Mandatory training in theatres was above the hospital target at 98.7%.

Assessing and responding to patient risk

- An early warning score system (EWS) was in use at the hospital. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. Staff carried out

monitoring in response to patients' individual needs to identify any changes in their condition quickly. In the records we reviewed, we saw that the EWS had been calculated correctly and patients had been escalated for medical review when this was indicated. Staff were aware of the procedure to follow if a patient deteriorated and there was access to a crash team in the event of a cardiac arrest.

- There was access to an on-call high dependency unit nurse and an intensivist at all times, in the event that a patient required level two care at the hospital.
- On admission and during pre-assessment, staff carried out risk assessments to identify patients at risk of specific harm, such as pressure ulcers and risk of falls. Where a risk was identified, patients were given a specific care plan to ensure they received the relevant care and treatment. In the records we reviewed, we saw that patients were placed on the pathway which related to the risks identified including pressure care.
- All patients listed for surgery were given a pre-assessment medical questionnaire to complete (PAM-Q). This was reviewed by a pre-operative assessment nurse and patients were triaged as to the level of pre-operative assessment they needed. Patients undergoing joint replacements and those with pre-existing health conditions were seen for a face to face assessment with a nurse. We saw evidence in the records we reviewed, that risks identified in the pre-operative assessment clinic were appropriately escalated to anaesthetist for review.
- Data provided by the hospital showed that 100% patients were screened for the risk of developing venous thromboembolism (VTE) between April 2015 and March 2016. The most recent audit completed in June 2016 showed that all patients had been assessed on admission; however, only 50% of patients were reassessed within 24 hours of admission, as detailed in hospital guidelines. There had been no cases of VTE or pulmonary embolism at the hospital during this time period.
- Patients were assessed for their risk of developing a venous thromboembolism (blood clot) on admission and were given treatment in line with NICE quality statement (QS) 66.
- There was a National Patient Safety Agency (NPSA) checklist in the patient pathway and additionally, a surgical safety checklist.
- Theatre staff used the World Health Organisation (WHO) surgical safety checklist. The most recent audit of this checklist in September 2016 showed 88% compliance with documentation and 73% compliance with the observational requirements of the checklist. The surgical safety checklist was introduced by WHO as a tool to improve the safety of surgery by reducing deaths and complications and therefore non-compliance with the checklist can place patients at increased risk of harm. The outcome of the audit did not identify appropriate actions or sufficient measures to address the shortfall in compliance. The plan identified that that a new measure would be addressed by the implementation of a new scheme in October or November 2016. This did not address any the immediate risk of non-compliance to patients.
- The theatre manager told us that an audit of the surgical safety checklist in 10 records was completed each month. However, when we asked to review the results of previous audits, the hospital told us there had been no previous audits of the use of this checklist. We were later told that the hospital planned to carry out a live audit of this checklist for 10 patients for the remaining months in 2016.
- The diagnostic imaging department used for interventional radiology procedures the World Health Organisation (WHO) Surgical Safety Checklist for Radiological Interventions, which aims to reduce harm during operative procedures, by using consistently applied evidence-based practice and safety checks to all patients. The department carried out its first audit of the use of the checklist in August/September 2016; we saw that this involved observing the use of the checklist and reviewing the record. The audit reported that the department was fully compliant with the checklist. The department told us the audit would be repeated but the frequency of future audits had not been decided at the time of the inspection. During the inspection we observed the checklist being used.
- The hospital had formally trained two National Safety Standards for Invasive Procedures (NatSSIPs) champions in August 2016 and it was planned that these members of staff would oversee the launch of a new policy for safe standards in the peri-operative environment. The aim of NatSSIPs is to reduce the number of patient safety incidents related to invasive procedures where never events may occur by asking

providers to review their current clinical practices. There was a Spire wide draft action plan in place for the implementation of local safety standards for invasive procedures (LoCSSIPs) which had comprehensive detail of all actions required to be taken by the hospital to ensure compliance.

- We reviewed nine records and found that in two, the surgical safety checklist had not been completed correctly, which meant patients were put at potential risk. Additionally we saw that key information about patient allergies was not recorded or had been incorrectly recorded. For example, one patient had an allergy to a certain type of antibiotic. This had been incorrectly recorded on the checklist as an allergy to a different medication. This had not been challenged by the anaesthetist during part one of the checklist, even though it had been recorded correctly elsewhere by this member of staff. On the second patient record, there was no documentation that the patient had a nut allergy. This meant that there was a risk that the patient may receive medication containing nuts resulting in an allergic reaction. This also demonstrated that the surgical safety checklist at the hospital was not embedded as a tool to improve patient safety.
- We observed a patient safety huddle at the beginning of a theatre list. We saw that any risks were highlighted with the team, such as patient allergy status or specific equipment requirements. We also observed that the order of the list was changed as a response to this huddle, as it was identified that there was a diabetic patient on the list and this would reduce the risk of fasting for this patient.
- A sepsis screening tool was available on wards and this was used in conjunction with a sepsis six care bundle. We saw a recent incident had highlighted that the implementation of the sepsis care bundle had been delayed and actions had been taken to address this in the future via a root cause analysis of the incident.
- Pre-operative assessments were completed in line with guidance issued by the National Institute for Health and Care Excellence (NICE). Following a root cause analysis completed after the death of a surgical patient, the clinical risk form used by pre-operative staff had been updated to include additional questions in relation to acute and chronic kidney disease. This form was used by pre-operative assessment staff to identify when a pre-operative assessment by an anaesthetist was required. As part of the action plan from the RCA, the hospital had identified that pre-operative assessment nurses required training in scoring the American Society of Anaesthesiologists (ASA) physical status system. This had not been implemented at the time of our inspection however the hospital was actively seeking out training courses.
- The HDU was most frequently used as an enhanced recovery facility, offering patients an additional period of recovery time post-surgery before returning to the inpatient ward. The majority of patients received level two care for one or two nights.
- In addition to input from a consultant surgeon, there was access to a consultant medical doctor if this was required pre or post operatively.
- Patients were instructed to contact the ward after discharge if they had any concerns that did not require an emergency response. There was a clear procedure for staff to follow if a patient contacted the ward with concerns to ensure staff identified the reason for the call and that appropriate action was taken.

Nursing staffing

- Staffing levels were planned on a weekly basis and were calculated using the number of surgical patients and anticipated acuity or dependency levels of the patients. This was then reviewed on a daily basis to ensure staffing levels matched the actual patient acuity and dependency. Gaps in the rota were filled by bank or agency nurses. The hospital had previously trialled a recognised acuity tool, but found it was not useful in their environment.
- We reviewed nursing rotas for the month prior to the inspection and saw that nursing staffing levels were sufficient and had been reviewed effectively to ensure they met the requirements of patients on each shift.
- Wards were generally staffed by registered nurses. Healthcare assistants were most frequently used on morning shifts to help with personal care tasks.
- The use of bank and agency nurses and health care assistants working on the wards was lower than the average of other independent acute hospitals Bank or agency workers were inducted to the ward or theatre, using an induction checklist. We saw that induction forms had been completed for two agency members of staff who had worked on the ward.
- If staffing concerns were identified, this was highlighted via the incident reporting system using a red flag. Senior

nursing staff in charge of the staffing rota told us they were able to staff the ward to the required level and that the senior management team supported their decision making if they felt additional nursing staff were required.

- There were 26 registered nurses (RNs) working in inpatient departments and 16 in theatre at the time of our inspection. In addition to this, there were two health care assistants supporting RNs on the ward and 10 in theatre.
- There was no locally agreed policy in place to support the use of scrub staff carrying out a dual role in theatre during minor procedures, such as assisting with sutures. . This is not in line with the recommendation by the Perioperative Care Collaborative (PCC). A policy should be in place based on a risk assessment to ensure patient safety and should identify the skills and competencies required by the staff member under taking a dual role. This policy was in draft form at the time of our inspection. Our discussions with managers, staff and observations confirmed that staff undertook dual roles during minor procedures only.
- There was an 'assisting with surgical procedures' policy in place, which detailed the role, competencies and scope of practice for surgical first assistants (SFAs). We observed that SFAs were working in line with this policy and that they did not undertake a dual role during major procedures. .

Surgical staffing

- Resident Medical officers (RMOs) were supplied by an agency and were resident at the hospital for period for seven days. Mandatory training, including advanced life support training, was provided and monitored by the agency. RMOs worked during the day and were available on call overnight. The agency provided cover for any periods of absence, such as sickness. An additional RMO was provided during any period when patients required care in a level two bed. Any new RMOs working at the hospital were inducted to the ward by a senior nurse using a standard induction checklist issued by the agency.
- The majority of consultants held substantive posts in NHS hospitals. As part of their practising privileges, consultants were expected to provide evidence of their competence to undertake surgical procedures, and were only able to perform procedures they regularly carried out in their roles within the NHS.
- Consultant cross cover was logged on a database, to ensure there was access to a consultant surgeon 24 hours a day if required. Staff knew where to access this information when required. The consultant handbook stated that that consultants must live within an appropriate distance of the hospital and if they lived further than 45 minutes away from the hospital, a risk assessment must be undertaken to ensure that consultant cover if the event of an emergency was adequate.
- We saw that when consultants brought their own surgical first assistants to assist during surgery, Spire policy had been followed to ensure the SFA had the skills and required documentation in place, such as professional registration, indemnity insurance and a check performed by the disclosure and barring service.

Major incident awareness and training

- The hospital had its own business continuity plan, which covered a number of major potential incidents, such as bomb explosion, fire, flood, loss or power, communication or water. The plan included action cards with specific instructions to follow for each emergency.
- There was a back-up generator in place should the power supply fail. This was regularly tested to ensure it was working.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Care and treatment was provided in line with evidence-based practice. The hospital used Spire wide care pathways for surgical inpatient and day cases. These pathways followed evidence based guidance from bodies such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. Updates to guidance, produced by such bodies, was issued corporately via a monthly safety bulletin, to ensure staff were up to date with best practice.
- The Surviving Sepsis Campaign guidelines were followed in the hospitals sepsis management guidelines, which included implementation of the

sepsis six care bundle along with guidelines for ongoing management. Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50).
- Spire's pre-operative assessment policy was in line with pre-assessment guidelines issued by NICE in 2016.
- Clinical scorecards were published quarterly that benchmarked the hospital against other hospitals within the Spire group or with national benchmarks, where available. Action plans were developed for any measures that did not meet the agreed target. Patient outcomes were monitored and audited quarterly and reported via the clinical scorecard.
- The hospital participated in national patient reported outcome measures (PROMS) for NHS patients. There were plans to extend this to also include privately funded patients in 2016, by submitting data to the Private Healthcare Information Network (PHIN). Data was also submitted to the National Joint Registry (NJR).
- The weight loss service participated in the National Bariatric Surgery Registry and benchmarked itself against national data.
- The hospital was an accredited Bupa breast care centre and recognised by the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) as a centre of excellence for bariatric surgery.
- There was a corporate audit calendar that was supplemented by additional local audit activity. An annual review was carried out by Spire's national clinical services team to ensure monitoring and improvement in patient outcomes.

Pain relief

- Post-operative pain relief was discussed during pre-operative assessments.
- There was access to a range of medications for pain relief, including patient controlled analgesia and strong pain relieving drugs. Patients were offered sedation and pain relief when undergoing endoscopy.
- Nursing staff and physiotherapists liaised to ensure patients received pain relief before therapy treatment when required.
- The physiotherapy team had access to a transcutaneous electrical nerve stimulation (TENS) machine for non-pharmacological pain management, if this was indicated.
- Patients told us their pain was well controlled and that nurses responded quickly to any requests for additional pain relief. Pain scores were recorded as part of the early warning score system.
- In 2015, 92% of patients reported their pain relief was excellent or very good on the hospital patient engagement survey.
- There was a multi-disciplinary pain management team that met quarterly, represented by staff from the high dependency unit, pharmacy, nursing, physiotherapy and an anaesthetist.
- The effectiveness of pain relief was audited on a yearly basis, however the governance lead had found that a recently issued tool prepared corporately and being piloted was not fit for purpose and this was therefore under review at the time of our inspection.

Nutrition and hydration

- There was work ongoing to improve advice given to patients pre-operatively, to ensure they would be appropriately hydrated within a safe time period. The hospital was aiming as part of the key performance indicators on the clinical scorecard for 50% of patients drinking clear liquids up to two hours before surgery. In quarter two, only 25% of patients had fasted in line within guidelines although the target had been achieved throughout the previous year. Maintaining a good level of hydration can improve outcomes following surgery and reduces the need for intravenous fluid replacement.
- Fluid balance was monitored and charts completed when this was required.
- The hospital scored above the England average on the PLACE for the quality of food provided.
- There was access to a specialist bariatric dietitian who provided specialist advice and support for patients undergoing weight loss surgery.
- Nursing staff told us they assisted patients who were unable to feed themselves or drink independently.
- Patients were provided with drinks and snacks when safe to do so following procedures.

Patient outcomes

- For patient reported outcome measures (PROMS), the hospital scored within the expected range on the

average adjusted health gain for primary knee replacement on each of the three measures, indicating that outcomes following knee replacement were similar to other providers of NHS treatment.

- PROMS data was gathered for hip procedures and groin hernias; however, there was insufficient data to make national comparisons. For primary hip replacement, high numbers of patients reported improvement on the three measures of health gain.
- The hospital audited the monitoring of patient temperatures in theatre and achieved this is in 98% of cases.
- Results of an audit of breast surgery (wide local excision) showed that the hospital was compliant with and above the Spire average for all expected standards.
- There were 20 unplanned returns to theatre between April 2015 and March 2016. The majority of these were cosmetic surgery cases where the return was due to a haematoma (a collection of blood at the surgical site) developing. The hospital had benchmarked the number of unplanned returns following cosmetic surgery with other hospitals and found that this rate was not high.
- There were 13 unplanned readmissions to the hospital within 28 days of discharge. This was not high when compared with independent acute hospitals we hold this type of data for. The readmissions were from a range of specialities and six of these were due to an infection.
- There had been six unplanned transfers to other NHS organisations between April 2015 and March 2016. This rate was not high when compared with other independent acute hospitals we hold this type of data for. Two of the transfers were to specialist cardiology centres due to post-operative cardiac complications and two were in response to deterioration of patients who subsequently needed level three care. Unplanned transfers were reported as incidents to allow a full investigation of the reasons for transfer.
- The endoscopy service provided at the hospital was not accredited by the Joint Advisory Group on GI Endoscopy (JAG). JAG accreditation indicates that the service provides endoscopy in line with the Global Rating Scale Standards but is not an essential requirement. The endoscopy suite at the new hospital had been designed in line with the requirements of JAG and there were plans to apply for accreditation following the move to the new site.

Competent staff

- The consultant handbook set out the procedure for granting and maintaining of practising privileges at the hospital. On application, the consultant was expected to provide mandatory documentation, practice details, references and proof of identity documentation. This information was reviewed by the medical advisory committee (MAC) where a decision was made on whether approval should be granted. There was a clear expectation for consultants to identify their scope of practice and provide evidence of competence to the hospital and the hospital maintained a log of the scope of practice for each consultant.
- Practising privileges including scope of practice were reviewed every two years and consultants were expected to provide details of medical revalidation. However, we found that there had been no consideration of investigating consultant anaesthetists who had been resistant to following the legal requirements of the supply and documentation of controlled.
- There were 14 consultants at the hospital that held practising privileges for cosmetic surgery. All of these consultants were registered on the General Medical Councils specialist cosmetic surgery register.
- The hospital had suspended the practising privileges of one surgeon between April 2015 and March 2016 following a complaint. The complaint was investigated and additional training was implemented before reinstating practising privileges.
- One hundred percent of staff working in theatre and in inpatient departments had received an appraisal. The appraisal system was called 'enabling excellence' and staff agreed objectives with their manager which were linked to those of the hospital.
- We reviewed the training files of six staff in theatre and saw that there were comprehensive, up to date competencies and that these had been self-assessed and additionally signed off by the theatre manager.
- Staff in theatre who undertook the role of surgical first assistant had received training in this role and received a recognised qualification. At the time of the inspection, the hospital was supporting another member of staff to undertake this training.

- Physiotherapy staff maintained competencies in respiratory physiotherapy, by attending a regular one day training session. They also developed their skills and knowledge by attending in service training sessions, in order to share learning.
- Staff told us they were supported with training and development. They told us that learning needs were identified during their appraisals and they were given time to complete training.
- New nursing staff on the wards were supernumerary until they had achieved the necessary competencies. During our inspection we saw that two nursing staff were working in this way.

Multidisciplinary working (in relation to this core service only)

- There was strong multi-disciplinary working within surgical services. Staff told us that working relationships between nursing staff, consultants and allied health professionals was good. We saw evidence of multi-disciplinary working in the notes we reviewed.
- There was a morning handover on the inpatient ward with the nurse and physiotherapist. In addition to this, a daily ward round was held where staff shared information a care and treatment. This was attended by a nurse, physiotherapist, the RMO and pharmacy.
- For some specialities there were specific multi-disciplinary team (MDT) meetings, for example the spinal MDT involved the consultant, physiotherapist, pharmacy and the high dependency unit. The bariatric specialist nurse and dietician team worked closely together.
- There were close links between the breast team and other local NHS trust providing specialist breast care and cancer treatments. This included attending MDTs at these trusts to discuss patients' care and treatment.
- Nursing staff made referrals to district nurses for ongoing care and treatment when this was required. Physiotherapists referred patients on for ongoing therapy on discharge when this was indicated.

Seven-day services

- Theatres were available six days per week and, for emergency procedures, on a Sunday or overnight. Theatre three was routinely used for spinal procedures on a Sunday due to consultant availability.
- Pharmacy services were provided routinely Monday to Friday and were available on-call if required. Systems were in place to allow staff to access take home medications outside of the pharmacy opening hours.
- Endoscopy was provided on a Monday evening and Wednesday morning.
- Physiotherapy was provided seven days a week. An on-call physiotherapist was available for any patients requiring respiratory physiotherapy or if their input would facilitate a discharge.
- The imaging department had an on-call radiographer available 24 hours a day, seven days a week for X-ray and CT. When complex spinal surgery was listed on a Sunday, there was access to an on-call radiographer for magnetic-resonance imaging (MRI).
- The resident medical officer was on site 24 hours a day and there was access to consultant cover for emergencies, 24 hours a day, seven days a week.

Access to information

- Staff had access to the information they needed to provide care and treatment to patients. Records were available on the ward and there were sufficient numbers of computers to allow access to hospital policies and procedures.
- There were folders available on the wards to provide additional information to support the delivery of care.
- Discharge letters were provided to the patient and sent to their GP on discharge to ensure continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Spire wide consent policy and a deprivation of liberty safeguards policy in place. The consent policy set out clear guidance for staff to follow when taking consent, including what steps to take if there was reason to doubt an adult's capacity to consent and taking consent from patients who did not speak English as their first language.
- Mental Capacity Act (2005) training had been completed by 80.4% of ward and theatre staff. The hospital was on track to meet the 95% target by the end of the training cycle. Staff had a basic understanding of the principles of the Act but had limited experience of working with patients who may lack capacity to consent due to the nature of the patient mix at the hospital. They told us how they would seek support and advice if this was required.

Requires improvement

Surgery

- Pre-operative assessment nurses had access to a dementia screening tool and told us they would use this if they had any doubt over a patient's capacity to consent.
- The hospital used a two-stage consent process for patients undergoing surgery. This involved discussion with patients about the risks and benefits of surgery in advance of the operation date to gain consent and a further discussion at a later date, usually the day of the operation, as the second stage. Consent for cosmetic surgery patients was taken in line with best practice, including an appropriate 'cooling off' period.
- In all records we reviewed, there was evidence of written consent to the surgical procedure that had been undertaken. We saw that consent was confirmed on the day of the procedure where it had been formally obtained at an earlier date, such as during an outpatient clinic consultation.
- The Spire resuscitation policy described procedures to follow in relation to cardio-pulmonary resuscitation and do not attempt cardio-pulmonary resuscitation (DNACPR) decisions. There was no requirement to complete a DNACPR orders in the records we reviewed.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Patients told us that staff were kind and caring towards them. We observed staff interacting with patients in a compassionate way. All patients were spoke with told us they would recommend the hospital to their family and friends.
- Staff in recovery ensured that patients were comfortable and took the time to provide them with additional care, such as giving out warming blankets when required.
- We saw that patients' privacy and dignity was maintained at all times. Staff respected patients' preferences and choices.
- Friends and family test results between October 2015 and March 2016 for NHS funded patients were between 98% and 100% which was similar to the England average for patients being treated in an independent hospital
- Results of the patient survey for private patients showed that 83% would recommend the hospital to their friends and family which was higher than the national average of 82%.
- In June 2016, 100% of patients reported they would recommend the hospital to their friends and family. The response rate during this month was 24%. All patients who responded to the survey said that the care and attention from nurses was good, very good or excellent.
- There was an agreed set of dignity and respect standards in place at the hospital that had been developed by the clinical effectiveness group. This was in the process of being shared throughout the hospital.
- On the hospital's patient engagement survey in 2015, 99% of patients reported they had been treated with dignity and respect whilst in hospital.

Understanding and involvement of patients and those close to them

- We observed staff providing patients with explanations of their care and what was happening whilst in the anaesthetic room and in recovery.
- Patients who were awake during procedures told us they had been reassured by staff throughout the procedure.
- Patients told us they were given enough information about their care and treatment. They were given opportunities by nursing staff and consultants to ask additional questions. There were patient information leaflets available on Malory and Austin Wards.
- Family members were involved in discussions about care and treatment including plans for discharge. Staff understood the need to provide support to family members as well as the patients, particularly when they may be worried about their relative during surgery.
- Staff respected patients' rights to make choices about their care. Patients and their relatives told us they were kept informed about their treatment.

Emotional support

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.
- Breast care specialist nurses were involved with patients throughout their care from initial consultation and

diagnosis, during their pre-operative assessment, in the anaesthetic room in theatre when required and post-operatively on the ward. These nurses also support cosmetic breast surgery patients.
- There was access to a bariatric specialist nurse and dietitian. These members of staff visited patients on the ward when this was required to give them additional emotional support and advise pre and post operatively.
- A bariatric patient support group ran every eight weeks to provide additional emotional support from staff and between patients.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Patients were able to access a wide range of elective surgical specialities in the hospital, including orthopaedics, general surgery, bariatrics, spinal, urology, ear nose and throat and cosmetic surgery.
- The hospital worked with local commissioners to develop contracts for the provision of NHS services.
- The provision of level two beds meant that patients with a higher risk of complications following surgery were able to undergo surgery at the hospital and have an extended recovery time from surgery with an enhanced level of care.
- The physiotherapy team planned to see all patients who had undergone a major joint replacement, such as a total knee replacement, twice per day to facilitate a quicker recovery from surgery.
- Pre-operative assessments were available on some evenings until 8pm. For patients undergoing joint replacements, appointments were co-ordinated between the pre-operative assessment team and physiotherapy department to reduce the number of occasions patients were expected to attend the hospital.

Access and flow

- Patients were listed for surgery at the hospital following outpatient consultations. There was a clear admission and discharge policy that set out clear guidelines for staff to follow when arranging admission and discharge, including emergency readmission.
- Patients were admitted for a planned number of nights and therefore planning for discharge was started on admission. Any change to the planned length of stay was discussed with the patient and the consultant in charge of their care.
- The hospital had consistently met the 18 week referral to treatment indicator between April 2015 and March 2016, with 97.7% of patients beginning their treatment within 18 weeks of referral. Although this indicator is no longer an expected standard, there is still a requirement for organisations to report this data.
- Staff told us there were times when patients who were admitted as day cases stayed overnight due to theatre lists running late or patient choice. The hospital did not routinely collect data on the number of patients whose planned day case admission had resulted in an overnight inpatient admission.
- There were 11 unplanned admissions to the high dependency unit between March and August 2016. The hospital monitored unplanned admissions to the high dependency unit by submitting incident reports. This allowed learning from these admissions to reduce the risk of a similar incident happening in the future.
- Although there were four available beds in the high dependency unit, the occupancy did not exceed 50% between March and August 2016 and was frequently only 25%.
- The hospital had cancelled 23 procedures for a non-clinical reason in the previous 12 months. Nine of these cases had been where a patient did not attend on the day of surgery or cancelled at the last minute. All of the remaining 16 patients had been offered an alternative appointment within 28 days.
- The service audited the time of patient discharges and compared this to other hospitals within the Spire group. In June 2016 around 50% of overnight stay patients were discharged before 11am which was slightly below (worse) the Spire average. Around 45% of short stay patients were discharged within six hours. Again this was below (worse) the Spire average. The hospital told us there was no issue with a shortage of beds and therefore discharges were arranged around patient need and preference rather than time.

- There was access to pre-labelled take home medications on the wards. This allowed patients to be discharged home when they were medically ready, even if the pharmacist was not on site.
- A physiotherapist could be accessed on-call out of normal working hours if their input enabled a patient to be discharged home sooner.

Meeting people's individual needs

- Nursing staff on the ward were informed by the pre-operative assessment team if a patient had any additional needs, such as the need for translation services, a learning disability or if they were living with dementia.
- Face to face translation was offered and available to patients during all periods of care when this was required. We saw that translators accompanied patients to the anaesthetic room, to ensure that patients were fully informed and consenting up to the point of anaesthetisation. Translators were also arranged for long periods during the day on the wards.
- The hospital used a Spire group-wide equality and diversity policy. Equality and diversity training was mandatory for all staff and had been completed by 90.6% of staff.
- Staff were able to give examples of how to meet a patient's individual needs, such as ensuring continuity of staff for patients with dementia, accommodating patients in high visibility rooms and using communication books. There was access to an additional bed if relatives were required to stay overnight with a patient. Staff also told us that it was important to make these adjustments on an individual basis and not apply a blanket approach.
- There was access to "This Is Me" via the hospital intranet site. "This Is Me" provides information about the person living with dementia, such as their likes and dislikes and personal and social information. A recent dementia bulletin had been issued to staff. This included basic information about dementia care and how this fits with Spire's work on compassion in practice. It also encouraged staff to sign up to be "dementia friends".
- PLACE scores for dementia were higher (better) than the England average for independent acute hospitals.
- There was good provision for bariatric patients at the hospital. In the pre-operative assessment, there was appropriate bariatric equipment such as chairs, plinths and weighing scales. In theatre, bariatric patients were operated on bariatric tables and recovered in beds, as opposed to trolleys. There was specific equipment used to transfer bariatric patients to reduce the risk of injury to staff and patients.
- There were two rooms at the hospital that were specifically designed for the needs of wheelchair users. These rooms had automatic opening doors, were more spacious and had assisted bathrooms facilities.

Learning from complaints and concerns

- The complaints policy set out a clear process to how complaints were managed and escalated in the hospital. A three tier process meant complaints could be resolved systematically for both NHS patients and those who self-paid. Complaints which escalated to stage three were reviewed by the central team for self-paying patients or the ombudsman for NHS patients.
- There were 22 complaints about surgical services at the hospital in the 12 months before the inspection. On average, these complaints were responded to and closed within 20 days during this time period in line with the provider policy.
- No complaints had been referred to the Parliamentary and Health Services Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISCAS).
- There were leaflets available on the wards that included information about how to make a complaint for both private and NHS patients.
- Staff were able to give us examples of complaints and changes that had been made to practice as a result of this. Complaints summaries and themes were reviewed at the clinical governance and heads of department meetings and learning was subsequently shared through departmental meetings.
- We reviewed one complaint and saw that concerns raised had been taken seriously by the hospital and changes to the rapid admission process had been introduced as a result of this.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Requires improvement

Surgery

Leadership / culture of service related to this core service

- The theatre team was led by a theatre manager and wards led by a nursing manager, supported by the matron and hospital director. Leaders were proud of their teams and the standard of care they provided.
- Staff told us that their leaders were approachable and open and they were proactive in keeping staff up to date. They felt comfortable reporting incidents and would be happy to raise concerns. There was a Spire group-wide whistleblowing policy in place and posters on staff noticeboards informing staff of the policy.
- During our inspection we identified serious concerns about the management of controlled drugs in theatre. We discussed these concerns with the matron, the theatre manager and the chair of the medical advisory committee (MAC). However, we found that there had been no consideration of investigating consultant anaesthetists who had been resistant to following the legal requirements of the supply and documentation of controlled.
- Staff felt that the hospital was a good place to work. They felt positive about the development of the new hospital and team morale was good.
- Leaders were supported to develop their skills through training courses and via their personal development plans.
- There were four whole time equivalent staff vacancies in theatre at the time of our inspection and the hospital was actively recruiting to these roles. Staff sickness was similar to other independent acute hospitals we hold this type of data for, with the exception of June 2016, when sickness for registered nurses in theatre was notably higher.
- There were three nurse vacancies on Malory or Austin Wards. The rate of vacancy (21%) was higher than other independent acute hospitals we hold this type of data for. Sickness levels were similar to other independent providers, with the exception for health care assistants in October and November 2015.
- Staff turnover in theatre and on the wards was lower than other independent acute hospitals.

Vision and strategy for this this core service

- The hospital aimed to provide the highest standards of care, from the time patients first contact the hospital and until after their treatment has been completed. Their vision was to achieve this by offering their patients exemplary care and compassion it showed to having the very latest treatments and technology available.
- Heads of departments had been involved in the development of strategic objectives and the hospitals annual plan. Departments including theatre and the wards then developed their own objectives to support the delivery of the overall hospital objectives.
- Heads of departments and the senior management team understood the hospital vision and values. Other staff were unable to describe the vision, but understood that the new hospital build offered new opportunities for the hospital to expand existing services and develop new services.

Governance, risk management and quality measurement for this core service

- There was defined governance and reporting structures in the hospital. Representatives from theatre and the wards attended the clinical governance committee, heads of department meetings, health and safety committee meetings and infection prevention and control committee meetings. Additionally the senior management team met weekly and this was attended by the theatre managing and inpatient nurse manager.
- There was a hospital risk register in place and each department also held its own risk register. The health, safety and risk management group met bi-monthly with a representative from each department in attendance. The risk register was formally reviewed at this meeting. Risk was also a standing agenda item at the weekly senior management team meeting and was discussed in detail at least once per month.
- Senior nursing staff and leaders were aware of the risk register and how to escalate risks to the departmental or hospital risk register.
- We reviewed the risk register and noted that not all risks had action due dates or details of who was responsible for completing the actions identified for wards and theatre departments. This meant that there was a risk of ineffective monitoring of actions taken to reduce risk. For example, the control measures in place to reduce the risk of delayed surgery had been rated as inadequate. An action was identified to implement a seven day booking rule, however there was no date for this to be implemented detailed on the register. Similarly, there was no date associated to an action

where the controls were rated as inadequate in relation to neurological observations for the ward. The hospital told us they were in the process of transferring the risk register to a new corporate template and that all risks on the register had supporting departmental risk assessments in place which detailed actions and controls.

- Audits did not always detail what actions were required to improve patient care and safety. For example, the most recent anti-microbial audit did not show evidence of what steps should be taken to improve prescribing compliance, what actions had already been taken and what actions were still outstanding. The WHO checklist audit did not identify any immediate steps to be taken despite identifying non-compliance with a key tool to ensure patient safety.
- We noted that there had been a high rate of non-compliance in theatres on the quarterly controlled drugs audit for quarter one and two of 2016 with a worsening rate of non-compliance. We saw no evidence of action taken as a result of these audits and there was no evidence in the minutes of the clinical effectiveness or governance meetings that these had been discussed. The matron, who was the controlled drugs accountable officer, advised us that she had not seen either audit and advised that she had no evidence that she had chased or requested the results of these audits. Performance on clinical scorecards was reviewed by the hospital governance committee and the MAC. In addition to this, the hospital was subject to an annual clinical review carried out corporately.
- Key performance indicators (KPIs) and the associated targets for the clinical scorecard were set corporately by the Spire central governance team. If the hospital did not meet the target for any KPI over two quarters, this was escalated to the central governance team and the hospital was expected to submit an action plan to demonstrate how it would meet the target.
- All applications for practising privileges were reviewed on a quarterly basis by the medical advisory committee (MAC). There was a system in place to review practising privileges every two years and to remove the privileges of those consultants who did not meet the required standards or had not worked at the hospital in the previous 12 months. Data provided by the hospital showed that 32 consultants had had their practising privileges removed because they had not provided the correct documents to the hospital.
- We reviewed the minutes of the MAC meeting from March and May 2016 and saw that the committee reviewed clinical scorecard performance, incidents, participation in clinical research and updates to guidance issued by bodes such as the General Medical Council and NICE. Actions identified from the meeting were monitored via an action tracker.
- There were plans in place to enable the hospital to submit data to the private healthcare information network (PHIN). The PHIN has a legal mandate with the Competition and Markets Authority (CMA) to work with independent acute hospitals to provide comprehensive, independent information to the public to help patients make informed decisions about their care and providers to improve the standard or care they provide. The was a PHIN steering group in place and the hospital had developed a summary care record for all private patients to support the submission of this information.

Public and staff engagement

- Departmental meetings were held monthly forward staff. During these meetings the head of department provided staff with key information. Meetings followed a set agenda and were minuted. Hard copies of minutes were stored in the staff room and staff were expected to sign to say they had read the information and we saw that they did. The hospital director also held forums for staff in the form of a 'coffee catch up'. This was an opportunity for the director to update staff about progress against the annual plan and a chance for staff to ask questions.
- Departmental meetings in theatre were well attended although they were less frequent; however, there was a structured and documented daily theatre morning meeting, where information was cascaded to staff, including information from incidents and audits when indicated.
- Staff were involved in the planning for the move to the new hospital and had been involved in the design of some areas.
- The most recent staff survey had shown that staff felt the new build of the hospital had distracted the hospital director from the day to day management of the existing hospital. Spire had responded to these concerns by bringing in an additional director to support the existing director during this time.
- A patient engagement survey was used for all patients. Feedback was shared with heads of departments and

individual staff members when improvements were required or comments were particularly complimentary. The hospital also used the Friends and Family Test for NHS patients.

Innovation, improvement and sustainability

- At the time of our inspection, a new hospital facility was being built nearby to allow surgical services at the hospital to increase. The new hospital was being built with six theatres, including one hybrid theatre, which would allow surgeons to operate in a less invasive way and therefore reduce the risk to patients. There was also a five bedded intensive care unit planned to receive patients from theatre. This would enable the hospital to care for patients undergoing more complex surgery or who have been assessed as being at a higher risk of complications following surgery and need a higher level of care.
- There were plans in place to recruit additional staff members and staff with more specialist skills and knowledge to support the delivery of new services at the new hospital site. This included recruitment of critical care nurses and cardiology specialist nurses.

Requires improvement

Services for children and young people

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

Summary of findings

We gave the services for children and young people at Spire Manchester Hospital an overall rating of requires Improvement. This was because:

- Paediatric records completion was not consistently in accordance with best practice.
- In the records we reviewed there was no documented evidence that paediatric early warning scores (PEWS) were acted upon, in accordance with the provider's policy.
- Safeguarding was not given sufficient priority at all times 30% staff working with children and young people in the capacity defined by the Intercollegiate guidance for safeguarding children and young people had received the correct level (three) of safeguarding training. However, all staff were level two trained.
- 36.9% of staff were up to date with their paediatric competencies at the time of our inspection. In theatres, 56.5% of staff were not up to date with their paediatric competencies. This is not in accordance with national guidance or the provider's procedure for the care of children.
- When incidents required more detailed investigation, which applied to 2/21 of the incidents that had occurred from September 2015 – August 2016, there was variability in the quality of the investigations. One case was appropriately investigated but the other did not identify all the issues that required addressing to ensure learning and prevention of further incidents.
- The provider relied upon consultants self-auditing their compliance with national guidance and the provider's own policies for care provided under paediatric pathways. This meant the provider could not assure itself that care was provided in accordance with national guidance and best practice.
- Staff training required improvement particularly in relation to paediatric competencies and the number of staff who were trained in advanced paediatric life support.
- The service measured some patient outcomes using the paediatric scorecard, which had been recently introduced at the hospital. However, there was no standard dataset across Spire hospitals for effective benchmarking within the group. The service told us this was being developed corporately, but no implementation date was provided.
- Audits had recently been introduced in the hospital, but action plans to address findings from audits were not embedded at the time of our inspection.
- There were no child-friendly consulting rooms and limited provision for children in outpatients, for example toys and seating. In one of two pre-assessment clinics that were being undertaken, the patients were seen for their observations from the children's playroom for inpatients.
- Children waited alongside adults for their outpatient appointments and were nursed on adult wards.
- Whilst a gap analysis had gone some way to assist the provider in achieving its strategy, the analysis undertaken was not comprehensive and omitted immediate risks to patients' safety.

Requires improvement

Services for children and young people

- The approach to service delivery and improvement was reactive and focused on short term issues that had been found at Spire's other sites as well as within the service.
- The service was unable to demonstrate learning through clinical audits.
- Risks that affected the paediatric service were not all recorded on the provider's risk register.
- The service did not compare itself to similar services using benchmarking.

However,

- Duty of Candour, a regulatory duty that relates to openness and transparency, was understood and correctly applied.
- Ward areas were visibly clean.
- The hospital had child specific resuscitation equipment (PECS), which was colour co-ordinated, based on children's weight.
- Policies and procedures were in place that were in accordance with best practice and national guidance e.g. NICE guidance.
- Children were provided with appropriate pain relief.
- Children's nutrition and hydration needs were met.
- Staff were kind and compassionate in their communications with parents and their children. They were given information in a way that they could understand.
- Children and young people were involved in their care and were aware of their treatment options.
- Feedback from children and young people who used the service and their families was positive, with quotes that the service was 'excellent' and that parents were 'very pleased with the care and the explanations given.'
- The services available to children and young people were planned according to service demand.
- There were "Child day-case/overnight stay care pathways" for children and young people undergoing elective surgery, which were in use.
- The hospital offered good access for children's routine operations. Outpatients' clinics were available in the evening as well as during the day.
- All staff we spoke with were aware of the service's vision and values and how they could contribute to this.
- Senior leaders took immediate action to mitigate and address issues that were identified to them during the course of our inspection.
- There was a positive culture within the service and staff worked closely as a team to deliver care to children and young people.

Requires improvement

Services for children and young people

Are services for children and young people safe?

Requires improvement

Incidents

- Staff told us they felt supported, knew how to report incidents, could tell us how lessons learnt were shared and told us they received feedback on incidents.
- From September 2015 to August 2016, 21 incidents were reported on the hospital's incident reporting system. Of these incidents, 90.4% were classed as no harm or low harm incidents. 9.6% (two incidents) were moderate harm incidents. Themes included operation cancellation on the day of surgery, medication incidents, post-operative complications and safeguarding reports. All of the operation related cancellations were operations that were cancelled by patients' families.
- We reviewed one root cause analysis report for a moderate harm incident that was being investigated at the time of our inspection. Appropriate action was being undertaken and relevant parties had been contacted.
- In another incident we reviewed, the recorded investigation was not comprehensive and had resulted in a missed opportunity to learn lessons as a result of the incident. We escalated this to a senior nurse, who agreed with our findings, and took immediate action to address this with their team by discussing immediate issues and reviewing the root cause analysis investigation report.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Duty of candour was understood by staff we spoke with and had been correctly applied in the root cause analysis reports we reviewed.

Cleanliness, infection control and hygiene

- All areas where treatment was provided to children and young people appeared visibly clean.
- We observed nurses in outpatients and wards using hand gel frequently and washing their hands before and after seeing patients.
- The hospital had an infection prevention and control lead, who chaired an infection prevention and control committee, which was attended by representatives from the ward areas and outpatients. Bi-monthly meetings were held which discussed any new and ongoing concerns. At this meeting action plans were also reviewed. The meeting minutes we reviewed showed evidence that actions were reviewed in a timely way.
- In the outpatient departments, housekeeping staff carried out daily cleaning of the rooms and nursing and health care assistant staff carried out weekly deep cleans of the rooms. We reviewed the weekly cleaning records which were fully completed each week during August 2016.
- The toys in the children's playroom were cleaned on a weekly basis. The cleaning records were fully completed for this for the month prior to the inspection.
- The hospital used 'I am clean' stickers for equipment once it had been cleaned.
- We saw that all clinical staff in the departments followed the 'bare below the elbow' guidance, to allow thorough hand washing and reduce the risk of cross infection.
- Patient-led assessment of the care environment (PLACE) is a system used whereby patients assess the quality of a patient environment. The hospital scored 97.8% in the PLACE for cleanliness between February and June 2016. This was just below the England average for hospitals.
- Hand sanitisers were widely available throughout the outpatient, physiotherapy and diagnostic imaging departments. We saw instructions on hand washing at sinks in clinic rooms, posters about the five moments of hand hygiene on staff notice boards and hand hygiene posters for patients and visitors throughout the hospital.
- The hospital carried out a six monthly audit of hand hygiene in all departments, by measuring how much hand sanitiser had been used. However, weighing hand sanitiser before and after the audit period did not demonstrate that staff were following hand hygiene principles. The hospital told us it was trialling an observational audit tool before the end of 2016.

Environment and equipment

- At Spire Manchester, children and young people were treated alongside adults in outpatients and on the main wards. The environment was designed with adults in mind throughout outpatients and in ward areas. This had been risk assessed by the provider and some mitigation was in place at the time of our inspection.

However, whilst most areas appeared visibly safe for children, there was a failure to identify and risk-assess the location of a fire extinguisher. This was placed on the floor, next to the children's playroom's door and the fire extinguisher was thus in reach of children of all ages. We escalated this at the time of our inspection, as this breached the provider's procedure for the care of children and young people. The issue was referred to the fire safety officer by the provider to be addressed during the inspection.

- The resuscitation lead within the hospital had introduced specialist children's resuscitation equipment. This was organised into kit bags for the differing age ranges of children cared for and was fit for purpose.
- Children were anaesthetised in an anaesthetic room, which had resuscitation drugs and equipment, including an age-appropriate defibrillator.
- There was a dedicated children's recovery bay within the recovery room, which was child friendly and contained resuscitation equipment for different ages of children.
- Rooms where patients stayed were risk assessed prior to a child's admission and age/gender specific bedding was provided.

Medicines

- Allergies were documented within paediatric patients' medical records. Paediatric patients were also given a wristband to wear which indicated what allergy they had.
- We found that children's records documented their weight. This helps practitioners to ensure that patients are given the correct amount of medication.
- Staff were aware of the policies for safe administration of drugs. Following a controlled drug error, procedures were put in place to prevent recurrence including introduction of a new e-learning training module and child specific infusion charts which were introduced across the Spire Group.

Records

- At the time of our inspection, we reviewed ten sets of medical records. In all the notes we reviewed, we found no completed surgical checklists that were dated and signed.
- In 30% records, the pre-assessment form 'assessing your child' had not been signed by a children's nurse. In 20% records, there was no evidence of escalation to a doctor following an increased PEWS, which is not in accordance with the provider's policy. In 20% records, there were numerous entries made in error, which were crossed out, but not countersigned. In 80% records, medical entries did not have the name of the doctor printed nor their designation. In 10% of records, another patient's care was documented along with the follow-up plan. A separate set of medical records had not been created for the second patient under a patient identification number. This meant that the records of care for that patient were not easily traceable or subject to the duration of retention of medical records.
- The notes were generally poorly organised and were not in chronological order
- We escalated our concerns to the provider, who reviewed the records with us; they agreed with our findings and undertook immediate action to address our concerns. Senior staff told us that paediatric medical records had not routinely been audited prior to our inspection. However, an audit of different records to the ones we reviewed had been undertaken in August 2016. This audit reviewed records for PEWS completion, recording of pain scores and temperatures within theatre. The score card showed 61% compliance for PEWS completion, 91% for pain score completion and 58% for temperature within theatre. These figures all fell below the provider's target of 95% completion.
- Between our inspection and unannounced inspection, the provider undertook a detailed records audit, covering PEWS completion, temperature recording, pain scores and other areas. With the exception of consultant documentation (which was 97% compliant), all other areas reviewed were below the provider's target of 95%. The percentage of records with: PEWS completed was 72%; intraoperative temperatures completed was 10%; temperatures completed was 65%; pain scores recorded was 90% and with fasting guidelines completed was 80%. The provider took immediate action and provided us with an action plan to address the above issues.

Safeguarding

- All staff involved in the care of patients under the age of 18 had completed level two safeguarding children training. Safeguarding levels within the service did not comply with the intercollegiate guidance for safe

staffing or the provider's procedure for the care of children and young people. The intercollegiate guidance states that all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns, should all be trained to level three Safeguarding children. At the time of our inspection, 26.5% of eligible staff had completed their level three safeguarding children training. We escalated this issue to the provider at the time of our inspection. An action plan was created to address the issue we raised.

- We discussed safeguarding with staff involved in the care of children. All staff we spoke told us they were aware how to access the named safeguarding lead and who to speak to if they had any concerns.
- Staff we spoke with were aware of child sexual exploitation and knew who to refer concerns to.
- Staff were aware of female genitalia mutilation (FGM) and knew who to refer concerns to.
- Staff gave us an example of a recent safeguarding concern they had made a referral for and had followed appropriate procedures.

Mandatory training

- The provider had a rolling target for the percentage of staff that had completed mandatory training. At the end of quarter three this was that 75% of staff should have completed their mandatory training and that by the end of the year that 95% of staff had completed their mandatory training. All staff in the paediatric team had completed their mandatory training. However, patients were also assessed by staff who worked in the adult team. The mandatory training levels for these staff varied from 60% - 97% for different elements of mandatory training. This meant that a proportion of staff working in direct patient contact roles did not have the required level of up to date mandatory training at the time of the inspection. Mandatory training included fire safety, health and safety, basic life support, infection control, safeguarding children level one and level two, safeguarding adults, manual handling, compassion in practice, equality and diversity, managing violence and aggression, and information governance.
- In accordance with national guidance (Royal College of Nursing –Safer Staffing 2013), there was a trained advanced paediatric life skills (APLS) member of staff on each shift when children were cared for on the ward areas for the month prior to the inspection.

Assessing and responding to patient risk

- National guidance (Guidelines for the Provision of Anaesthetic Services (GPAS) 2016) highlights the importance of staff assessing paediatric patients prior to their surgery, caring for them during their procedure and post-operatively having up to date paediatric competencies. During our inspection we requested confirmation of the number of staff that were up to date with their paediatric competencies. The provider told us that 36.9% of staff had up to date paediatric competencies. We escalated this issue to the provider and immediate action was taken to mitigate this risk.
- We looked at the pre-assessment clinics that were undertaken to assure ourselves that children were assessed by paediatric trained staff, in accordance with national guidance and the provider's procedure for the care of children and young people. Pre-assessment clinics were run in two parts, one which was led by adult trained nurses and the other that was led by a paediatric nurse. We found that paediatric nurses did not have the right skills to perform some of the pre-assessment tests, for example paediatric nurses had not been trained in scoliosis lung function tests, electrocardiogram (ECG) reading or venepuncture.
- Adult trained nurses were undertaking the physiological assessments without a paediatric nurse present and at the time of our inspection; we were informed that these nurses did not have paediatric competencies, as recommended by Royal College of Anaesthetists guidance. Paediatric nurses undertook a separate pre-assessment looking at psychological needs and showing the patient the environment where procedures would be undertaken. Senior managers were aware of this risk, yet had not identified it in the recent gap analysis they had undertaken (July 2016) nor was it recorded on the risk register. We escalated this issue to the provider and the provider immediately mitigated this risk by holding joint pre-assessment clinics.
- National guidance (Guidelines for the Provision of Anaesthetic Services (GPAS) 2016) requires that a member of staff with training in advanced paediatric life skills should always be present in a recovery area. We

reviewed operations that had been undertaken in August 2016. On eight out of 24 occasions (33.3%) when children were operated on, there was not an APLS trained staff member in recovery. However, the staff who were on duty had completed paediatric immediate life support training (PILS). We escalated this issue to the provider and immediate action was taken to mitigate the risk.

- The provider used PEWS to help identify deteriorating patients. However, during our review of records we found that these scores were not consistently acted upon when patients deteriorated, which is not in accordance with the provider's own policy. In our records review, we identified two patients who had deteriorated. Their records did not show evidence that the nursing team had requested a medical review or that a doctor had reviewed the patients. We escalated this to the provider at the time of our inspection.
- We saw evidence in records that the provider ensured that at pre-assessment children's height and weight was recorded.
- We saw evidence that the provider had clear emergency treatment calculations in place that staff were familiar with.
- There was a policy in place regarding stabilisation of patients and transfer to a local NHS hospital with a high dependency unit or critical care unit.
- Patients and their families were given clear guidance and information leaflets when children were discharged.
- Children and young people were nursed in private rooms. The service ensured children were appropriately supervised by keeping children in adjacent rooms in the ward areas.

Nursing staffing

- The provider told us that staffing levels were planned in line with planned admissions for surgical procedures. At the time of our inspection, there were no children admitted on the wards. Paediatric staff were completing pre-assessment clinics.
- The staffing on the critical care unit met national guidelines for the treatment and care of patients requiring level 2 care. This meant that there was minimally one nurse to two patients at all times, and often this care was provided on a one to one basis. The critical care lead told us that they were actively recruiting to ensure that the hospital had the capacity to provide care for planned additional critical care beds when the hospital moved to a new building.
- We reviewed the day case/inpatient activity for August 2016. On every shift when children were being operated on there was only one registered children's nurse on duty. This is not in accordance with Royal College of Nursing (RCN) guidance on safe staffing, which recommends that: "there should be a minimum of two registered children's nurses at all times in all inpatient and day care areas."
- We asked staff how this worked in practical terms, with only one registered children's nurse on duty. Staff told us that the children's nurse would take patients to theatre and return them back to the ward or recovery staff would bring patients back to the ward. This meant that on occasion, nurses who cared for adult patients were left with responsibility for children's care, which is not in accordance with the provider's own policy. National guidance also recommends that "nurses working with children and young people (CYP) should be trained in children's nursing with additional training for specialist services or roles."
- We asked the provider to confirm whether nursing staff who worked with children and young people had children's competencies. They informed us that 11 out of 31 nurses (35.5%) did not have children's competencies. We escalated our concerns to the provider, who immediately mitigated this risk and put in place an action plan to address this issue. This included theatre staff returning patients from theatre so paediatric nurses could remain on the ward.
- The service had a registered children's nurse who was accountable for the children's pathway.
- The service used specifically trained agency paediatric nurses with current competencies to provide care to for paediatric scoliosis patients who were initially recovered in the HDU.

Medical staffing

- At Spire Manchester all children were admitted under the care of a named consultant with paediatric practising privileges. . A named consultant paediatrician was available for liaison and immediate cover when a child was admitted. The on-going care of inpatients/ postoperative patients was managed by consultant paediatricians.

Requires improvement

Services for children and young people

- In accordance with the provider's procedure for the care of children and young people, all consultants had to apply for practising privileges before they could work at the hospital. This process required consultants to demonstrate evidence that they undertook paediatric work as part of their NHS practice and provide evidence of relevant qualifications and training.
- Staff told us that if a child or young person was admitted for an operation, the paediatrician would stay at the hospital until the child was stable. If the child stayed overnight, the paediatrician provided out of hours cover. As a result, there was always a paediatrician available for liaison and advice and who could treat the child within 30 minutes.
- Parents told us that the anaesthetist explained the process to them before the operation.
- The hospital had a registered medical officer on duty at all times with paediatric competencies.
- Twenty-six out of 46 theatre staff (56.5%) responsible for working with children and young people were not up to date with their paediatric competencies. This is not in accordance with the provider's procedure for the care of children and young people or the Royal College of Anaesthetists guidance on the provision of paediatric anaesthesia services (2016). We escalated this issue to the provider for immediate action. The provider mitigated the immediate risk and put in place an action plan to ensure all staff were up to date with their paediatric competencies by October 2016.

Major incident awareness and training

- Senior staff told us that staff were aware of the service's major incident policy and knew what to do in the event of an emergency.
- There was a back-up generator in place should the power supply fail. This was regularly tested to ensure it was working.
- The hospital had its own business continuity plan, which covered a number of major potential incidents, such as bomb explosion, fire, flood, loss or power, communication or water. The plan included action cards to follow for each emergency and specific instruction for the imaging and outpatient departments for the continuity of services.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because:

Evidence-based care and treatment

- Consultants were personally responsible for ensuring they were compliant with Spire's corporate policies and relevant guidance. No separate audit was undertaken to ensure consultants' compliance with the provider's pathways or national guidance, such as NICE guidance. Although our records review confirmed that the provider's pathways had been followed by the consultants, the provider had no self-assurance methods in place at the time of our inspection. We escalated this risk to the provider at the time of the inspection.
- Staff followed the corporate policies that were in place for the care of children and young people within the hospital.
- The hospital used standard care pathways as commissioned and developed by Spire head office, to help guide patient care. Pathways contained patient risk assessments and prompts to monitor the PEWS score, pain control and fluid balance.
- Spire's national Clinical Governance and Quality Committee met quarterly to discuss as part of the standard agenda, updates to national guidelines. Policies and procedures were updated on a national basis. The policies were then monitored and cascaded locally by the governance lead and implemented where required.
- Safety bulletins were shared with all staff at departmental meetings. The monthly safety bulletin was issued to all hospitals by the national clinical governance committee including a list of latest NICE guideline updates and other changes to regulation or national guidance for local attention.
- The hospital had recently introduced three-monthly audits of compliance with best practice guidelines, which was reported via the paediatric clinical scorecard. This covered PEWS completion, pain relief, temperature recording from theatre and fasting guidelines.

Requires improvement

Services for children and young people

- The hospital participated in Spire's national audit programme. The children and young people's service leads had recently scheduled a meeting to introduce a paediatric local audit plan to help monitor compliance with national guidance and corporate policies.
- The service had a sepsis policy and each nursing area had sepsis indicators and a flowchart for managing a patient's symptoms.

Pain relief

- Children and young people had their pain assessed and appropriate methods of reducing pain were offered. There were processes in place for pain scoring any child that was undergoing surgery and for pain levels to be reassessed during a patient's stay.
- Nurses were encouraged to use the Face, Legs, Activity, Cry, Consolability scale (FLACC) score system to assess children's pain, particularly in cases were children were unable to verbally report their pain. FLACC is a behavioural tool used to assess patients' pain. Nurses were also encouraged to ask children about their own pain levels and to discuss this with their parents. Records showed evidence of completion of age appropriate pain related charts for 93% of patients.
- At the time of our inspection there were no in-patients or day cases on the ward. Parents and children fed back on the service's survey tool that pain had been effectively monitored.
- The service had a paediatric anaesthetist who was available to prescribe appropriate pain relief.

Nutrition and hydration

- The hospital had clear pre-operation fasting guidelines, which were listed in the Procedure for Children and Young people.
- Parents told us and we saw evidence that clear instructions were given at the pre-admission meeting with children.
- The hospital catering service provided a range of age-appropriate foods to suit patients' ages and dietary needs. Staff told us that on admission, children's dietary needs were assessed and the kitchen informed as required. Food could be provided according to the children's needs, for example, dairy free and age appropriate foods.
- Care plans we reviewed included appropriate nutrition and hydration assessments and management plans.

Patient outcomes

- The service measured some patient outcomes using the paediatric scorecard, which had been recently introduced at the hospital. However, there was no standard dataset across Spire hospitals for effective benchmarking within the group. The service told us this was being developed corporately, but no implementation date was provided. At Spire Manchester the service had begun to audit and report the number of patients who were returned to theatre, readmission rates, critical care transfers, the number of patients who acquired an infection and medicines management via the paediatric clinical scorecard. This audit was completed on a three-monthly basis and had commenced five months prior to our inspection. Data showed all areas, excluding patient satisfaction, were below the provider's national targets. An action plan was in place to address this.

Competent staff

- National guidance (Guidelines for the Provision of Anaesthetic Services (GPAS) 2016) highlights the importance of staff assessing paediatric patients prior to their surgery, caring for them during their procedure and post-operatively and having up to date paediatric competencies. During our inspection we requested confirmation of the number of staff that were up to date with their paediatric competencies. The provider told us that 38/103 (36.9%) of staff were up to date with their paediatric competencies. We escalated this issue to the provider and immediate action was taken to mitigate the risk.
- Staff told us at Spire Manchester and across the Spire group paediatric competencies were not task based. This is not in accordance with best practice. We escalated our concerns regarding this at the time of our inspection and were informed that this was under review across the entire Spire group. An interim action plan was put in place to ensure senior staff were aware of who had which competencies so patients were cared for by appropriately trained staff.
- The paediatric team had recently had venepuncture training, but were not signed off as competent at the time of our inspection.
- Nursing staff reported that they received good support and their induction was comprehensive.

Requires improvement

Services for children and young people

- All staff had had their appraisals and told us they found them of benefit.

Multidisciplinary working

- The children and young people team followed the procedure for the care of children and young people in relation to discharging patients. This meant that GPs and school nurses/health visitors were informed about patients being discharged from hospital.
- For elective surgery cases, there was a senior children's nurse on call when children were being seen and treated, which is in accordance with national guidance.
- The service ensured that consultants were only given practising privileges within the limits of their professional competence.
- We saw staff working collaboratively with outpatients and theatre staff at the time of our inspection. For example, a patient was distressed with regard to having their pre-operative assessment observations and about coming into hospital. The nursing team worked together to discuss a range of approaches that could be used to minimise the patient's distress and prevent the operation from being delayed. The nursing staff then worked together with theatre staff to describe 'the spaceship' (theatre suite).
- The service had specific pathways in place that were created by the provider's head office who commissioned services. These included the child daycase overnight stay pathway.
- Arrangements were in place to transfer patients to another hospital should a patient's clinical needs require it.
- The service had access to physiotherapy for patients post-surgery for example for scoliosis patients

Seven-day services

- Diagnostics services such as X rays and pharmacy services for children were available seven days a week.
- When complex spinal surgery was listed on a Sunday, there was access to an on-call radiographer for magnetic-resonance imaging (MRI).
- There was access to consultant cover for emergencies, 24 hours a day, seven days a week.

Access to information

- Staff had access to care and risk assessments, case notes and test results for children.
- There was a system in place to ensure that medical records generated by staff holding practising privileges were available to staff or other providers who may be required to provide care or treatment to the patient.
- Paediatric nurses encouraged the use of Personal Child Health Records (Red books) so that parents had a continuous record of their child's growth and development and could share the information with other health professionals.
- GPs were notified of a patient's discharge in writing, to ensure continuity of care. School nurses or health visitors were also notified of a patient's discharge from the hospital in 90% of cases.

Consent

- Staff understood arrangements for consent and the relevant legislation. The hospital had different rules for children and young people at different ages. The hospitals 'Procedure for the Care of Children' put the patient's best interests central to the process. If a young person was under 16 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 Competency) to understand the nature of treatments. They would give the young person ample time to consider all the options.
- The consent process consisted of two stages, in accordance with good practice.
- 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

Compassionate care

Requires improvement

Services for children and young people

- During our inspection we observed the care that was provided to three outpatients. Staff demonstrated understanding and respect for patient's personal, cultural, social and religious needs.
- The staff we observed took their time to build rapport and interact with the children and their parents, in order to involve them with decisions about their care in a respectful and considerate manner.
- Staff were sensitive, encouraging and supportive of children and those close to them. For example, one child became distressed about having observations undertaken. The nurse took extra time and used play as a distraction to reduce the patient's distress levels.
- We asked senior staff how children, young people, and their families were engaged and involved in the design and running of the service. This was limited to patient satisfaction surveys.
- The patient satisfaction survey for April – June 2016 showed that patients and their families were 100% satisfied with the care they had received.
- The medical records we reviewed evidenced timely provision of pain relief.

Understanding and involvement of patients and those close to them

- During our inspection, staff communicated clearly with patients and those close to them so that they understood their care, treatment and condition. We saw staff engaging with parents, those close to children and the children themselves to plan and agree care and treatment that was to be provided.
- Information was presented in a child friendly format. We saw staff listening to children and responding to their needs.
- Nurses were compassionate and caring with children young people and their relatives. Patient and parent feedback showed they were satisfied with communication and care. We heard from parents how paediatric nurses were sympathetic and encouraging towards children.
- All staff we observed gave patients and those close to them the opportunity to ask further questions about their care and treatment.
- The service had a chaperone policy which enabled older children to speak to clinicians without their parents present.

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.
- Consultants and managers explained the options and possible timescales to parents, without exerting any pressure, ensuring that parents had time to decide about treatment options.

Are services for children and young people responsive?

Good

Service planning and delivery to meet the needs of local people

- The services available to children and young people were planned according to service demand.
- Children and young people could access the service through either self-referral or their GP.
- We asked senior staff how children, young people, and their families were engaged and involved in the design and running of the service. This was limited to patient satisfaction surveys. There was not a children's and/or a parents/carers panel or advisory group. However, staff within the service recognised the need to develop a children's advisory group and plans were in place to introduce this at the new hospital.
- There were "Child day-case/overnight stay care pathways" for children and young people undergoing elective surgery, which were in use.
- At the time of our inspection, with the exception of a children's play area on one of the two adult wards, the hospital lacked dedicated children's areas. All children were cared for in adult areas. At Spire Manchester staff recognised that there was limited provision for children and young people. The hospital was due to relocate to a purpose built hospital with a designated children's ward and child friendly areas in January 2017.
- Pupils from local schools were involved in service planning for the new children's ward.
- In accordance with the service's procedure for care of children and young people room risk assessments were undertaken prior to a child's admission.

- Children visited the areas where they would be staying at the pre-assessment appointment.
- In accordance with the provider's policy, children were encouraged to keep in touch with their friends while in hospital by bringing in their own electronic devices. Wi-Fi was available for all patients.
- Staff told us that parents were able to stay with their child in their room. If both parents wished to stay, a nearby room was offered to them. Staff told us a meal and refreshments would be provided if needed.
- At the time of our inspection, plans were in place to move the service to the hospital's new site in a purpose built environment. This included a designated children's area with six beds and a further two high dependency beds.

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 have operations during the school holidays.
- The provider's records showed that 33% of patients were funded by the NHS; the remaining 67% were funded by other sources.
- The procedure for the care of children and young people set out the criteria for admission to paediatric pathways. The service had a seven-day booking rule to ensure that pre-assessment clinic appointments could be completed prior to admission.
- Senior staff told us that consultants could also perform day case procedures within short notice, providing there was sufficient time for the pre-operative assessment and for suitable staffing to be arranged.
- All children were admitted under the care of a named consultant with paediatric practising privileges. A named consultant paediatrician was available for liaison and immediate cover when a child was admitted. The resident medical officer had paediatric competencies. The paediatric scorecard measured the number of cancelled appointments. Each cancelled appointment was also incident reported so any trends could be identified. Readmissions were also monitored via the paediatric scorecard.

Meeting people's individual needs

- The hospital co-ordinated appointments for children with more complex needs. These patients were infrequently admitted. Most surgery that was undertaken was elective and for low-risk patients.
- There were no child-friendly consulting rooms and limited provision for children in outpatients, for example toys and seating. In one of two pre-assessment clinics that were being undertaken, the patients were seen for their observations from the children's playroom for inpatients.
- In the recovery area in theatres, a bay was screened off and made suitable for children. However, this was located within the main recovery area.
- There was no visible provision for children in outpatients, for example toys/smaller seats. However, staff told us that they would provide toys for children on request. We reviewed the provision and this consisted of colouring pens and a toy doctor's kit.
- We saw evidence that children were invited to the hospital prior to surgery, so they could visit the ward areas and theatre suite.
- The hospital offered evening and weekend clinics to provide flexible access to appointments for the local community; outpatient services were available Monday to Friday (8am to 8pm) and on Saturdays (9am to 12noon).
- Staff told us that surgery could be scheduled during school holidays when it was clinically appropriate to do so, so as not to interfere with a child's schooling.
- The hospital offered outpatient appointments and operation times to suit the individual family. Children were prioritised on theatre lists and grouped together.
- The hospital used an interpreting service. Face to face translation was offered and available to patients during all periods of care when this was required. We saw that translators accompanied patients to the anaesthetic room, to ensure that patients were fully informed and consenting up to the point of anaesthetisation. Translators were also arranged for long periods during the day on the wards.

Learning from complaints and concerns

- The hospital used a Spire group-wide complaints policy. We reviewed the policy, which set out a two stage process for complaints from NHS patients and three stage process for complaints from self-paying patients. Stage one involved an investigation and response by the hospital. If a complaint went to stage two, it was

reviewed by Spire Group's Medical Director for private (self-paying and insured) patients or an independent investigation by the Parliamentary and Health Service Ombudsman for NHS patients. If the complaint from a private patient escalated to stage three, the complaint was investigated independently by the Independent Sector Complaints Adjudication Service (ISCAS).

- From September 2015 to August 2016 two complaints had been made in children and young people's services. These complaints were investigated and explanations were provided. The complaints were managed in accordance with the provider's policy and appropriate action was taken.
- Children were able to provide feedback using the child friendly patient survey.

Are services for children and young people well-led?

Requires improvement

Vision and strategy for this this core service

- Hospital managers, paediatric nurses and consultants had a vision for children and young people's services. This initially focused on transferring the existing paediatric service over to the new hospital in a purpose built environment. Future plans included becoming a regional centre for paediatric services and developing surgical pathways for more complex surgery.
- The service had a strategy for delivering their priorities for delivering good quality care. A gap analysis had been undertaken against the service strategy, in order to provide a clearly focused action plan to enable the service to achieve the strategy's aims. This action plan was periodically reviewed to reflect progress.
- However, whilst the gap analysis identified most areas that required improvement, there were several areas that were not included on the action plan, which required further attention. For example, the analysis did not include the provider's failure to comply with RCN guidance for safer staffing in relation to the number of nursing staff working with children and the provider's position in relation to paediatric competencies. This meant immediate risks to patient safety had not been addressed at the time of our inspection.
- All staff we spoke with were aware of the service's vision and values and how they could contribute to this.

Governance, risk management and quality measurement for this core service

Senior staff told us that following the appointment of the nursing lead in paediatrics there had been improvements in the governance arrangements, risk management and quality measurements within the children and young people's service. This included a GAP analysis of the service, implementation of paediatric specific staff training and closer supervision of paediatric nursing staff. However, whilst some clinical audits were undertaken, learning opportunities were not consistently identified. When performance did not meet the hospital's targets, action plans to address improvement were not completed and the service did not benchmark itself with similar services.

- At the time of our inspection the provider did not consistently follow the corporate procedure for the care of children and young people.
- There was a hospital risk register in place and each department also held its own risk register. The health, safety and risk management group met bi-monthly with a representative from each department in attendance. The risk register was formally reviewed at this meeting. Risk was also a standing agenda item at the weekly senior management team meeting and was discussed in detail at least once per month.
- Senior nursing staff and leaders were aware of the risk register and how to escalate risks to the departmental or hospital risk register.
- We reviewed the risk register and noted that not all risks that were identified within the children and young people's service were recorded. We escalated this to the provider at the time of the inspection and they addressed this by reviewing their gap analysis, revising their action plan and updating the risk register.
- We noted that there had been a high rate of non-compliance in theatres with regard to temperature recording of patients. This had occurred in quarter two 2016 and the provisional results for quarter three demonstrated a similar trend. We saw no evidence of action taken as a result of this so escalated our concerns to senior staff at the time of our inspection. We also addressed our concerns regarding the quality of patients' records. The provider immediately undertook a comprehensive records review that supported our

findings. Senior staff then reminded all staff of the importance of quality record completion and put in place a regular records audit along with posters to remind staff regarding this issue.
- Issues relating to the children and young people's service were discussed at the MAC meetings by the paediatric clinical lead who regularly attended the meetings.
- Performance on clinical scorecards was reviewed by the hospital governance committee and the MAC. In addition to this, the hospital was subject to an annual clinical review carried out corporately.
- All applications for practising privileges were reviewed on a quarterly basis by the medical advisory committee (MAC). There was a system in place to review practising privileges annually and to remove the privileges of consultants who did not meet the required standards or had not used the hospital in the previous 12 months.
- During our inspection we saw evidence that learning from other location's inspections had been implemented at Spire Manchester.

Leadership / culture of service

- The children and young people's service was led by a children's nurse who had been in post for a couple of months at the time of our inspection. The nursing lead was aware of the challenges to delivering quality care and had taken significant steps towards identifying them all by the time of our inspection. An action plan was in place to drive service improvement and this was reviewed on a monthly basis.
- Staff told us that their leaders were approachable, open and proactive in keeping staff up to date. They felt comfortable reporting incidents and were happy to raise concerns.
- During our inspection nursing leaders demonstrated that they were keen to improve services.
- We saw staff working collaboratively to resolve issues that arose during our inspection. Staff also demonstrated that they were proactive in seeking support and advice from their peers.
- Staff told us that they felt valued and supported in their roles. The culture encouraged candour, openness and honesty.
- There was a Spire group-wide whistleblowing policy in place and posters on staff noticeboards informing staff of the policy.
- Staff were supported to develop their skills through training courses and via their personal development plans.

Public and staff engagement

- We asked senior staff how children, young people, and their families were engaged and involved in the design and running of the service. The service undertook patient satisfaction surveys. Plans were in place to introduce a children's advisory group at the new hospital.
- The provider had begun trend analysis from patient feedback in the three-months prior to our inspection. Children and young people gave their feedback using child friendly patient surveys. Patient satisfaction was 100% for the three-months prior to our inspection. Nurses told us that as a result of patient feedback the range of dietary options from the kitchen had increased.
- We asked nurses about their involvement in the planning and delivery of the service. Staff told us their views were actively sought by the paediatric lead in planning the children's ward at the new hospital.

Innovation, improvement and sustainability

- At the time of our inspection, a new hospital facility was being built nearby which would allow children's services at the hospital to increase. The new hospital was being built with a purpose built children's ward to allow more paediatric patients to be catered for. The new hospital was planned to enable consultants to provide care for children undergoing more complex surgery, or who have been assessed as being at a higher risk of complications.
- There were plans in place to recruit additional paediatric nurses to support and deliver a wider range of services at the new hospital site.

Good

Outpatients and diagnostic imaging

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

Summary of findings

We rated outpatients and diagnostic imaging good overall. This was because:

- There were systems in place for reporting risk and safeguarding patients from abuse. Staff were aware of how to report incidents that took place in the departments and we saw evidence of incidents being investigated and learning being shared within the team.
- From observations we saw that equipment was maintained, appropriately checked and visibly clean. Medical equipment was checked and maintained by an independent company.
- Clinical areas and waiting rooms were all visibly clean and tidy. Patient records were stored securely and were only accessible by those authorised to do so. This ensured that patient confidentiality was maintained at all times.
- The departments used evidence based guidance to inform their practice.
- Patients and their relatives we spoke with told us they were supported by staff that were caring, empathetic and helpful to their needs. Patients were positive about how they were treated by staff. Staff maintained patient privacy and dignity across the departments and provided emotional support to patients.
- Patients were kept well informed about the treatment they were receiving in the hospital.
- Services were planned and delivered to meet the needs of patients. The hospital offered a wide range of services, which were planned and delivered in a way which met the needs of local people. Patients told us there was good access to appointments and flexibility to attend appointments at times that suited their needs.
- All staff told us that managers of the service were available and supportive. Staff were positive about the culture within their departments and said the senior management team were visible and approachable.

However,

- The hospital did not hold a full medical record for insured and self-paying patients using the outpatient department. Although it did have a process for requesting all records needed.
- Not every non-emergency patient having a CT scan involving an iodinated contrast agent had their kidney function tested prior to their scan, which is a recommendation of Royal College of Radiologist guidelines.
- On one occasion during the inspection we found patients standing in the waiting area as there were not enough seats in the outpatient department waiting area to always accommodate all of the patients waiting for appointments.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- The hospital reported 89 clinical and 12 non-clinical incidents in the outpatient and diagnostic imaging departments between April 2015 and March 2016.
- The hospital used a computer system for reporting incidents. Staff we spoke with in the outpatient, physiotherapy and diagnostic imaging departments knew what constituted an incident and knew how to use the computer system. Incidents where patients had received more radiation than they should have had would be reported using the computer system and reported to the manager of the diagnostic imaging department, who would, where appropriate to do so, notify the Care Quality Commission (CQC). There were no radiation incidents reported between April 2015 and March 2016.
- Staff told us that learning from incidents was discussed as part of the departmental meetings. Staff in the outpatient, physiotherapy and diagnostic imaging departments gave us examples of different incidents which had occurred and the actions that had been taken as a result of them.
- On the staff noticeboard in each department, we saw a poster giving examples of three recent incidents, outlining what had caused the incident and the actions taken or lessons learned.
- Incident trends and specific incidents were discussed at hospital-wide meetings. We saw evidence that clinical incidents were reviewed at the clinical governance committee meetings (we reviewed minutes of meetings held in September 2015, February 2016 and June 2016) and non-clinical incidents were reviewed at the health and safety committee meetings (we reviewed the minutes of the meetings held in June 2016 and August 2016). We reviewed the minutes of the medical advisory committee (MAC), which is a leadership group of consultants. In the March 2016 meeting only the numbers of incidents were recorded, but in the May 2016 meeting, following changes to reporting to improve the information provided to the MAC, a record of individual incidents and trends was discussed.
- Between April 2015 and March 2016, the hospital reported one serious incident requiring an investigation, this related to a patient having an anaphylactic reaction to the gadolinium contrast media given to him during an MRI scan. Contrast is a substance injected into someone before a scan to enhance the images taken. We reviewed the root cause analysis investigation completed by the service and found it to be comprehensive and involved different teams in the hospital. The investigation identified lessons learned from the incident and actions to take to prevent a recurrence. On the inspection we saw evidence of changes made as a result of the incident including changes to training and new monitoring equipment.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Between April 2015 and March 2016 there had been one incident, which had triggered the duty of candour process; this was the serious incident relating to anaphylactic shock. The diagnostic imaging department told us about an incident which had happened the week before the inspection, which also had triggered the duty of candour process. The service was in the process of investigating the incident.
- Staff we spoke with had a good understanding of the principles of being open and honest with patients when things went wrong and senior staff understood the steps they needed to take if there was an incident which triggered the duty of candour.

Cleanliness, infection control and hygiene

- The outpatient, physiotherapy and diagnostic imaging departments were visibly clean and tidy.
- The hospital had an infection prevention and control lead, who chaired an infection prevention and control committee, which was attended by representatives of the outpatient, physiotherapy and diagnostic imaging departments. There was therefore a clear route for infection prevention and control issues to be escalated.
- The hospital used a Spire group-wide infection prevention and control manual, which provided information and advice to staff on different areas such as personal protective equipment, hand hygiene and isolation precautions.

Good

Outpatients and diagnostic imaging

- All staff had to complete a module in infection prevention and control, as part of the 2016 mandatory training programme. At the time of the inspection, 86% of staff in the outpatient department and 92% of staff in the diagnostic imaging and physiotherapy departments had completed the training. The hospital target was 95% by the end of 2016. The module also included information on personal protective equipment.
- Staff in the diagnostic imaging department could describe the process for patients who required isolation, for example because they had suspected hospital acquired infection such as methicillin-resistant Staphylococcus aureus (MRSA) this included the use of protective equipment and deep cleaning following the procedure.
- The hospital carried out a monthly health and safety inspection of the diagnostic imaging, physiotherapy and outpatient departments. As part of the hospital's own health and safety inspection, the cleanliness, waste disposal and personal protective clothing and equipment were reviewed. The hospital's own health and safety report set out an action plan to address areas for improvement. Actions plans were reviewed at the health and safety committee meetings.
- In the outpatient departments, housekeeping staff carried out daily cleaning of the rooms and nursing and health care assistant staff carried out weekly deep cleans of the rooms. We reviewed the weekly cleaning records, which were fully completed each week in the month before our inspection.
- In the diagnostic imaging department housekeeping staff completed daily cleaning of all rooms, apart from the MRI room. Radiographers carried out daily cleaning of the MRI room and cleaned equipment daily and between patients. We reviewed the cleaning schedules for every room, which had been completed every day in the month before our inspection. We also observed radiographers cleaning an X-ray room after a patient had been imaged.
- Three of the 17 clinic rooms in the outpatient department had carpeted floors. Carpeted floors are harder to clean in the event of spillages, which can pose a greater risk of infection. We were told that there were no plans to replace them, because of the move to the new hospital towards the end of 2016. However, we were told that the rooms were not used for wound dressing or invasive procedures.
- On the inspection we saw 'I am clean' stickers in use in the outpatient department, to indicate that, following previous use, a piece of equipment had been cleaned, ready for the next use.
- Copies of the hospital's patient information leaflet on infection control were available for patients in the outpatient department. This included information on hand hygiene, equipment and the environment.
- Hand sanitisers were widely available throughout the outpatient, physiotherapy and diagnostic imaging departments. We saw instructions on hand washing at sinks in clinic rooms, posters about the five moments of hand hygiene on staff notice boards and hand hygiene posters for patients and visitors throughout the hospital.
- The hospital carried out a six monthly audit of hand hygiene in all departments, by measuring how much hand sanitiser had been used. However, weighing hand sanitiser before and after the audit period did not demonstrate that staff were following hand hygiene principles. The hospital told us it was trialling an observational audit tool before the end of 2016.
- Gloves were available throughout the treatment and clinic rooms in the departments. We observed staff in the MRI room washing hands before and after, and wearing gloves during, the administration of an injection. This was in line with the infection control manual and meant that the risk of cross infection was reduced.
- The hospital had a schedule to replace all curtains in clinical areas every six months. All of the curtains we saw had been changed within the last six months. A list in the outpatient nurses' room, which recorded when the curtains needed to be changed next, was reviewed.
- We saw that all clinical staff in the departments followed the 'bare below the elbow' guidance to allow thorough hand washing and reduce the risk of cross infection.
- Patient-led assessment of the care environment (PLACE) is a system used whereby patients assess the quality of a patient environment. The hospital scored 97.8% in the PLACE for cleanliness between February and June 2016. This was just below the England average for hospitals (98.1%).

Environment and equipment

- Resuscitation equipment was available in the outpatient department for adults and children; the equipment was shared with the outpatient, physiotherapy and diagnostic imaging departments.

There was separate resuscitation equipment in the bariatric, and ear, nose and throat clinic areas. We checked the equipment in the outpatient department and found tamper proof tags were fitted and staff had completed daily and weekly checks of the adult resuscitation equipment. There were anaphylaxis kits in the outpatient department, the diagnostic imaging department and outside of the bariatric clinic rooms on the first floor.

- In all of the diagnostic imaging rooms, the treatment rooms, the physiotherapy gym and the main outpatient reception, there were call buzzers which would notify the emergency on-call team if pressed. If a button was pressed, members of the emergency on-call team would be alerted of the location of the call. Staff told us that each week a different call button in the hospital was pressed to test response times.
- We saw monitoring equipment and suction equipment was located outside of the MRI scanner, which could be used if a patient suffered from a reaction to the contrast media used. Contrast media is a substance injected into someone before a scan to enhance the images taken. There was also mobile monitoring equipment, which could be used across the diagnostic imaging department.
- The hospital had a service level agreement with an external company for the maintenance and repair of all of the equipment. We reviewed log books for faults and errors with the equipment in the diagnostic imaging department, which were complete and up-to-date. We were told the equipment in the diagnostic imaging department was also reviewed at appropriate intervals by the radiation protection adviser. We saw evidence of monthly calibration testing of the MRI scanner taking place by radiographers in the department.
- Equipment we checked across the outpatient, physiotherapy and diagnostic imaging departments was appropriately safety tested. We found labels on each piece of equipment saying when the next check was due.
- Appropriate personal radiation protective equipment was available for staff and patients in the diagnostic imaging department. We saw a range of lead gowns, lead glasses and gonad protection for staff and patients. Staff in the diagnostic imaging department wore personal dose meters and there were fixed dose meters in the fluoroscopy and CT rooms. We checked four members of staff and confirmed they were wearing dose meters, which were recording the radiation levels.
- We saw evidence that waste was properly separated and managed. In all of the clinical rooms we saw pedal operated bins for clinical and non-clinical waste, in addition to separate sharps bins which had been signed and dated when assembled.
- The hospital scored 92.7% for the patient-led assessments of the care environment (PLACE) of condition, appearance and maintenance between February and June 2016. This was just below the England average for hospitals which was 93.4%.

Medicines

- The hospital had an on-site pharmacy, which was open on Monday to Friday between 8.30am and 5.30pm and on Saturday between 9am and 12noon. There was also an on-call pharmacist, 24 hours a day, for seven days a week. The pharmacy was located on the ground floor near the main reception.
- The pharmacy carried out bi-monthly audit of the safe and secure storage of medicines in outpatient and diagnostic imaging departments. We reviewed the July and September/October 2016 audits, which identified actions for non-compliance. By carrying out an audit, the hospital were provided with assurance about the storage of drugs in the departments.
- Medicines in the outpatient department were stored and monitored appropriately. Medicines were kept in a locked cabinet in a room with key code access. The keys were held by the lead nurse on duty. Staff told us that the medicines were reviewed monthly to check they were within their expiry date. We checked a sample of 10 drugs and 10 consumables (single use items such as bandages or plasters) which were all within their expiry date. We also reviewed the oxygen cylinder in the minor procedures unit, which was full and within its expiry date.
- Medicines in the outpatient department that needed to be stored at a lower temperature were stored in a locked fridge in one of the minor procedures rooms. We saw that the temperature of the fridge and the ambient temperature of the room was checked and recorded daily, which meant that the service could be assured that the drugs were stored at the correct temperature, so they were effective when they were used.

Good

Outpatients and diagnostic imaging

- In the diagnostic imaging department, drugs and contrast media were stored in a locked cabinet in a locked room. While the cabinet was in a locked room, during the inspection we found that the key was left in the cabinet.
- We observed staff in the diagnostic imaging department checking the volume, type and expiry date of a drug before it was administered.
- Consultants in the outpatient department provided private prescriptions to patients. The private prescription pad was stored in a locked cabinet at the reception. Prescription sheets were numbered and logged out to show which consultant had made the prescription.
- Staff in the diagnostic imaging department used patient group directives (PGD's). These are written instructions for the supply and administration to groups of patients. PGD's were used for a range of contrast media and medicines used in the scanning and imaging of patients. We reviewed the PGD's and found they were up to date and completed for all relevant staff.

Records

- We reviewed the relevant medical records of 15 patients across the outpatient and diagnostic imaging departments and found that the records were completed, legible and signed.
- We saw that records were securely stored within the departments. The outpatient department stored the records in cabinets at the main reception. The diagnostic imaging department used an electronic system to store records, including images taken.
- All NHS patients who used the outpatient department had a full medical record, which would be retrieved from the records department ahead of an appointment.
- The hospital did not hold a full medical record for insured and self-paying patients. Consultants were responsible for retaining records (if the patient had been seen previously) and bringing them to their clinic. The hospital told us that while they did not hold a full medical record, the notes of consultations could be accessed at any time, on request, through the consultant secretaries. For new insured or self-paying patients the consultant would have a GP referral with the patient's reason for referral and relevant medical history. As the hospital did not hold a full medical record for each patient using the hospital there was a risk that not all information was available during appointments with other consultants at the hospital or as part of someone's inpatient admission.
- The hospital had identified this as a risk and had an action plan in place for a full medical record to be held for every patient. The hospital said there was a team that had been brought together to implement this project. Staff told us that steps had already been taken, for example, records of outpatient appointments would be requested and added to the hospital record before a patient had surgery. We reviewed the action plan which had a target of all patients having a single patient record by the end of March 2017.
- The outpatient department carried out a twice yearly audit of the record for minor procedures carried out in the department. We reviewed the two most recent audits and saw action plans in place for areas of non-compliance. We also saw that actions were discussed in the departmental meeting and would be reviewed in the next audit.

Safeguarding

- The hospital used a group wide policy for the safeguarding of vulnerable adults and children. We reviewed the policy, which sets out the roles and responsibilities of staff if they needed to escalate concerns about the safety and welfare of patients. There were safeguarding flow-charts on all of the staff noticeboards, summarising how to raise a safeguarding concern. We also saw posters with information for staff about safeguarding women or children with, or at a risk of, female genital mutilation (FGM).
- Staff were required to complete level one and level two Safeguarding adults and children training, as part of the mandatory training requirements for 2016. At the time of the inspection, 89% of staff in the outpatient department had completed the safeguarding adults and children training and 95% of staff in the diagnostic imaging and physiotherapy department had completed the safeguarding adults training and 92% had completed the safeguarding children training. The heads of department in outpatients and diagnostic imaging both had completed level three safeguarding training.
- Staff we spoke with had a good understanding of what should be reported as a safeguarding concern. Staff knew who the safeguarding leads were in the hospital

and said they would raise a concern with them and also with their manager. Staff in all departments gave us examples of safeguarding concerns they had escalated to the safeguarding lead where they had been concerned about the welfare of a patient.

- Staff in the diagnostic imaging department told us that they had a protocol for a radiographer to review every request for imaging before proceeding to ensure the right patient received the correct scan at the right time. Staff gave us an example of where they had checked with a consultant about the X-ray images being requested, because they had concerns that it was unnecessary. The consultant had provided assurance and evidence of the benefits of the X-ray before they proceeded.

Mandatory training

- The hospital's mandatory training cycle ran from January to December each year. The hospital's target was to complete 95% of mandatory training courses.
- Mandatory training was made up of a mixture of computer based modules and practical modules. Some modules needed to be completed by all staff, including basic life support, safeguarding, equality and diversity, fire, health and safety, infection control and information governance. Other mandatory training was specific to a staff member's role for example acute illness management, blood transfusion, intermediate life support, the mental capacity act, life support, medical gases and radiation protection.
- At the time of the inspection 92% of mandatory training had been completed by staff in the outpatient department and 93% by staff in the diagnostic imaging and physiotherapy department.

Assessing and responding to patient risk

- Staff in the departments knew how to respond to patients who became unwell and how to obtain help from colleagues. The hospital used a group-wide Spire resuscitation policy. We reviewed the policy which set out the steps staff should take if someone suffered either respiratory or cardiac arrest. Staff told us that if a patient became unwell they would call the emergency on-call team or bleep the resident medical officer (RMO), depending on the severity of the patient's illness. We were told that it would be the emergency on-call team or RMO's decision whether to transfer a patient by ambulance to the local acute NHS trust.
- Staff told us patients in the outpatient department attending follow-up appointments could be admitted to the hospital, as an emergency re-admission, if they became unwell. This would need to be agreed by their consultant and in-line with the Spire admission and discharge group-wide policy. If a patient or visitor became unwell in the outpatient department and had not been treated as an inpatient, the hospital would complete an emergency assessment and transfer them to the nearest A&E department.
- All patients who were having a scan involving contrast media were given a questionnaire to complete in the diagnostic imaging department. This was used to identify and assess any risks, such as previous reaction to contrast, allergies, renal or heart complications or pregnancy. The purpose of this questionnaire was to reduce the risk of any adverse reactions or harm to patients.
- The diagnostic imaging department did not take bloods to test the serum creatinine levels (an indicator of poor kidney function) for every non-emergency patient having a scan involving an iodinated contrast media, which is a recommendation of the Royal College of Radiologists' guidelines. The guidelines acknowledge that a questionnaire, which the department was using, allows a busy unit to proceed with a contrast without recourse for a blood test. A blood test minimalises the risk of contrast induced acute kidney injury. As it is only a recommendation of the Royal College of Radiologists it is not a legal requirement.
- The diagnostic imaging department had local rules and risk assessments for each of the rooms. We reviewed the local rules and risk assessments and found they were relevant to the equipment in the room and up to date. For example in the fluoroscopy room there were risk assessments available for radiation exposure, angioplasty complications and radiation protection.
- The diagnostic imaging department had a process for alerting a clinician if there were abnormal findings on a scan. If a radiologist found abnormal findings, they completed an alert notification, which the manager would send to the relevant consultant for urgent action to be taken. On the inspection we saw evidence of urgent action being taken as a result of an alert that had been raised.
- Patients who had been given a contrast agent were given advice to hydrate and remain in the department

for 20 minutes after the procedure was completed. This was in line with Royal College of Radiation guidelines and reduced the risk of a patient having a reaction to a contrast agent, without medical staff nearby to help. During our inspection we observed a radiographer giving the correct guidance to a patient.

- We were told that radiologists double reported on all mammography scans taken in the diagnostic imaging department. This meant that any risk of breast tumour being undetected was reduced.
- We saw signs outside the areas where radiological exposures were taking place in line with Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. This ensured visitors or staff could not accidentally enter a controlled area. There were also signs outside the MRI room warning patients who had a pace maker fitted of entering the area.
- We saw signs on the doors of all the rooms in the diagnostic imaging department and in reception warning female patients of the risks of being exposed to radiation if they were pregnant or might be pregnant. Female patients were asked about pregnancy before a scan took place.
- The hospital had a service level agreement with a company who provided the radiation protection advisor. This ensured independent scrutiny of whether the hospital was complying with IRMER. Staff told us that they had a good working relationship with the radiation protection advisor, who they had very good access to. The head of the diagnostic imaging department was the radiation protection supervisor for all of the areas.

Nursing staffing

- There was no set guidance for safe staffing levels in the outpatient department. The outpatient department set the staffing rota two weeks in advance and based the levels of staffing and the skill mix on the clinics scheduled for that week. The staffing levels were reviewed and staff told us that there was a lot of flexibility amongst staff to increase the staffing levels on shifts if it was needed. The hospital provided us with information, which showed that between January and March 2016, there were no unfilled shifts.
- Information the hospital gave us indicated that the outpatient department employed 12.5 whole time equivalent (WTE) nursing staff and 5.2 WTE health care assistants.
- Staff told us that although they were busy, they had enough staff to safely cover the clinics. At the time of our inspection, the department had three vacancies for nursing staff, which had been advertised, but they had been unable to fill the posts.
- The outpatient department did not use any agency staff and where contracted staff were not available to cover shifts, they used bank staff. Staff told us that bank staff had to complete the same induction as contracted staff and we saw that the hospital had specific mandatory training requirements for bank staff. This ensured that the bank staff understood the hospital and its policies and provide consistent care.

Medical staffing

- There were 377 doctors and dentists with practising privileges at the hospital. 157 of the 377 had not carried out any episodes of care between April 2015 and March 2016. In the outpatient department, consultants with practising privileges (permission to practise as a medical practitioner in that hospital) used the department's clinic rooms to hold their clinic. We were told that consultants would hold a clinic every two weeks or more frequently.
- The hospital used an external company to provide resident medical officers (RMO). The RMO was on site 24 hours a day, seven days a week.

Allied health Professionals

- The diagnostic imaging department told us there were 10 contracted radiographers working in the department. The diagnostic imaging department had an on-call radiographer for X-ray and CT scans, 24 hours a day, seven days a week, and for MRI at the weekends when spinal surgery was taking place at the hospital.
- The diagnostic imaging and physiotherapy departments told us they employed bank members of staff. Bank staff had to complete the same induction as contracted staff and we saw the hospital had specific mandatory training requirements for bank staff. The diagnostic imaging department told us they occasionally employed locum radiographers. We were told that when they were employed, they would always be supervised in their work. We reviewed the induction process, which included relevant and specific information about the

department and its procedures. This was supported by the hospital's induction policy, which set out the requirements for an induction of a temporary member of staff.

- The diagnostic imaging department had a service level agreement with a company to provide radiographers for the echocardiogram (cardiac ultrasound) service. We were told that if demand for this service increased, the department would consider employing contracted radiographers for this service.

Major incident awareness and training

- The hospital had its own business continuity plan, which covered a number of major potential incidents, such as bomb explosion, fire, flood, loss or power, communication or water. The plan included action cards to follow for each emergency and specific instruction for the diagnostic imaging and outpatient departments for the continuity of services.
- The hospital had a back-up generator to maintain an uninterruptable power for the CT, MRI and fluoroscopy rooms. This meant that if a procedure was in progress, it could be safely concluded if there was a loss of power. On the inspection we saw evidence of the monthly checks carried out of the back-up generator.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate 'effective', as we do not currently collate sufficient evidence to rate this.

Evidence-based care and treatment

- Care and treatment within the outpatient department was delivered in line with evidence-based practice. We saw examples of hospital-wide policies referring to national and international professional guidance. For example, the infection control manual referred to the World Health Organisation (WHO Guidelines on Hand Hygiene in Health Care, 2009), the chaperone policy referred to the General Medical Council (Intimate examinations and chaperones, 2013) and the resuscitation policy referred to the Resuscitation Council (UK) (Resuscitation Guidelines, 2010). The weight loss service at the hospital referred to National Institute of Clinical Excellence Guidelines (NICE) on obesity in its documentation and guidance.
- We saw that the diagnostic imaging department referred to National guidelines from the Royal College of Radiography and compliance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 in its advice and procedure documents for staff. We observed staff following the regulations during procedures.
- The weight loss service at the hospital was recognised as a Weight Loss Surgery Centre of Excellence by the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO), one of only two centres in the country to receive that recognition.
- The diagnostic imaging department used diagnostic reference levels to monitor the radiation doses received by patients from each scan. We reviewed the diagnostic reference levels which were displayed in each room and checked and audited by the radiation protection advisor.
- The hospital carried out CT scans as part of a health assessment for people who did not have symptoms requiring investigation. These CT scans were carried out in line with Department of Health guidance on individual health assessments. We saw that there was a strict criteria which had to be met before a person could be scanned. We saw that the screening was audited and all referrals had to be agreed by a radiologist before a scan could be given.

Pain relief

- In the outpatient department, consultants were able to provide private prescriptions to patients who required pain relief. Patients could collect medications from the on-site pharmacy.
- In the diagnostic imaging department, local anaesthetic was used in preparation for the injection of a contrast agent before MRI scans.

Patient outcomes

- The diagnostic imaging department collected information on images which were rejected, because the image quality meant they could not be used. We

were told that this information was available to the radiation protection adviser, who could review trends in the number of images rejected and, if deemed appropriate, put in place actions to reduce the number.
- The weight loss service participated in the National Bariatric Surgery Registry. The National Bariatric Surgery Registry was maintained by the British Obesity and Metabolic Surgery Society and collected data about weight loss for two years after surgery for different procedures. The service benchmarked itself against the national data.

Competent staff

- Staff in all departments had a mid-year and end of year appraisal. Information provided by the hospital showed that in the last year 100% of staff in the outpatient and imaging departments had had an appraisal.
- The hospital had a new starter employee guide and checklist, which needed to be completed by new starters within a month of joining. We reviewed the checklist, which ensured that a new member of staff was familiar with the hospitals procedures and policies and had been booked in to start mandatory training.
- We reviewed staff records in the outpatient and diagnostic imaging departments and found that each member of staff had been set their own specific objectives, which were reviewed during the appraisal process. We found a record of the mid- and end of year appraisals, competencies and all the training which had been completed.
- The hospital told us that when a consultant applies for practising privileges, they must submit mandatory documentation, practice details, references and proof of identity documentation. This information is reviewed at the three-monthly MAC meeting where a decision is made on whether approval should be granted.
- The hospital held a record of every consultant's competencies and the scope of practice they are able to carry out at the hospital. We reviewed the record for one practising radiologist, which was complete and up to date.
- The hospital told us that every two years, each consultant's practising privileges are reviewed. Statistical data, such as clinical indicators, significant events and complaints are reviewed to decide whether a consultant should retain their practising privileges. The hospital said that where there is any reason for concern raised outside of this review programme, such as an incident, a patient complaint, a concern raised by a staff member or through an unusual rate of performance as a result of audit, then an ad-hoc review will be completed with assistance from the relevant MAC representative for that specialty and the MAC chairman, using the Spire Managing concerns policy.
- Radiographers in the diagnostic imaging department were trained to work across at least two areas of radiography (for example X-ray and MRI) and they were encouraged to expand their practice. We saw evidence of the competencies in the staff files. We were told that one radiographer was trained and competent to work across every area of radiography in the department.
- Nursing staff in the outpatient department were responsible for being the lead nurse in a speciality in the department. This meant they would gain additional experience and knowledge and develop any relevant competencies. In the staff files we saw that specific objectives were given to the nurse for the area of specialty.
- Physiotherapists told us they were supported in their continued professional development at the hospital. We were told that a monthly meeting was dedicated to continued professional development and the hospital hosted training events, which they were encouraged to attend.
- We were told that the nursing revalidation process in the outpatient department, which involved demonstrating to the Nursing and Midwifery Council (NMC) current nursing practice and continued professional development, was overseen by the managers in the department.

Multidisciplinary working (related to this core service)

- The diagnostic imaging and outpatient departments were staffed by a range of professionals working together as a multidisciplinary team to provide comprehensive service to patients.
- The hospital employed specialist breast care nurses in the breast clinic. They worked as part of a multidisciplinary team, which offered a 'one stop shop' clinic for patients who could have a mammogram and see the consultant or breast care nurse during the same visit to the hospital.
- The hospital employed specialist bariatric nurses in the weight loss service, as part of a multidisciplinary team, in addition to the bariatric surgeon and dietician.

Good

Outpatients and diagnostic imaging

- The hospital offered a number of 'one stop shop' clinics, which involved patients seeing different professionals and having diagnostic images at the same appointment, to enable quicker diagnosis and treatment. Staff told us that they offered a hand and wrist clinic, involving a hand surgeon and physiotherapist and a hip and groin clinic, involving a hip surgeon, hernia surgeon, radiologist, sports and exercise doctor and a physiotherapist.
- The breast care clinic worked with a local NHS specialist hospital for patients who required radiotherapy and/or chemotherapy and the oncology specialists were all part of a local specialist breast care multidisciplinary team.
- In the outpatient department, consultants would routinely send letters to the patients' GP. We reviewed 10 outpatient records and they each contained letters to the patients' GP. Staff told us that they would also liaise with the GP, if they needed to do so, for the patient's ongoing care, for example if there were wound problems after surgery.

Seven-day services

- The outpatient, physiotherapy and imaging departments were open between 8am and 8pm on Monday to Friday. The outpatient department was open on Saturday morning if consultants were holding any clinics and the diagnostic imaging department was open on Saturday for MRI scans if there were patients waiting for a scan.
- The diagnostic imaging department had an on-call radiographer available 24 hours a day, seven days a week for X-ray and CT. If complex spinal surgery was being carried out at the weekend the diagnostic imaging department would have an on-call radiographer for MRI.
- The resident medical officer (RMO) was on site 24 hours a day, seven days a week.

Access to information

- All images and reports in the diagnostic imaging department were stored on an electronic system, which was accessible by radiographers, radiologists and relevant consultants.
- The diagnostic imaging department had access to an image exchange portal, which enabled the service to securely access and share images with NHS or other independent hospitals. We observed staff using the system to access a previous radiological image for a patient.
- We were told that some of the radiologists who worked at the hospital had remote access to the computer software used in the department, meaning they could securely view images at home. While they could not complete their report on the images, in the event of an emergency or abnormal finding, they could review the images and explain their findings to the consultant.
- Consultants who worked in the outpatient department had access to the computer programme which scheduled their clinics. This meant that they and their secretaries were able to review the clinic times and patients scheduled for that clinic.
- All of the hospital policies and procedures were stored on the intranet, which was accessible to all staff and procedures specific to the diagnostic imaging department were stored on a shared folder, which was accessible to relevant staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All clinical staff had to complete a module on the Mental Capacity Act (MCA), as part of their yearly mandatory training. At the time of the inspection 93% of staff in the outpatient department and 78% of staff in the diagnostic imaging and physiotherapy department had completed the training. This was below the target for completing 95% of mandatory training.
- The hospital used a Spire group-wide consent policy which we saw addressed situations where patients lacked the ability to give consent.
- Staff we spoke with understood the principles of consent and the Mental Capacity Act. Staff gave us examples of times when they had identified that patients had lacked capacity. Staff told us that it was a consultant-led service and if a patient lacked capacity to provide consent for any procedure they would escalate it to the responsible consultant and not continue with the treatment. The consultant would carry out a capacity assessment.
- In the diagnostic imaging department, written consent was taken for any procedure which involved a contrast agent. We reviewed five paper records which were all completed and signed. However, the writing on one of

the records was not legible to read. We also observed consent being taken for one procedure and found that a full and clear explanation of the procedure and risks was given.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- All of the patients we spoke with during the inspection said they had been treated well by staff in the outpatient, diagnostic imaging and physiotherapy departments.
- Staff in all departments told us they were passionate about caring for the patients in the department and that patient care was their top priority. Staff told us they would go 'above and beyond' to ensure the patients received excellent care. Staff told us that in the ophthalmology clinic, they sent Christmas cards to all their patients and the hospital told us that a patient who visited the hospital on his one hundredth birthday was given a birthday card.
- We observed staff in the outpatient and diagnostic imaging departments being professional, polite and caring with patients before and during treatment. We observed staff making patients feel at ease during scans in the diagnostic imaging department.
- The hospital reported to us that they had suspended a consultant from practising at the hospital after a patient and staff in the outpatient department reported he was rude and dismissive to a patient and as a result he had to undertake communication training.
- The hospital provided us with the most recent outpatient survey, from March 2016. In the survey, 78 patients on one day were asked to rate different aspects of the service. In the survey 72% of patients said the quality of nursing care was excellent, 23% said it was very good and 4% said it was good. In the same survey, 70% said the quality of the consultation from the consultant was excellent, 29% said it was very good and 1% said it was good. 65% of patients said the care from staff carrying out a test or scan was excellent, 33% said it was very good and 2% said it was good. 72% of patients said the care from physiotherapy staff was excellent and 28% said it was very good.
- The diagnostic imaging department carried out a survey over one day in July 2016. Of the 17 patients who responded, 70% said the efficiency and professionalism of staff was excellent, 24% said it was very good and 6% said it was quite good.
- The physiotherapy department carried out a survey between July and September 2016 in which they asked 68 patients to rate questions out of five, where five is excellent and one is poor. When asked how good the physiotherapist was at: showing care and compassion; making you feel at ease; really listening; being interested in you as a whole person, the average score was 4.9 out of five for each question.
- The departments had measures in place to protect patients' privacy and dignity when they were having treatment. Treatment rooms in the outpatient department had signs showing when they were 'in use' and consulting rooms in the physiotherapy department had 'door viewers', so members of staff could discreetly see if they were in use. We observed staff in the outpatient department knocking on clinic rooms before entering.
- The reception desks in all the departments were far enough from the nearest seating, so that staff were able to maintain privacy and dignity when speaking with patients.
- The hospital used a Spire group-wide policy for using chaperones for appointments. We reviewed the policy, which listed the types of procedures which a chaperone must be offered for. We saw posters in every clinic room and imaging room informing patients that they could ask for a chaperone for any appointment. We saw the hospital's training document for chaperones and completed competency forms in staff files. Staff we spoke with said that they acted as chaperones, in particular for clinics involved intimate examinations. They said a record was made when there was a chaperone at the appointment.

Understanding and involvement of patients and those close to them

Good

Outpatients and diagnostic imaging

- Patients we spoke with during the inspection told us they were given appropriate information by clinicians about their care and treatment. Patients explained to us that they were told about different treatment options available and what these would involve.
- We observed staff in the diagnostic imaging department clearly explaining why radiological procedures were being carried out and what they would involve.
- Patients we spoke with told us they were given information about who to contact if they were worried about their condition or treatment after they left the hospital.
- In all the reception areas, there were large signs informing private patients that they would be responsible for the cost of their treatment, including any additional tests or minor procedures which they might need.
- The diagnostic imaging department carried out a survey over one day in July 2016. Of the 17 patients who responded 65% said the explanation of procedures before and after, was excellent and 35% said it was very good. 94% of patients who responded said they were told how to get their results.
- The physiotherapy department carried out a survey between July and September 2016 in which they asked 68 patients to rate questions out of five, where five is excellent and one is poor. When asked how good the physiotherapist was at: fully understanding your concerns; explaining things clearly; helping you to take control; and making a plan of action with you, the average score was 4.9 out of five for each question.

Emotional support

- Staff we spoke with understood the emotional impact care and treatment could have on patients. In the outpatient department, a member of staff gave us an example from the same day when she had taken blood for a patient who had never had their blood taken before and had been nervous about it, so she had reassured the patient and invited them to lie down on the bed during the procedure.
- Staff we spoke with told us they would give emotional support and information to patients who were affected by their care, treatment of condition. For example, a member of staff told us a nurse in the outpatient department had spent two hours comforting a patient who had been given life changing news.
- Staff in the weight loss clinic told us that patients who had been discharged from the service were still welcome to call and have a drop in session after the clinic if they needed any further support or advice about their weight loss.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital offered a range of 32 specialities to meet the needs of the local people. Between April 2015 and March 2016, 36% of appointments were for orthopaedic surgery; 14% for general surgery; 9% for ear, nose and throat; 5% for neuro surgery, paediatric surgery and rheumatology; 4% for dermatology, gastroenterology, plastic/cosmetic surgery, urology and visa medicals; 3% paediatric medicine and ophthalmology; and less than 2% or fewer for the other specialities offered.
- Managers in the outpatient department told us that they reviewed the number of patients at every clinic, every three months, and gave consultants more or less clinic time depending on how many patients they had. This showed that the department was being responsive to the demand of patients using the hospital.
- The outpatient department had facilities for treatment to be carried out, without needing to be admitted as an inpatient. There were two treatment rooms in the outpatient department, where a range of treatment was carried out, such as wound dressing, dermatological procedures and moles and cyst removal. There was also a minor procedures room, which carried out minor procedures such as procedures on veins.
- The diagnostic imaging department had responded to demand for MRI scans, by opening on Saturday mornings if patients were waiting for scan. The diagnostic imaging department also told us they had also reduced the length of appointments from 30 minutes to 20 minutes, so more patients could be seen during a day.
- The departments were all open between 8am and 8pm on weekdays and certain clinics were held on Saturday

mornings, giving people of working age the flexibility to attend before or after work. However, there would be less flexibility for outpatient appointments depending on the speciality or consultant a patient needed to see.

- The departments shared a well-signposted entrance and patients were signposted throughout the hospital.
- Free car parking was available in the hospital car park. During our inspection we saw cars parked on double yellow lines, outside of parking bays, which indicated that there were not enough parking spaces for all patients and visitors. Staff told us that staff, patients or visitors could park on roads beside the hospital if the car park was full.
- The diagnostic imaging department had cubicles outside the CT and MRI rooms, which patients could use to get changed into a gown before having a scan. There were also patient lockers, where patients could securely leave their clothes and belongings during a scan.
- In the waiting area for the outpatient department there were seats of different height and style, which allowed patients to sit in a chair which was comfortable for them. However, on one occasion during the inspection we saw that all of the chairs were used and one patient had to stand while waiting for their appointment. There were sufficient chairs outside the diagnostic imaging and physiotherapy reception, as well as outside of the MRI and CT rooms. In the bariatric clinic there were chairs which were suitable for patients using the clinic.
- There was a small children's play and toy box in the waiting area of the outpatient department and a small toy box in the waiting area for imaging and physiotherapy departments. However, there were few toys and they were only suitable for very young children.
- There were newspapers in all waiting areas and a television with subtitles in the waiting area of the outpatient department.
- Hot and cold drinks were available in the reception areas for all the departments and the hospital had a canteen, which sold food and snacks. The canteen was situated by the main entrance to the hospital.

Access and flow

- Between April 2015 and March 2016, the hospital performed better than the 92% indicator for incomplete pathways beginning treatment within 18 weeks of referral. In the same period more than 98% of patients began treatment within 18 weeks of referral. This is a measure of NHS patients who are waiting to receive treatment.
- Between April 2015 and March 2016 all NHS patients were seen within six weeks, this meant that the hospital achieved the diagnostic target of completing all tests within six weeks.
- Staff told us that in the outpatient department the time it took for an appointment would depend on the specialty and whether a patient wanted to see a named consultant or the next available consultant. The longest wait would be two weeks (the gap between a consultant's clinics), but it was likely to be a lot sooner.
- Patients we spoke with said they were given some flexibility and choices when they arranged their appointments in the outpatient department. NHS patients were able to use the Choose and Book system if they were referred to the hospital by their GP.
- An outpatient survey carried out in March 2016 asked 78 patients on one day to rate different aspects of the service. The survey results showed 57% of patients said the ease of making an appointment was excellent, 33% said it was very good, 9% said it was good and 1% said it was fair.
- Staff in the diagnostic imaging department told us most scans or images would be arranged within two or three days from referral. Staff told us there were free slots in the MRI and CT list to accommodate emergency requests. We reviewed the lists on both days during the inspection and saw evidence of free slots in the list.
- Some radiologists had remote access to the reporting software, which allowed them to provide an urgent verbal report of a scan or image. Staff told us that they aimed to report on scans within 48 hours.
- Staff told us it was the consultant's responsibility to act on patients who did not attend their appointments. For example they may offer a new appointment or discharge the patient. Patients using the weight loss clinic would be called by one of the team if they did not attend. This was so they could find out why the patient did not attend and to book another appointment. The hospital told us it did not keep a record of how many patients do not attend their appointments. This meant it was unable to monitor or manage the 'did not attend' rates.
- Staff in the outpatient department told us that if a patient was waiting for an appointment for longer than

15 minutes, they would speak to them, apologise and tell them how long they were likely to wait so they could leave the reception area if they chose to. Patients we spoke with said that appointments usually ran on time. One patient said he had been waiting for 15 minutes for his appointment, but was told about the delay when he arrived at reception.

- In the March 2016 outpatient survey, 63% of patients said their appointment was on time, 16% said there was a delay of less than 10 minutes, 9% said there was a delay of between 10 and 20 minutes, 6% said there was a delay of more than 20 minutes and 7% said there was a delay of 30 minutes or above.
- Staff in the outpatient department did not monitor the timeliness of all appointments, which meant service leads were unable to establish how frequently clinics were running behind schedule and by how long.
- The diagnostic imaging department carried out a survey over one day in July 2016. Of the 17 patients who responded 59% said the promptness of service was excellent, 29% said it was very good and 12% said it was quite good.

Meeting people's individual needs

- The hospital used a Spire group-wide equality and diversity policy. All staff in the hospital had to complete equality and diversity training as part of their mandatory training. At the time of the inspection 100% of staff in the outpatient department and 96% of staff in the diagnostic imaging and physiotherapy department had completed the training.
- The hospital had a dementia lead and told us that it offered training in dementia to staff. We reviewed an information leaflet for staff about dementia, which set out good practice for staff. The hospital scored 88.8% for the patient-led assessments of the care environment (PLACE) of dementia between February and June 2016. This was higher than the England average (75.3%) for hospitals.
- The hospital was well equipped for bariatric patients. Rooms used by the weight loss clinic were designed to accommodate bariatric patients, with specially designed chairs and bed. The waiting area had a number of seats suitable for bariatric patients. The hospital had scales and an electric wheelchair, which could both be used for patients up to 50 stones.
- The hospital used a translation service, providing translators who could attend the hospital and a telephone based translation service. Staff in the outpatient department told us that patients who visited the hospital spoke a wide range of languages and they used the translation service daily. Staff said that for outpatient appointments, they generally used the telephone service. In the departments there were leaflets about procedures carried out in the hospital and other topics, such as anaesthetic and hospital acquired infections. We saw that the leaflets gave relevant information about the procedure and advice for patients about aftercare. In the outpatient department there were also leaflets from different charities and support services for people who had been diagnosed with cancer. Leaflets for the bariatric clinic were available in English and Arabic, as the service was used by many patients who spoke Arabic as a first language. The service also developed information about dieting and recipes which was culturally appropriate, for example we saw a leaflet about weight loss, while fasting during Ramadan. This showed the service was responsive to the needs of the patients who attended the clinic. While other leaflets were only in English, the hospital confirmed that it had a service level agreement to translate any piece of written information within two hours. If more urgent translation was required, these could be read out over the phone via a certified translator within 15 minutes.
- Staff told us that there were few patients who visited the hospital who had learning disabilities or other additional needs. However, if a patient or their family needed additional support, they would try and accommodate for the patient. For example, a patient with learning disabilities would be taken straight through to a clinic room, so they did not have to wait in a busy environment. Patients who had reduced mobility were taken in a wheel chair from the outpatient department to the diagnostic imaging department.

Learning from complaints and concerns

- The hospital used a Spire group-wide complaints policy. We reviewed the policy, which sets out the two stage procedure for complaints from NHS patients and three stage procedure for complaints from private patients. Stage one involved an investigation and response by the hospital. If a complaint went to stage two, it was reviewed by Spire Group's Medical Director for private patients or an independent investigation by the

Good

Outpatients and diagnostic imaging

Parliamentary and Health Service Ombudsman for NHS patients. For private patients the complaint could then be escalated to stage three, which was an independent investigation by the Independent Sector Complaints Adjudication Service (ISCAS).

- Staff in the outpatient department told us if someone was unhappy with the care or service they had received, they would try to resolve it themselves and inform their manager. Patients were given a 'Please talk to us' leaflet, which included information about making a complaint. There were two versions of the leaflet, one for NHS patients and one for private patients. We found the leaflets provided useful information about making a complaint and escalating the complaint.
- The hospital received 18 complaints between January and June 2016 from patients who attended the outpatient, physiotherapy and diagnostic imaging departments. We reviewed the complaints register and found no specific trends.
- The hospital gave examples of where they had changed practice to improve the service as a result of complaints. For example, a complainant was refunded for the cost of taking bloods and a consultant suspended and instructed to take training in communication following a complaint that he was rude and dismissive.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership / culture of service

- Staff in all the departments said their managers were approachable, open and very supportive. Staff in the diagnostic imaging department told us they had been involved in decision making processes. For example, they were involved in deciding what equipment they would use in the new hospital. In the physiotherapy department staff told us their manager had involved them with developing the service.
- Staff in all departments were positive about the culture and said that morale was good. Staff told us the departments were 'close knit' and 'like a family'. In the outpatient department staff told us there was a good relationship between the medical and nursing staff.
- All the staff we asked were familiar with the hospital's senior management team and said they were visible and regularly visited the departments.
- The hospital had a Spire group-wide whistleblowing policy in place and posters on staff noticeboards informing staff of the policy. Staff we spoke with told us they would be comfortable speaking up if they had a concern to either their managers or directly to the senior management team.
- Information the hospital gave us showed that between April 2015 and March 2016 in the outpatient department there was no turnover for nurses or healthcare assistants. Vacancies in the department were for new posts which had been created.

Vision and strategy for this this core service

- Staff we spoke with in the outpatient and physiotherapy departments had a good knowledge of Spire's and the hospital's vision. Staff we spoke with in the diagnostic imaging department had different levels of knowledge of Spire's or the hospital's vision. However, all staff in all departments had a good understanding of the future plans for the hospital and their departments.
- Staff were enthusiastic about the move to the new hospital site and the opportunity to work in a new environment, with new equipment and facilities. The departments did not have formal written strategies, but the move to the new hospital and developing the business were the main focuses for all the departments we visited. Staff in the outpatient and imaging departments told us about the development of cardiology being a focus, as equipment at the new hospital would enable more procedures.
- Staff in the diagnostic imaging department said the new CT scanner in the new hospital would give the department opportunities to offer new procedures and increase the business, due to it being the first of its type in the region.
- In the physiotherapy department, staff told us they were involved in the development of new services, such as an athletic screening service, which would involve using new technology to assist their work.

Governance, risk management and quality measurement for this core service

- There was defined governance and reporting structure in the hospital, which the departments fed into. Managers from the departments attended the clinical

governance committee, heads of department meetings, health and safety committee meetings and the infection prevention and control committee meetings. The manager of the outpatient department also attended the clinical effectiveness meetings.

- Departments held their own team meetings, in which information was fed back from the hospital-wide meetings. We were told that the outpatient department held team meetings every two months, the diagnostic imaging department held meetings every two or three months and the physiotherapy department held weekly meetings, which covered different topics on rotation, such as department news, hospital news, service development and continued professional development. We reviewed minutes of the most recent meetings in each department, which we were told were emailed to all staff.
- In each of the departments there were noticeboards, which, we observed, displayed up to date information about business objectives, the vision, patient satisfaction and learning from incidents and key policies and information bulletins, such as whistleblowing policy, hand hygiene, sepsis and the 'six Cs' (six values for nursing and caring staff: care, compassion, competence, communication, courage and commitment).
- There was a hospital risk register in place and each department also held its own risk register. We reviewed the risk register, which reflected risks identified by staff during the inspection. The register set out the cause, controls and actions taken for each risk. The health, safety and risk management group met bi-monthly with a representative from each department in attendance. The risk register was formally reviewed at this meeting. Risk was also a standing agenda item at the weekly senior management team meeting and was discussed in detail at least once per month.
- The hospital also held a register of all the risk assessments in place in each department. We reviewed the register and found they had comprehensive risk assessments to cover a wide range of risks in the departments.
- All applications for practising privileges were reviewed every three months by the medical advisory committee (MAC). The specialities were all represented by members of the MAC. There was a system in place to review practising privileges annually and to remove the privileges of consultants who did not meet the required standards or had not used the hospital in the previous 12 months.

Public and staff engagement

- The outpatient department used a number of ways to find out the views of patients; they carried out a three monthly survey to collate views of patients who visited the department on one day. The department also used the Friends and Family Test to find out the views of NHS patients. Staff told us that the results of the three monthly outpatient surveys were reviewed by an external company and considered by managers in the department. The service had highlighted concerns about the short length of a consultant's appointments, which was addressed. Staff told us that results of the survey were discussed at a team meeting.
- The physiotherapy department carried out a three monthly patient satisfaction survey, in which it asked a number of questions about the patient's experience. We reviewed the last survey, which was completed between July and September 2016, which identified actions around participation and highlighted the best performing member of staff.
- The diagnostic imaging department had carried out a survey of patients who visited the department on one day in July 2016. At the time of the inspection, the department had not decided how often it would be repeated.
- The hospital held monthly coffee catch up sessions, which were an opportunity for all staff to here from senior managers about the hospital's plans. Staff told us this was an informal opportunity to hear about and discuss the plans for the hospital.
- The hospital set up a monthly committee with staff representatives from across the hospital to discuss the move to the new hospital. A representative on the committee told us they were given information about the hospital to share with their teams. Staff in the diagnostic imaging department said they had all been involved in the decision making about the equipment which had been bought.

Innovation, improvement and sustainability

- The physiotherapy department offered treatment for sports injuries using innovative equipment, such as an anti-gravity treadmill (a treadmill in a pressure

controlled chamber to minimise weight bearing pain by reducing pressure on the patient's lower body) and extracorporeal shock wave treatment (a non-invasive treatment for joint pain). In October 2015, the department hosted an external hand and wrist sports injury masterclass for doctors, physiotherapists and sports therapists. The department was developing the service to include an athletic screening service and Pilates.

- The diagnostic imaging department had appointed a new team leader in preparation for the move to the new hospital. The team leader would be responsible for interventions carried out in hybrid theatre (an operating theatre with imaging devices). The hybrid theatre would allow the service to carry out a wider range of cardiology procedures at the hospital.
- The diagnostic imaging department had chosen a CT scanner for the new hospital, which we were told would give the lowest radiation dose of any scanner in the country.
- The diagnostic imaging department offered digital mammography, which is offered at few independent hospitals. This is a mammography technique, where X-ray protections are taken from a range of different angles and reconstructed to produce a 3D image of the breast.

Outstanding practice and areas for improvement

Outstanding practice

- The resuscitation lead at the hospital had introduced a colour coded resuscitation system in paediatrics which was in line with best practice.
- The bariatric service provided all leaflets in Arabic and developed information about dieting and recipes which were culturally appropriate, for example a leaflet about weight loss, while fasting during Ramadan.
- The hospital offered a range of one stop shop clinics for patients who could have diagnostic tests and see clinicians from a range of disciplines, such as the hip and groin clinic involving a hip surgeon, hernia surgeon, radiologist, sports and exercise doctor and a physiotherapist.

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that record keeping in respect of controlled drugs is accurate and complete.
- The hospital must ensure that every patient using the hospital has a full medical record.
- The hospital must ensure that accurate, complete and contemporaneous records are kept in respect of each patient including the World Health Organisation safer surgery checklist.
- The provider must ensure that when treatment is provided to visitors an individual medical record is created and retained in line with the requirements of best practice guidance.

Action the provider SHOULD take to improve

- The provider should evaluate the paediatric staffing arrangements to ensure that children are cared by staff with paediatric competencies throughout their visit/ stay at the hospital.
- The provider should assure itself that on days when paediatric patients are operated on, there are sufficient children's nurses on duty to provide the recommended staffing skills mix and numbers outlined in the RCN guidance for safer staffing 2014.
- The provider should ensure there is consistent comprehensive investigation of incidents, so that learning can be shared.
- The provider should carry out regular records audits in accordance with best practice.
- The provider should assure itself that theatre staff providing care to children and young people have training to the levels outlined in the Royal College of Anaesthetists guidance 2016.
- The provider should routinely collate and monitor patient outcomes data.
- The provider should consider increasing their provisions for children for example creating child-friendly consulting rooms and improving its facilities for children in outpatient.
- The provider should assure itself that the gap analysis of the paediatric services undertaken is comprehensive, with an appropriate action plan to address areas for development in a timely manner.
- The provider should consider a blood test to the kidney function of all non-emergency patients having a CT scan involving an iodinated contrast agent.
- The provider should ensure that all staff in the diagnostic imaging and physiotherapy departments has completed the relevant training on the Mental Capacity Act 2005.
- The provider should consider putting place a system is in place to record and monitor the number of patients who do not attend appointments at the hospital.
- The provider should consider putting in place a system is in place to record and monitor how frequently clinics are running behind schedule and by how long.
- The hospital should ensure that staff cleanse their hands after touching patient surroundings and between patient contacts.

Outstanding practice and areas for improvement

- The hospital should ensure that actions to mitigate risks on the risk register are monitored in an effective way. The hospital should ensure that results of audits are reviewed effectively and action plans identify sufficient actions to improve patient care and safety.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ensuring that persons providing care or treatment to service users have the qualifications, skills, and experience to do so safely. The proper and safe management of medicines. Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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.

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.