Spire Murrayfield Hospital

Quality Report

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

Ratings

Overall rating for this location	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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Murrayfield Hospital is a private hospital which has been providing independent health care services on the Wirral since 1982. It is part of Spire Healthcare. Spire Murrayfield is registered to provide the following regulated activities:

- Diagnostic and screening
- Family planning
- Services in slimming
- Surgical procedures, including cosmetic surgical procedures
- Termination of pregnancy
- Treatment of disease

We carried out an announced inspection of Spire Murrayfield on 20 and 21 September 2016 and an unannounced inspection on 29 September 2016. We carried out this inspection as part of our comprehensive inspection programme of independent healthcare hospitals. Overall we have rated Spire Murrayfield Hospital as Requiring Improvement.

During our inspection we looked at three core service areas; surgery, outpatients and diagnostics and the termination of pregnancy service. We have not provided a rating for termination of pregnancy services because the service dealt with very small numbers of patients, meaning there was insufficient evidence to arrive at a rating.

There was a mobile computerised tomography (CT) service which visited the hospital on a weekly basis. This service was not registered at Spire Murrayfield and was therefore not inspected by the inspection team.

Are services safe at this hospital?

- Staff were trained in the recording of incidents on the electronic incident system. When we spoke with staff, all staff knew how to record incidents and what type of events constituted an incident.
- The hospital did not have any clear policies or use a dependency tool that indicated how many staff were needed to safely care for patients. A dependency tool is important as it determines the individual needs of patients which is then used to calculate the total number of staff required. Following the end of the inspection period, the management team provided information which indicated that they had recognised the need for implementing such a system.
- All staffing levels complied with recommended guidelines; however we found instances when the number of qualified nurses were below the specified level identified by Spire Murrayfield in the data sent by the hospital to the CQC prior to inspection.
- There was a duty of candour policy in place and all staff that we spoke with understood the principles of duty of candour. We saw an example of where harm had been caused and how the hospital had taken the appropriate steps to comply with the duty of candour legislation. However, the hospital had not taken all the required steps to inform patients when a cluster of venous thrombo-embolism (VTE) incidents had occurred.
- There had been a cluster of eight cases of VTE which occurred at the hospital in the reporting period. From these eight cases, seven patients developed a pulmonary embolism. The senior management team and the medical advisory committee (MAC) were aware of the issue. Serious adverse event forms had been completed and had not identified any breach of policy or clinical protocols. However, a more detailed root cause analysis investigation had not been completed, which was required in the Spire Healthcare policy. This meant that potential opportunities to learn from them and prevent recurrence may have been missed.
- Services were consultant led and there was a resident medical officer (RMO) on site 24 hours a day, seven days a week.
- Compliance with mandatory training was low throughout the hospital. This included a low number of staff who were up to date with training for basic and immediate life support.

Summary of findings

- We found some instances where medication was prescribed on paper prescription charts that were not always clear and two occasions of more than one chart present in patient notes.
- We found that health care assistants were completing VTE risk assessments, without the assurance of having their competency to do so assessed. The hospital addressed this immediately and put in place an action plan to introduce competency assessments for this task in the two weeks following the inspection.

Are services effective at this hospital?

- Local policies, procedures and care pathways for all services were based on evidence and guidelines produced by Royal Colleges' and National Institute for Health and Care Excellence (NICE).
- The hospital had an annual audit timetable that was followed by all departments. The timetable was reviewed regularly by a number of committees, including the Clinical Governance and Medical Advisory Committees.
- Outcomes data indicated that the hospital was performing at a comparable level with other independent hospitals for the services it provided.
- Patients were assessed for fluid and nutrition requirements using formal tools. Fluid and nutrition intake was monitored and recorded in patient records. All records that we reviewed contained fluid balance charts. Patients were fasted for surgery in line with national guidelines.

Are services caring at this hospital?

- We observed that patients were treated in a caring and compassionate way at all times. Staff addressed patients with respect and dignity and discussed the emotional needs of patients with inspectors.
- We found that the senior management team placed great emphasis on considering patients' emotional needs and treating patients with compassion. The hospital promoted the six C's (care, compassion, courage, communication, commitment and competence) and encouraged a person –centred approach to care.
- Patients told us that they were treated with kindness and respect at all times. We also received thirty comment cards related to our inspection, which reported that staff were kind, caring and that they were treated with respect.

Are services responsive at this hospital?

- We found that the senior management team worked collaboratively to plan services for patients using the hospital. This team reviewed how services were delivered and considered the needs of patients when redeveloping services. An example of this is the recent redesign of outpatients services in line with patient needs.
- The hospital had an admissions policy with detailed criteria for patients who could be safely treated at the hospital. We found this policy was being implemented.
- The hospital was highly responsive in terms of access and flow for all services, particularly termination of pregnancy and outpatients. All patients were seen in a timely manner and referral to treatment times were being met.
- The hospital considered the needs of patients with complex needs who used its services.

Are services well led at this hospital?

- There was a clear vision and strategy for the hospital. The senior management team were able to articulate this vision and disseminated it throughout the hospital.
- We found that there were robust governing structures in place, which included a number of groups with different functions and included clinical governance, combined health and safety/risk and senior management team.
- The hospital had developed a set of standard operating procedures and working instructions to support the Spire corporate policies that already existed. However, we found that the provider's policy for VTE was not in line with national NHS recommendations. This was because the provider's policy stated that VTE incidents that occurred within 30 days post-surgery should be investigated. Guidelines from the national VTE prevention programme (2013) state that incidences of VTE can be attributable to surgery and should be investigated up to 90 days post-surgery.
- The hospital did not provide sufficient management overview of the termination of pregnancy service.
- The hospital did not have a formal staffing policy in place.

Summary of findings

- The Medical Advisory Committee (MAC) was well attended and had representation from each medical/surgical specialty. The MAC reviewed all applications for practising privileges. The MAC was well integrated into the clinical and corporate governance arrangements and reported a strong working relationship with the hospital management team.
- There was a focus on safety and risk in the governance structures and this was reflected throughout the hospital.
- There was strong leadership in evidence at the hospital. The hospital director working closely with a small senior management team to provide a focus on the quality and safety of services provided to patients.
- Staff morale was extremely high, with all staff we met with reporting high levels of satisfaction within their roles and with the leadership and senior management team.

We saw one area of outstanding practice;

- Two members of the physiotherapy team attended a six week pilates course approved by the Australian Physiotherapy and Pilates Institute (APPI) in order to offer a complimentary pain relief therapy for patients. Pilates is used as a preventative and multi-disciplinary approach to treatment. The classes were also open to patients without a referral.

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

Importantly;

- The hospital must ensure that all incidences of venous thrombo-embolism resulting in a pulmonary embolism are thoroughly investigated in line with Spire policy and national guidance. This is so that potential learning is identified and improvements are made when needed.
- The hospital must have a robust system to determine the numbers of staff required at any given time on the inpatient ward.
- The hospital must ensure that there are sufficient numbers of staff who are up to date with basic and immediate life support training.
- The hospital must ensure that all staff have the necessary competencies for the tasks they are required to perform.

Termination of pregnancy service

- Records by health professionals must be clear and easy to read.
- Evidence of counselling offered must be included in patient records.
- Medication charts must be clear, with all prescribed medication included and only one per patient.
- The hospital must monitor the outcome of each termination of pregnancy.
- The hospital needs to audit the uptake of Long Acting Reversible Contraception.
- The hospital must evidence screening for sexually transmitted infections.
- The hospital must evidence a discussion with patients about HSA4 form and evidence that this has been sent.

We issued a section 29 warning notice to the provider as we were not assured that all incidents were robustly investigated. A Section 29 warning notice tells a provider or registered manager that they are not complying with a condition of registration, requirement in the Health and Social Care Act 2008 or a regulation, or any other legal requirement the CQC view is relevant. Warning notices are issued in line with the CQC enforcement policy if there 'appears to the commission' to be a breach of relevant regulations. A warning notice can be served on any registered person.

In addition we identified areas where the provider should take action;

In Surgery

- The hospital should consider how to become compliant with building note HBN 00-09.

Summary of findings

- The hospital should review equipment checking procedures, ensuring that resuscitation equipment on the ward is checked robustly and is in date.
- The hospital should review processes to make sure that all cleaning agents are locked away in an appropriate storage area so that they are not accessible to members of the public.
- The hospital should consider ways to ensure that all staff decontaminate their hands when required.
- The hospital should consider storing emergency anaphylaxis medication in a more secure area so that it is not accessible to members of the public.
- The hospital should consider ways to ensure that all staff are fully aware of female genital mutilation (FGM) and their legal obligation to report any identified incidences of it.
- The hospital should improve compliance with overall mandatory training.
- The hospital should make sure that consultants include their GMC number on all occasions when signing patient records.
- The hospital should make sure that 'stop before you block' signage is used in all anaesthetic rooms and should consider monitoring compliance with 'stop before you block' during procedures.
- The hospital should ensure that efficacy of administered pain relief is documented in line with Spire policy.
- The hospital should ensure that written communication is provided on all occasions when Duty of Candour is being discharged.
- The hospital should improve its performance in relation to compliance with fasting guidelines prior to patients undergoing surgery.
- The hospital should consider using Q-PROMS to monitor cosmetic surgery outcomes and compare them nationally.
- The hospital should ensure that they keep evidence of all achieved competencies for staff in their personal files so that these can be evidenced when required.
- The hospital should find ways to share information about implants used during surgery to the patient's GP on discharge.
- The hospital should consider introducing guidance for staff about patients who suffer with delirium following an anaesthetic so that staff have consideration for this when managing patients.
- The hospital should ensure that all policies take into account national guidance.

In the Termination of pregnancy service

- The provider should consider ways to identify feedback from TOP patients to improve the service.
- The provider should provide clear and accurate information in patient leaflets.
- The provider should make it clear when complications should be recorded as incidents.
- The provider should ensure that analgesia is prescribed in line with RCOG guidelines.
- The provider should record evidence of all discussions about risk of complications including any increase in risk of complications.

In Outpatients and diagnostics

- The hospital should ensure that all PGD's are signed by an appropriate member of staff.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	The hospital did not use a dependency tool to determine the required staffing numbers or have formal guidance detailing how many staff were required on the inpatient ward. Health care assistants were completing risk assessments for patients on admission without having been assessed for competency. Additionally, we found incidences of risk assessments completed by health care assistants that had not been countersigned by a registered nurse as required. The hospital had policies for incident management and investigation but these were not always followed. The management team had not always followed duty of candour legislation when patients had suffered patient harm. However; the hospital followed and met the association for perioperative practice (AfPP) guidelines for staffing in theatre. Care pathways were evidence-based and had been developed in accordance with national guidelines such as those from NICE and the Royal College of Surgeons. Staff delivered care and treatment in a caring and compassionate way. Patients were treated with dignity and respect.
Outpatients and diagnostic imaging	Good 	There was a culture of reporting investigating and learning from incidents. The departments were visibly clean and there were low levels of healthcare related infections. There were effective procedures to stabilise and transfer patients who became unwell. Evidence-based guidance and best practice was followed. There was effective multidisciplinary working, where different disciplines worked well together to provide a more holistic service to patients. Feedback from people who used the service was continuously positive, they said staff were compassionate and kind

Summary of findings

and were attentive to their needs. Patients were involved in decisions about their care and treatment. Care was planned and delivered in a pleasant and appropriate environment with the needs of patients and their relatives being taken into account. Complaints were dealt with appropriately. Leaders were visible, experienced, competent and enthusiastic. There were strategies and plans in place for the future of the hospital, in particular, the recent restructure of the outpatients department. There was effective governance, audits and internal measures of performance and quality. There was a positive staff culture.

Termination of pregnancy

Not sufficient evidence to rate

The service is available to self–funding patients from the age of 18 years and no later than 14 weeks gestation. The service offered both medical and surgical terminations of pregnancy. There were processes in place to protect patients from avoidable harm and abuse; however, hand–written records were difficult to read and provide clarity about discussions and treatment of patients, including prescription charts. Patients accessed the service in a timely manner with access to screening, counselling and contraception if required.

Summary of findings

Contents

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Spire Murrayfield Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging; Termination of pregnancy.

Summary of this inspection

Background to Spire Murrayfield Hospital

Spire Murrayfield is situated on the Wirral in a semi-rural location. The hospital is a single storey building, situated within its own grounds with a large car park. It is part of the Spire group of healthcare providers and provides a wide range of hospital care and treatments. It has 25 inpatient beds which are used on a regular basis and 17 individual day-case beds. It is registered to take a maximum of 46 inpatients and also provides day case and outpatient services. The hospital provides services to both NHS and privately funded patients which include surgical services, limited medical services, outpatients and diagnostics services and a termination of pregnancy service to both NHS and privately funded patients.

The majority of the hospital work undertaken at Spire Murrayfield involves surgical services and it provides inpatient and outpatient services for the following specialities; orthopaedics, ear, nose and throat (ENT), Gynaecology, General Surgery, Endoscopy, Urology, Ophthalmology and Gastroenterology. The hospital has three theatres, two with laminar flow, its own registered pharmacy, a pathology laboratory, a physiotherapy treatment area and a sterile services department used for decontamination and sterilisation of theatre instruments.

Spire Murrayfield provides treatment for adults only. The hospital previously treated children from age three to 17 but had stopped providing services for children in summer 2016. If the service is resumed it will be inspected separately.

There was an interim registered manager in post, who had submitted an application to CQC to become the registered manager.

Our inspection team

The team included five CQC inspectors and specialist professional advisors in the following areas; governance, consultant obstetrician, specialist nurses and a radiographer.

How we carried out this inspection

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?

Before visiting we reviewed a range of information we held about the hospital and each of the core services. We also reviewed data that we had requested from the hospital. We visited the hospital for our announced inspection on 20 and 21 September 2016 and on 29 September 2016 for the unannounced.

During the inspection we spoke with a range of staff in the hospital, individually and through two focus groups. These staff included the interim registered manager, the senior management team, representatives from the Medical Advisory Committee (MAC), nursing staff, medical staff, administrative staff and ancillary support staff. We also spoke with patients who were receiving treatment during the inspection and reviewed comment cards from patients who had received treatment in the two weeks prior to the inspection.

Summary of this inspection

Information about Spire Murrayfield Hospital

Spire Murrayfield has the following facilities:

- One ward with 57 inpatient beds although the hospital is registered to use 47 of them; 25 of which are used on a regular basis. This also includes a 17 Day Care Bedded Unit which was reconfigured in 2016 to provide single patient accommodation.
- 13 Outpatient Consulting Rooms including two dressing rooms and a minor ops room
- 3 theatres 2 which have lamina flow, a 3 bedded extended recovery suite and an SGS accredited Sterile Services Unit.
- Radiology facilities consist of X-ray and fluoroscopy room, ultrasound, digital mammography, biometry, a newly replaced Toshiba wide bore MRI
- Scanner, Spire mobile CT visits site one day per week.
- Physiotherapy facilities include five treatment rooms and a gymnasium that provides a variety of individual and group sessions for patients including pre-operative joint classes.
- Other facilities include a registered pharmacy, pathology and BUPA Health and Well Being Centre.
- Consultant specialities include; Orthopaedic, general, ophthalmology, gynaecology/fertility, urology, ENT, spinal, vascular, cosmetics, colorectal, gastroenterology, breast, chronic pain and bariatric services. In outpatients additional specialities include; nephrology, care of the elderly, respiratory, physician, rheumatology, dermatology, psychiatry, psychology, cardiology, podiatry and chronic pain management. '

There were 6,235 inpatient and day case episodes of care recorded at the hospital in the reporting period (Apr 15 to Mar 16); of these 57% were NHS funded and 43% were other funded. Twenty-one percent of all NHS funded patients and 31% of all other funded patients stayed overnight at the hospital during the same reporting period. There were 33,132 outpatient total attendances in the reporting period (Apr 15 to Mar 16); of these 56% were NHS funded and 44% were other funded.

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
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Termination of pregnancy	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Requires improvement

Surgery

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

Information about the service

The Murrayfield Hospital is part of the Spire group, which has a number of hospitals nationally. The hospital opened in 1982 and provides surgical services to the local population. Hospital facilities include two laminar flow theatres and a further theatre which is used for minor surgery. There are 26 en-suite rooms and 17 day case beds which are used to care for patients.

Care and treatment was led by consultants employed through practising privileges. The main types of treatment provided by the hospital were orthopaedics, ear, nose and throat (ENT), Gynaecology, General Surgery, Endoscopy, Urology, Ophthalmology and Gastroenterology. The hospital also carried out diagnostic tests and endoscopic investigations (internal camera examination using a flexible or rigid endoscope); intralipid infusion (intravenous infusion of a sterile fat emulsion for women undergoing IVF treatment); and, rehabilitation and respite care.

There had been 6,262 attendances to theatre between April 2015 and March 2016; 57% of patients were funded by the NHS, while 43% were funded by private medical insurance or paid themselves. Additionally, 24 paediatric patients (less than 1%) had undergone surgery during the same period. However, the hospital had stopped treating paediatric patients prior to the inspection.

We visited the hospital as part of our announced inspection programme on 20 and 21 September 2016. We returned for the unannounced part of the inspection on the 29 September 2016. During the inspection we visited the inpatient ward and theatre areas. We spoke to a number of staff of different grades including health care assistants, nurses, consultants and members of the management team.

We observed how care and treatment was provided, reviewed a sample of patient records as well as hospital policies and risk assessments. We also reviewed information that was provided before and after the inspection.

Requires improvement

Surgery

Summary of findings

We rated Surgery as 'Requires Improvement' overall. This is because;

- The hospital did not use a dependency tool or have formal guidance detailing how many staff were required on the inpatient ward.
- The hospital had policies for incident management and investigation. However, these were not always followed. This was because there was limited evidence to show that a full investigation had been undertaken following incidents of venous thrombo-embolism (VTE) in line with national guidance and Spire policy. This meant that the potential to learn and improve from those incidents may have been missed.
- The management team had not always followed duty of candour legislation when patients had suffered patient harm. We found occasions when written correspondence had not been provided in line with legislation.
- Health care assistants were completing risk assessments for patients on admission without having been assessed for competency. Additionally, we found incidences of records completed by health care assistants that had not been countersigned by a registered nurse as required.
- Overall compliance with mandatory training was low and did not meet the Spire target.
- The hospital had not made any adjustments to the environment for people living with a learning disability or those living with dementia.
- The hospital used a corporate risk register to monitor and mitigate risks. However, not all risks had been identified and added to the register.
- We found that on one occasion an improvement was not made in a timely way to improve services once an issue had been identified. We saw that the Medical Advisory Committee had identified an area for improvement in January 2016 but changes had not yet been implemented in September 2016.

However;

- The hospital followed and met the association for perioperative practice (AfPP) guidelines for staffing in theatre.
- Care pathways were evidence-based and had been developed in accordance with national guidelines such as those from The National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.
- Staff delivered care and treatment in a caring and compassionate way. Patients were treated with dignity and respect; this included ensuring their privacy was being maintained when they were being examined.
- Records indicated that referral to treatment times between April 2015 and March 2016 had been positive. Patients had been seen within 18 weeks of referral on over 90% of occasions.
- The hospital had a vision and strategy. The overall strategy had been developed taking into account the departmental strategies. Staff that we spoke to were able to identify with this.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We rated Surgery as 'Requires Improvement' for safe. This is because;

- The hospital did not use a dependency tool or have formal guidance detailing how many staff were required on the inpatient ward. When sampling rotas, there was limited assurance that the numbers of staff were appropriate to meet the needs of patients.
- The hospital had policies for incident management and investigation. However, these were not always followed. This was because there was limited evidence to show that a full investigation had been undertaken following incidents of venous thrombo-embolism (VTE). This meant that potential learning had been missed, as had the opportunity to make improvements.
- The management team had not always followed duty of candour legislation when patients had suffered patient harm. We found occasions when written correspondence had not been provided in line with legislation.
- We found several pieces of equipment to be out of date on the resuscitation trolley that was located on the inpatient ward.
- Health care assistants were completing risk assessments for patients on admission without having been assessed for competency. Additionally, we found incidences of records completed by health care assistants that had not been countersigned by a registered nurse.
- Overall compliance with mandatory training was low and did not meet the Spire target.

However;

- Staffing levels in theatre were appropriate and met guidance from the association of perioperative practitioners (AFPP).
- The hospital had SGS accredited decontamination services on site for sterilising equipment.
- Medicines were stored appropriately and were in date. The hospital also showed consideration for the correct management of controlled drugs, following relevant legislation correctly.

Incidents

- The hospital had an up to date incident reporting policy that was available on the intranet. Staff that we spoke to were able to identify types of things that were reported as incidents.
- The hospital used an electronic reporting system and staff were able to demonstrate how this was used. All substantive staff and consultants had access to the system. However, agency staff did not. They told us that if they wanted to report an incident they would escalate it to a manager to do it for them.
- Spire policy stated that if a patient developed a surgical site infection or a venous thrombo-embolism (VTE), this should be investigated using a root cause analysis (RCA) approach. An RCA is used to examine the full history of occurrences when an incident occurs so that the root cause can be identified and improvements made where required.
- There was limited assurance that the management team had followed this process on a number of occasions and RCA's had not always been completed when required. The hospital had reported eight incidents of VTE occurrences between January 2015 and August 2016. Seven of these had resulted in patients developing a pulmonary embolism (a blood clot in the lungs). This meant that potential opportunities to learn from them and prevent recurrence may have been missed.
- The management team told us that they had carried out investigations into these incidents. However, documentation showed that only serious adverse event forms were completed. These gave a brief description of the incidents and allowed for initial actions to be taken where appropriate but did not extend to the level of detail that would be involved in a RCA investigation.
- The hospital had a duty of candour policy which was available on the intranet. The duty of candour was also embedded in the hospital's adverse event and near miss reporting policy. 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.
- Senior staff were aware of the duty of candour process and understood the legal requirements of the duty. However, there was a differing level of understanding of the duty of candour between the seven staff members (nurses and healthcare assistants) we asked about it.

Staff members were aware that the duty related to being open and honest with patients when things go wrong. Two staff members appropriately told us a consultant or senior nurse would discuss the incident with the patient. Another staff member confirmed that an incident report would be generated and the incident reported to a line manager, following which the hospital would write to the patient.

- We reviewed a sample of incidents that required duty of candour to be instigated. We found that on seven of the incidents of VTE, the hospital had not completed this fully in line with legislation. This was because written correspondence outlining the incidents or providing information about investigations undertaken had not been provided. The hospital confirmed following the inspection that this had been omitted and that they had now provided this.
- Between the period of April 2016 and August 2016, the hospital had reported one serious incident but there were no 'never events'. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The one serious incident that occurred was reported as a burn to a patient during surgery. We reviewed the RCA investigation that had been completed and found that the appropriate members of staff had been involved in the investigation. Actions had been taken as a result so that the risk of it happening again was minimised.
- Staff confirmed that they had received feedback after submitting an incident report. We were given examples of how learning from incidents had been disseminated. Examples of this included via email or as part of the daily handover. A weekly staff briefing was also used to share information and learning about incidents, complaints and the top five risks
- Between the period of April 2015 and March 2016 there were 272 clinical incidents reported by staff in theatre or the inpatient ward. The majority of these had resulted in no patient harm. However, 44 had resulted in a low level of patient harm and 36 had resulted in a moderate level of patient harm. Additionally, there had been 27 non-clinical incidents reported during the same period.
- We reviewed a sample of incident reports between the period of March 2016 and August 2016. The majority of incidents reported had been as a result of surgery cancellations, unplanned transfers, surgical site infections and medication errors. There was evidence of incidents being investigated after being reported.
- Morbidity was discussed as part of the medical advisory committee (MAC) meetings which were minuted.

Safety thermometer

- The hospital submitted data to the NHS safety thermometer for NHS funded patients who had received care and treatment.
- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care.
- Between April 2015 and August 2016, there had been eight reported incident of venous thromboembolism (VTE). Guidelines from the National Institute for Health and Care Excellence (NICE) recommend that all patients should be VTE risk assessed on admission and reassessed 24 hours after surgery. An audit record completed in April 2016 for a set of ten patient records showed that VTE pathways had been followed in accordance with NICE guidance on all occasions.
- Patients were also assessed for the risk of falls and pressure ulcers on admission to the hospital. Compliance with these risk assessments was not normally audited, however, between April 2015 and March 2016 there had been no incidences of hospital acquired pressure ulcers. Additionally, the hospital had remained below the Spire target for the number of inpatient falls.

Cleanliness, infection control and hygiene

- The hospital had an infection control policy which was available on the intranet. Staff were able to locate this when needed. The hospital also had an infection and prevention control lead.
- We observed both the theatre and ward areas to be visibly clean. Housekeepers were available during normal working hours, seven days a week and were responsible for cleaning the ward and theatre areas. The management team confirmed that if housekeepers were not available out of hours then a room or area would be closed until the following morning.
- The hospital had two theatres which used a laminar flow system. Laminar flow is a system that is used to circulate filtered air in order to reduce the risk of airborne contamination and exposure to chemical

pollutants. If staff were to enter or leave theatre during an operation, they had to use the anaesthetic room so that the air flow in theatre was not affected. We found the system in both theatres to be working well.

- The number of surgical site infections that were acquired during operations was monitored by the management team. Between April 2015 and March 2016, there had been six incidences of surgical site infections reported. These had been reported to the infection and prevention control group as well as the medical advisory committee so that improvements were made when needed.
- The hospital had reported no incidences of hospital acquired infections between the period of April 2015 and August 2016. This included infections such as methicillin-resistant staphylococcus aureus (MRSA), colostrum difficile (CDIFF), methicillin-sensitive staphylococcus aureus (MSSA) and carbapenemase producing enterobacteriaceae (CPE).
- The hospital had a decontamination suite that was located next to the theatre area. Decontamination staff were available during normal working hours, six days a week and were responsible for the decontamination of all surgical equipment that required sterilisation following a surgical procedure. The decontamination service had received SGS accreditation. Once equipment had been decontaminated, a green 'I am clean' sticker was attached so that staff were able to identify equipment that was ready for use.
- Endoscopes (instruments used to examine the internal cavities of the body) were decontaminated and sterilised after use. A printed decontamination log accompanied each piece of equipment after decontamination and drying and into theatre for use. The log was subsequently inserted into the patient's record following the procedure. This meant there was a full decontamination audit trail available for each endoscope used.
- Records indicated that theatres were deep cleaned once every 12 months. This service was provided by an external company.
- Patients were screened for infection as part of the pre-operative clinic. If a patient was positive for having an infection such as MRSA, the infection control policy stated what precautions had to be implemented. This included using appropriate personal protective equipment (PPE) and managing the patient in a doored cubicle.
- When preparing to go to theatre, patients were asked to shower, to remove any hair around the site that surgery would take place and were given the appropriate gowns to wear.
- In theatre we found that surgical staff showed consideration to infection and prevention control procedures and best practice guidance (NICE CG74) in using sterile gowns and gloves as well as the use of incise drapes and antiseptic skin preparation.
- On the ward area, there was only one basin in the patient bedrooms we looked at. It is recommended that a minimum of one clinical hand wash basin is available in each single room, in addition to the general hand wash basin for personal hygiene in the en-suite facility (Health building note 00-09, Infection control in the built environment, Department of Health). There were no additional hand wash basins on the ward corridors for patients, the public or staff to use.
- There were hand gel dispensers at the entrance to every area where patient treatment was carried out. We observed staff using these appropriately; however, this was inconsistent. We saw staff entering and leaving the ward without using hand sanitiser gel.
- We saw the hospital was measuring the amount of hand sanitiser used in clinical areas over a week period to monitor whether or not staff were sanitising their hands. We were provided with the results for one week which indicated it was being used.
- At the time of our inspection, one inpatient was suspected of having an infection, and was therefore isolated. An isolation trolley with aprons, gloves, and hand gel was placed outside the room; however, the door to the room was left open. This increased the risk of transmission of infection.
- The hospital took part in patient led assessments of the care environment (PLACE). Between February 2015 and June 2015, the hospital scored 98% for cleanliness. The hospital had an action plan in place for addressing environmental issues highlighted by the PLACE audit.

Environment and equipment

- All areas of the hospital were on the ground floor. There were 57 individual en-suite rooms as part of the ward area, although the hospital was registered to use 47 of these. Some of these were awaiting refurbishment and contained baths rather than showers. These rooms were

still being used but were allocated based on patient needs and preferences. Additionally, there was a separate ward area that had a total of 17 beds. This was used for day case surgery only.

- Theatres were accessed by automatic doors which were secured by an electronic keypad. Each theatre had its own anaesthetic room. There was a three bedded recovery area as part of theatres which was used to recover patients post-surgery.
- Both the ward area and theatres had access to resuscitation trolleys, a difficult airway trolley and a major haemorrhage trolley. Staff told us that it was the responsibility of the night staff to ensure that these had been checked. Tamper tags were present on all of them which meant that staff were assured that nothing had been used since the last time that they were checked. In theatre, records indicated that these had been checked appropriately.
- Daily checklists for the resuscitation trolley located in the corridor near the nurses' station were completed every day (except one) in July 2016, and fully completed every day for August and September 2016. The hospital's resuscitation policy was in a folder with the trolley. The sharps bin on the trolley was appropriately labelled and in date. However, the trolley was visibly dusty and we found paediatric defibrillator pads, paediatric carbon dioxide detectors, blood clotting tubes, and defibrillator pads which had date expired in August 2016. We raised this with staff who immediately replaced the expired equipment.
- The hospital had three endoscopy stacks, which included monitors, light sources, and video processor units. This meant there was sufficient equipment to undertake the procedures. All three were portable appliance tested (PAT test) in July 2016 with a next testing date scheduled for December 2016.
- A central maintenance contract was in place with the supplier for repair or replacement of the endoscopy stack equipment and endoscopes. The theatre manager told us there had been no situations where the endoscopy stack equipment needed to be repaired or replaced. Endoscopes reported as faulty were replaced within 24 hours under the maintenance contract.
- Endoscopes were decontaminated in a dedicated decontamination room behind the theatres. This room included a scope washer-disinfector unit and a drying cabinet. These units were also maintained under contract with the manufacturer; however, the hospital maintenance team had undertaken manufacturer training which meant they were able to complete some repairs where parts were available.
- The service had equipment that was used to transfer a patient to another hospital when needed. This equipment included things such as a portable ventilator. We found that this had been stored appropriately and was sealed with a tamper tag.
- Records indicated that staff checked equipment in the anaesthetic room and completed a daily checklist. This was in line with guidance from the Association of Anaesthetists (2009) for the safe management of anaesthetic related equipment.
- We checked a sample of equipment in theatre and on the ward for compliance with servicing and portable appliance testing (PAT) and found these to be in date. The hospital employed a technician who had developed a database to monitor hospital assets. This provided oversight of whether equipment had been serviced in a timely manner.
- Control of substances hazardous to health (COSHH) legislation was adhered to on most occasions. Flammable liquids were stored in appropriately designated areas. However, on one occasion we observed that 'Haz-Tab' (chlorine disinfection dilution tablets) were stored on a shelf and not in a locked cupboard in the dirty utility room on the inpatient ward.
- Waste was managed appropriately in dirty sluice rooms. Clinical waste was segregated from domestic waste and dirty linen bins were used when needed. However, paint was peeling on the walls; there were holes in the walls, and an exposed pipe. A low foam multi-surface cleaner (an irritant) was stored under the sink, and in-date urine reagent testing strips were found on the counter-top. We saw the floor had dirty marks and was dusty. We also observed that chlorine disinfection dilution tablets were stored on a shelf and not in a locked cupboard. This increased the risk of an inadvertent accident.
- Staff were positive about the availability of the correct amount of equipment. We found that staff rotated disposable equipment so that the risk of them going out of date was reduced.
- Ward corridors were clear and clutter-free and appeared clean. Although the door to the linen store had been left

open, linen was stored off the floor and within plastic covers. A patch of floor in the linen store, approximately 80cms in length was taped and required repair or replacement.

- We checked a range of single use equipment held within the ward storeroom. The majority of this equipment was within date; however, we identified a drawer that contained drainage bags which were all date expired. The ward manager immediately disposed of the out of date bags, but also provided assurance that the particular type of bag we found was no longer used on the ward.
- The service used a paper based recording system to identify serial numbers of implants that were used. This provided a system to identify patients if a safety alert about the implant that had been used was received.

Medicines

- The hospital had an up to date policy for the safe storage, recording of, administration and disposal of medicines. This was available on the intranet.
- There was a pharmacy department that was open during normal working hours, Monday to Friday and on Saturday until 1pm. The hospital employed a pharmacist who was responsible for ensuring that medications were available when required and dispensed appropriately.
- Outside of these hours, the resident medical officer (RMO) was able to access the pharmacy when required. Hospital policy stated that they had to be accompanied by a nurse if any medication was withdrawn.
- Controlled drugs were managed in accordance with the Misuse of Drugs Act 1971. We took time to check cupboards on the ward and in theatre, finding that the quantity of drugs reconciled with what was recorded in the register and they were in date. Additionally, all records had been countersigned and the amount administered and disposed of had been recorded. There was clear evidence of pharmacy audit checks recorded in the log books. A separate log was held which recorded medications that were nearing their expiry dates. This meant staff were aware of drugs that were approaching expiry, and assisted pharmacy staff in identifying medications to be disposed of.
- Fridge temperatures were all found to be within normal ranges at the time of the inspection, which meant that medicines were stored at the correct temperature. Records indicated that staff completed daily fridge temperature checks in line with the hospital policy. Between 1 September 2016 and 25 September 2016, records indicated that daily checks had been completed on all occasions. Medicines in the fridges were stored correctly and were in date. However, we found that the fridge in theatre was not locked.
- The hospital had a fridge for storing blood. This contained four units of 'o negative' blood for emergency use and cross matched blood was stored there also.
- General medicines were stored and prepared appropriately in locked clinical areas. We checked a sample of these, finding them to be in date and stored correctly. However, emergency anaphylaxis drugs were kept in a transparent container that was attached to the wall, the lid of which was secured only by tamper tags. We found these to be easily accessible to members of the public.
- Lockable cupboards were available in each room so that patient's medication was stored appropriately. This medication was added to the patient's prescription card and administered by a member of staff.
- We checked a sample of six prescription cards and found that allergies were documented and that they had all been completed correctly.

Records

- The hospital used a paper based records system; blood and other tests results including radiology images were electronic. We found that records were kept appropriately in a secured staff area. Additionally, records were also kept by the patient's bedside. These records consisted of charts listing physiological signs, risk assessments, medications prescribed and the treatment pathway that the patient was following.
- We looked at ten sets of records and found that they had been completed correctly on most occasions. These included clinical notes, anaesthetic records, surgical records and post operation care plans. Risk assessments such as those for Venous Thrombo-Embolism (VTE), falls and pressure ulcers had all been completed. However, on all occasions, the consultants had not included their general medical council (GMC) number when signing the documentation.
- Theatre registers were completed for every procedure undertaken. We found that these records had been completed and that staff members who had been part of each procedure were easily identifiable.

- We reviewed eight sets of patient records, for patients who had received intralipid infusion (intravenous solution to aid egg implantation during in vitro fertilisation procedures). All the records were legible with the name of the reviewing doctor or nurse clearly documented and all entries signed and dated. All the records had a clear diagnosis and management plan, nursing assessment and venous thromboembolism assessment recorded.
- Only two of the records indicated that an initial pressure ulcer assessment had been completed within six hours of admission and only three of the records included nutritional and falls risk assessments. However, this was due to the relatively short admission times for intralipid infusion, which meant that not all patients were admitted for long enough to warrant these additional assessments.

Safeguarding

- The hospital had a safeguarding policy which was located on the intranet. Staff we spoke to knew how to locate this. Staff were able to describe what constituted a safeguarding concern and were able to describe how it would be escalated.
- Spire Healthcare had included female genital mutilation (FGM) training as part of the mandatory training programme for all staff in January 2016. However, there was inconsistency in staff knowledge of female genital mutilation. Two nursing staff members were aware of FGM and told us there had been no cases identified in the hospital; however, two further members of staff were unable to tell us about female genital mutilation (FGM). This was important as since October 2015, it has been mandatory for health and social care providers to provide information of any known cases of FGM to the police.
- Staff had access to a safeguarding level 2 module which had to be completed via e-learning. This met guidance from the Royal College of Nursing (2016), which recommends that all staff who have direct patient contact should have a minimum of safeguarding level 2. Records indicated that staff on the inpatient ward were 73% compliant with level 2 safeguarding for adults and 69% compliant with level 2 safeguarding for children. Additionally, 51% of staff were up to date with the same modules in theatre.
- There was a safeguarding lead based at the hospital that was trained to level 3 and was available during normal working hours, 5 days a week. If a safeguarding issue had been identified as part of a pre-operative assessment or as a result of an inpatient stay, the information was passed to the lead for review. There was also a 24 hour contact number for safeguarding referrals for staff to use that were highlighted as part of the safeguarding policy.
- The service also had a resident medical officer on site 24 hours a day, seven days a week who was trained to level 3 safeguarding for adults and children.

Mandatory training

- Mandatory training was available to all hospital staff and was mainly completed via e-learning. The e-learning modules had been developed by the Spire education team and were available to all Spire staff.
- As part of the e-learning course, there were nine standard modules that all staff had to complete. These included fire safety, health and safety, compassion in practice, manual handling, equality and diversity, safeguarding adults, safeguarding children and infection control. Overall compliance with these was 55% for staff in theatre and 45% for staff on the ward. This was below the Spire quarter three target of 75%.
- Hospital policies stated that everyone working on the inpatient ward and in theatre should be trained in basic life support. However, records indicated that only 17% of staff in theatre and 38% of staff on the ward had been trained in basic or immediate life support.
- Additionally, records indicated that two members of staff had been identified to complete adult advanced life support training and were both up to date with this. The resident medical officer had completed and was up to date with adult advanced life support training. Basic Life Support training was provided by the hospitals Resuscitation Lead. Immediate Life Support (ILS) and Advanced Life Support (ALS) training was provided at a different Spire hospital by senior trained instructors.
- Role-specific training was provided which included things such as blood transfusion, managing violence and aggression, mental capacity and management of controlled drugs. In theatres ten members of staff were up to date with training in blood transfusion and nine members of staff in the management of controlled drugs. The way the information was presented did not make it clear how many staff had been identified to complete this role specific training.

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

Assessing and responding to patient risk

- All patients received a pre-operative assessment in line with the National Institute for Health and Care Excellence (NICE) guideline CG3. The hospital had a clear policy indicating the level of assessment that patients required, which we found staff were following.
- As part of the first consultation, patients were required to complete a medical questionnaire which was reviewed by a member of staff. A nurse led face to face appointment was arranged if indicated. If a patient had been scored as high risk, a referral was made to the anaesthetist for further review.
- On admission, risk assessments were completed for all patients including assessments for VTE, falls and pressure ulcers. Pregnancy testing was also provided for patients of child bearing age. If a patient was at risk of bleeding, protocols were in place to request four units of cross matched blood to be ready in case of an emergency. However, we found that health care assistants were completing risk assessments for patients on a routine basis without having been assessed for the correct competencies. Additionally we found that assessments completed by healthcare assistants were not always countersigned by a registered nurse prior to having surgery. This was particularly important for the assessment of VTE as there had been nine incidents recorded between January 2015 and August 2016. The management team acknowledged the importance of this during the inspection and put a competency programme in place for health care assistants to complete.
- Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify patients with any medical conditions or those deemed at risk of developing complications after surgery and a decision was made whether they could be operated on at the hospital.
- A theatre team brief was held before each theatre list was started. This meeting highlighted all procedures that were being undertaken and allowed staff to confirm that the appropriate equipment was available to complete this. Additionally, any areas of risk were discussed and plans were made to manage this.
- Pre-operative marking is required to promote correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level. The national patient safety agency (NPSA) and the Royal College of Surgeons (RCS) strongly recommend that the mark should subsequently be checked against reliable documentation to confirm it is (a) correctly located, and (b) still legible. This checking should occur at each transfer of the patient's care and end with a final verification prior to commencement of surgery. All team members should be involved in checking the mark. This was completed for the procedures we observed at the time of the inspection and site marking had been completed by the consultant prior to attending theatre.
- The World Health Organization (WHO) surgical safety checklist identifies three phases of an operation: before the induction of anaesthesia (sign in), before the incision of the skin (time out) and before the patient leaves the operating room (sign out). In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation. We found that 'sign in', 'time out' and 'sign out' was completed on all occasions that we observed as part of the inspection.
- The Spire audit programme highlighted that documentation audits measuring compliance with the WHO checklist should be completed bi-annually. Records indicated that the last time that this had been completed was in March 2016. This showed that overall compliance was good, 'sign in' (97%) and 'sign out' (95%), although results indicated that not all parts of the 'sign out' phase was completed. The area most commonly missed was discussing any post-operative-concerns. An action plan had been implemented to improve compliance with this.
- The hospital used modified versions of the WHO safety checklist for ophthalmic surgery and endoscopy procedures.
- Guidance from the National Patient Safety Agency (NPSA) states that 'stop before you block' procedures should be used when patients are undergoing an anaesthetic. 'Stop before you block' is used to prevent any avoidable patient harm caused by a wrong site anaesthetic block. The hospital did not use any visual

aids and reminders which promoted this to staff in the anaesthetic room. However, staff were able to tell us about this and we observed it being completed in procedures that we were present for. The hospital did not currently have an observational audit programme measuring compliance with this.

- Patients were recovered by competent staff following surgery. This was done on a one to one patient to staff ratio. Recovery staff followed policy and procedures when transferring a patient to the ward.
- Paper charts were used to record baseline observations. The anaesthetist completed this during the operation and this was then continued in recovery and on the ward. This allowed staff to see any changes in a patient's condition.
- The hospital used the national early warning score (NEWS) to identify a deteriorating patient. Staff were aware of this and were able to describe when they would ask for a patient to be reviewed. This was in line with hospital policies and procedures. NEWS charts and guidance was included as part of each individual observation chart. We checked a sample of ten patient records and this had been completed correctly on all occasions. Additionally, records indicated that NEWS scores had been completed correctly on between 95% and 98% of occasions between January 2016 and June 2016.
- Staff were able to explain the steps they would take to inform the nurse in charge, the resident medical officer, and the consultant, if the NEWS score indicated that the patient's condition might be deteriorating. One staff member described the 'A to E' patient assessment approach carried out in the case of resuscitation; that is, airway, breathing, circulation, disability, and exposure.
- There was consultant cover available for each speciality.
- A sepsis screening tool (SIRS) was used to identify patients who were suffering from septic shock. This criteria was based on a patients baseline observations. If the criteria was met, the patient was reviewed immediately by the resident medical officer (RMO). Ward staff held consultants' contact details which meant that, out of hours, the RMO could contact the consultant directly if necessary. Sepsis recognition training was delivered to staff through the acute illness management course (AIMS).
- The hospital was a member of the Cheshire and Mersey Critical Care Network and had a formal written transfer agreement in place with the network to ensure patients could be transferred to a local acute trust if needed, as required by the Independent Healthcare Advisory Services (2015). Staff had access to contact details for the local trust if they required to transfer a patient. An emergency ambulance was requested to complete the transfer.

Nursing and support staffing

- Guidance from the National Institute for Health and Care Excellence (NICE SG1) recommends that providers should develop procedures to ensure that the number of registered nurse and health care assistants working on the wards are sufficient to provide safe nursing care at all times.
- The hospital did not have any clear policies or use a dependency tool that indicated how many staff were needed to safely care for patients. A dependency tool is important as it determines the individual needs of patients which is then used to calculate the total number of staff required. Following the end of the inspection period, the management team provided information which indicated that they had recognised the need for implementing such a system.
- An informal staff to patient ratio of 1:5 in the morning, 1:6 in the afternoon and 1:7 in the evening had been set by the management team. However, on one occasion during the inspection this had not been met. Additionally, records indicated that during August 2016, there had been 13 occasions when this had not been met. For example, on the 25 August 2016, the staff to patient ratio between 7am and 11am was 1:7 when the recommended ratio was 1:5. Records also indicated that this was a similar picture in September 2016. This meant that we were unsure if the needs of the patients during this period had been met. However, during the inspection we did not see an impact on care and treatment that was provided as a result of this.
- However, the management team told us that a planning meeting took place once a week between the ward manager and the theatre manager to determine how many staff were required to safely care for patients. This was based on the number and types of operations that had been scheduled as well as the needs of the individual patients.
- NICE (SG1) recommends that hospitals need to have a system in place for nursing red flag events which can be reported by staff, patients or relatives. The guidance also states that there should be procedures for effective

responses to unplanned variations in predicted patient's nursing needs at any time. The hospital did not have any formal guidance for staff to follow in an emergency where staffing levels or patient acuity had changed.

- Nursing staff handed over patient information that they were responsible for at the end of every shift. We attended a nursing handover and found that a set handover structure was followed and that the handover process was robust.
- A low number of agency nurses were used on the ward. The average monthly use of agency nurses varied from 4% to 8% between June 2015 and March 2016. The hospital had an induction checklist that a member of agency staff undertaking their first shift had to complete and sign. This included things such as receiving an orientation. However, the checklist did not include the hospital medicines management policy. This was important as agency staff administered medicines as part of their responsibilities. We raised this with the management team who instigated the process of adding this to the induction checklist.
- In theatre, staffing levels met guidelines set by the Association for Perioperative Practice (AfPP). These guidelines state that if there is more than one procedure on the theatre list, the staffing requirements are a circulating nurse, an operating department practitioner (ODP), two scrub practitioners and a recovery nurse. The AFPP guidelines also state that if an operation requires a surgical first assistant (SFA), then they must be in addition to the numbers previously mentioned.
- We looked at rotas for August 2016 and September 2016 and records indicated that there had been sufficient numbers of staff in theatre on all occasions.
- There were 3.8 whole time equivalent staff (WTE) within the theatre areas available to assist in endoscopy procedures.
- The use of agency staff in theatre had been high. Between August 2015 and March 2016, the monthly average varied between 28% and 44%. There were three WTE vacancies for theatre staff at the time of the inspection that had been advertised. The management team told us that recruiting theatre staff had been a continual problem and that the recruitment team from Spire were involved in supporting them to find a solution to this.
- Sickness rates for nursing staff had varied between April 2015 and March 2016, with the highest monthly average being 30%. However, staff turnover was low. Between the same period only 10% of nursing staff had sought other employment outside of the organisation.

Medical staffing

- Care and treatment was consultant led. The surgical team included a consultant and an anaesthetist who were employed through practising privileges. This meant that the hospital had agreed to them providing care and treatment based on their experience and qualifications.
- Once a patient had undergone surgery, the consultant who had undertaken the operation was responsible for the continued care of the patient. This included responding to a change in a patient's condition or if any advice was sought. If the consultant was unavailable, there hospital had a procedure for another consultant to be contacted if there were any problems. Similarly, there was also a named anaesthetist who was also able to attend if required.
- There was an emergency on call theatre team covering out of hours periods who were able to attend if a patient needed to return to theatre.
- The hospital had two resident medical officers (RMOs) who were employed through an agency. The RMO was available 24 hours a day, seven days a week and were resident on site. If the RMO was unable to fulfil their duties, another RMO from the same agency was provided. We saw that the RMO had an induction to the hospital and their training records were kept on site and included things such as advanced life support.
- We found that there was no formal patient handover from the consultant to the RMO. Continuity of patient care was maintained by a documented care plan which was consultant led and the RMO attended nursing staff handovers on a daily basis.

Major incident awareness and training

- There was a corporate policy for major incidents that was available on the intranet. Records indicated the hospital had completed an internal table top exercise in August 2016 which simulated a major incident scenario and how it would be managed.

Requires improvement

Surgery

- The hospital was copied into the Emergency Planning Group meeting minutes from the local NHS trust, and could be called upon to accept the transfer of low acuity patients in the event of a local major incident in order to release beds in the NHS trust.
- Major incident training was included as part of the mandatory training that staff received including fire safety training, managing violence and aggression and management of an infectious outbreak, which was included in the infection prevention and control module. In addition, regular scenarios were tested such as obtaining emergency blood supplies and managing a cardiac arrest.
- One staff member was able to describe the actions taken because of the accidental spillage of formalin (an antiseptic disinfectant), which required the attendance of the local fire service. However, other staff that we spoke to, including members of the management team were unsure of what their role was in the event of a major incident.
- The hospital had a back-up generator which was used in the event of a power failure. This had been tested regularly by the on-site maintenance team.

Are surgery services effective?

Good

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

- Care pathways were evidence-based and had been developed in accordance with national guidelines such as those from The National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.
- The service completed a number of audits every year to measure the services provided and to inform staff where improvement was required.
- Data was submitted for patient reported outcome measures (PROMS) which showed that patient outcomes for treatments such as primary knee or hip surgery were the same as results from similar services nationally.
- There was evidence of a joint approach by staff when delivering patient care. Physiotherapists, pharmacists and the resident medical officer worked closely with nursing staff on the ward.
- Staff had access to an annual appraisal where they were able to discuss their performance and development needs.
- Consent was gained before treatment was provided. In all cases that we observed, this was recorded appropriately and confirmed when needed.

However;

- The hospital did not submit patient reported outcome measures for cosmetic surgery (Q-PROMS) which measured patient satisfaction following cosmetic surgery procedures. This meant that there was limited data showing how effective cosmetic surgery had been.
- The efficacy of pain medication was not always recorded. This meant that there was no documented evidence that the pain relief administered had been effective.

Evidence-based care and treatment

- The hospital used care pathways that had been designed by Spire and were followed when delivering care and treatment to patients. A care pathway was in place for all treatments provided. If a new treatment was added, a care pathway was requested from the Spire team to reflect this. All care pathways had been developed in accordance with National Institute for Health Care Excellence (NICE) guidelines and The Royal College of Surgeons guidelines. These were available on the intranet and were printed and placed in patient records for use. The care pathways incorporated the majority of documentation, including pre-admission, risk assessments and discharge records.
- Regular updates were also received from Spire, including updates on NICE guidance as well as safety and drug alerts.
- The hospital had an annual audit timetable that was followed by each department. Designated members of staff had the responsibility of completing these. Audits included compliance with completion of records and risk assessments as well as compliance with blood transfusion pathways. The audit timetable showed that most planned audits had been completed in a timely manner.
- The hospital used a paper based system to record all implants used. However, they had registered with the health and social care information centre (HSCIC) to be involved in the national breast and implant register when the system is up and running. This was in line with

the regulations stated in the Department of Health (2016) Review of the Regulation of Cosmetic Interventions (2016) which require that hospitals keep electronic details of implants used and should be easily accessible in the case of a product recall.

- The hospital used evidence-based care protocol for intralipid infusions. At the time of the inspection we were initially shown a draft version of this; however, we raised this with senior staff who provided a copy of the authorised ratified protocol.
- The hospital used the World Health Organisation's surgical safety checklist within endoscopy, and compliance with this was audited as part of the hospital's audit programme.
- The hospital was working towards accreditation by the Joint Advisory Group on GI Endoscopy (JAG). The hospital carried out the global rating scale (GRS) audit annually; this self-reporting census enabled the hospital to analyse its progress towards the JAG measures. The hospital developed an action plan to address the gaps identified by this analysis.
- The hospital identified a consultant lead for endoscopy. It was also working with Spire's corporate team towards implementation of a new computerised system for endoscopy that was compliant with JAG requirements, and would enable the collection of appropriate data.
- The hospital expected, following collection of the relevant data, to be able to apply for JAG accreditation in mid-2017.

Pain relief

- Pain relief and pain management was discussed at the pre-operative assessment stage. Consultants had different preferences of pain relief, and were tailored to the needs of individual patients.
- Once medication to control pain had been prescribed, it was the responsibility of the resident medical officer (RMO) and the nursing staff to review how effective this had been. Staff told us that if they had concerns, they were able to have the medication reviewed by the consultant.
- Pain relief was recorded as part of the observation record sheet. Different levels of pain were scored. This prompted a review by a clinician if it exceeded a specified level. Nursing staff completed intentional rounding which was completed hourly (intentional rounding was used to ensure that patients were checked on a regular basis and that their needs had been met).
- Patients that we spoke to were positive about the way that their pain had been managed. Patients informed us that if they had been in pain, staff had responded quickly.
- The hospital's patient satisfaction survey for August 2016 showed that 89% of patients who responded to the survey were satisfied that their pain was controlled a 'great deal', 9 % said it was controlled a 'fair amount' and only 2% said that pain was not controlled at all. Overall, between August 2015 and August 2016, 91% of patients indicated that staff did everything they could (great deal) to control pain.
- We looked at ten sets of records and found that initial pain scores had been documented on all occasions. However, on five occasions the efficacy of the medication given had not been clearly documented.
- An audit had been undertaken to measure the effectiveness of pain management in July 2016. Results from this showed that all patients had received appropriate pain relief but the efficacy of the medication given had only been documented on 57% of occasions. However, only seven sets of records had been used for this audit and an action plan had not been implemented to make improvements.
- Pain management was taken into consideration prior to discharge and staff ensured that patients were happy with the arrangements that had been made. Pain medication was included in the patients discharge letter.

Nutrition and hydration

- Patients were told to not eat or drink for three hours prior to surgery which was in line with Spire and best practice guidelines. This was included as part of the patient treatment pathway. Records indicated that between January 2016 and June 2016, compliance with this had been 55% which was above the Spire target of 50%.
- Food and fluid intake was monitored using food charts and fluid balance charts. We saw that all ten records that we checked all had fluid balances documented in line with Spire guidelines.

- There was access to a dietitian who was employed by another hospital. All bariatric patients received a referral to a dietitian for assessment.
- Additional dietary advice or special requirements were discussed with the patient on arrival to the ward and daily throughout their admission. The majority of patients we spoke with said they were happy with the standard and choice of food available.
- We reviewed eight sets of records for patients who were admitted for intralipid infusion. Of these, three patients had their nutritional needs assessed. Although the sample was small, this may reflect the limited amount of time patients remained in the hospital for their infusion procedures.
- We saw there was a comprehensive selection of meals available from a menu which was available for patients.
- The hospital's patient satisfaction survey for August 2016 showed that 59% of patients who responded considered the quality of the food was 'excellent'; 26% considered it to be 'very good' and 13% considered the food to be 'fair'. Overall, between August 2015 and August 2016, 88% of patients considered the food was 'excellent' or 'very good'.
- The hospital's PLACE audit results for 2016 scored 97% for ward food, which was better than the English average of 89%.

Patient outcomes

- The hospital had collected patient reported outcome measures (PROMS) and had participated in audits undertaken by the National Joint Registry (NJR). Records indicated that outcomes for primary knee replacements and primary hip replacements had been similar to outcomes reported b similar services nationally.
- PROMS data had also been collected for varicose vein surgery but had not been able to compare outcomes for this nationally as there had only been 30 cases between April 2014 and March 2015. However, records indicated that out of 14 records, there had been improvements made as a result of the procedures undertaken.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on Q-PROMs for all patients receiving procedures such as breast augmentation (enlargement) and blepharoplasty(cosmetic surgery to the eyelids). Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations. The hospital did not use the Q-PROMs recognised tool to collect patient satisfaction with the operation. There were no plans to implement this at the time of inspection.
- The Private Healthcare Market Investigation Order (2014) requires every private healthcare facility to collect a defined set of performance measures and to supply that data to the Private Healthcare Information Network (PHIN). PHIN was not available at the time of the inspection but the hospital was fully engaged with this process and was in a position to provide data when PHIN was officially launched.
- Between April 2015 and March 2016, there had been three unplanned returns to theatre. Additionally, between April 2015 and March 2016, there had been thirteen unplanned readmissions out of a total of 6,262 procedures. This was not high when compared to a group of independent acute hospital which submitted performance data to the CQC. These incidents had been investigated, identifying areas for potential improvement when needed.
- The hospital used the Spire clinical scorecard to benchmark its performance against a set of corporate indicators, which meant the hospital was able to also benchmark against other hospitals in the group. Progress was monitored every six weeks in the clinical governance report to the medical advisory committee. Plans were put in place to identify objectives and actions needed to reduce the number of red indicators on the scorecard. This resulted in a reduction from nine to three red indicators in the period between January and December 2015.

Competent staff

- Staff received an annual appraisal so that achievements, development opportunities and areas for improvement were discussed. Records indicated that 100% of staff across the hospital had completed this between August 2015 and August 2016. Staff we spoke with, including nursing staff, theatre staff, housekeeping staff, confirmed they had been given an appraisals, referred to as 'Enabling Excellence'. The appraisal process reviewed staff competencies and progress towards completion of mandatory training, identified areas of improvement and areas of achievement.
- The perioperative care collaborative (PCC) had set out clear guidance for competencies of surgical first

assistants (SFA). The SFA role involved assisting consultants with key skills such as retraction and the movement of internal organs during procedures. These skills were in addition to those of a scrub practitioner.

- The PCC position statement regarding the SFA (2012) stated that this must be undertaken by someone who has successfully achieved a programme of study that has been benchmarked against nationally recognised competencies underpinning the knowledge and skills required for the role.
- The hospital employed four members of staff who had achieved the competencies to complete this role having completed an external accredited course. Evidence of course certificates were kept in each individual's competency folder to evidence this. However, the management team were unable to provide written evidence of competency assessments for staff undertaking this role that had not completed the accredited course. This meant at the time of inspection we were unsure if staff had been assessed as being competent to perform this role by an appropriate person.
- All other members of staff had a personal file that included competency books. Competencies were assessed for all roles including but not limited to health care assistants, registered nurses, operating department practitioners and scrub nurses. We sampled a number of these and found that they had been completed appropriately. However, as referred to in the safe domain, HCA's did not have the competencies for completing VTE assessments.
- There was evidence that staff had been encouraged to progress within their role. This had included theatre health care assistants being supported to complete associate theatre practitioner courses and scrub nurses undertaking operation department practitioner roles.
- The hospital employed a nurse practitioner for clinical education and quality improvement to develop and assess staff on evidence based competencies. The nurse practitioner developed and implemented a healthcare assistant assessment tool, and was in the process of developing a Situation, Background, Assessment and Recommendation (SBAR) tool aimed at standardising communication with patients and staff.
- There was a policy in place for staff commencing employment at the hospital. New staff received a hospital induction as well as a supernumerary period. This meant that staff had the opportunity to work alongside a more experienced member of staff without having the responsibility of looking after patients. Staff confirmed that they had received these.
- The management team had developed a database to confirm professional validation. This included but was not limited to staff employed as nurses and physiotherapists. The hospital reported it had achieved 100% completion of registration revalidation (the process to maintain registration with the professional body) for consultants working under practicing privileges and inpatient nurses. Ninety-one per cent of inpatient nursing staff had revalidated in the twelve months prior to April 2016.
- The hospital had a system to check competencies of consultants who had applied to work under practising privileges. All applications had been reviewed by the medical advisory committee who ensured that they had undertaken the treatment they had applied to provide on a regular basis. Additionally, all consultants received an annual appraisal which provided a review of their performance. This was usually completed by the consultants responsible officer or a trained consultant appraiser in their employing NHS Trust. Any concerns regarding care and treatment provided were discussed with the appropriate person so that improvements were made and lessons learnt.
- The hospital provided annual data to each consultant as part of their whole practice appraisal with their local NHS trust. A process was in place to review consultant's documentation every two years before practicing privileges were extended. The hospital also had a process in place for suspending the practicing privileges of consultants who had not provided appropriate annual documentation. This included suspending the consultant's profile on the hospitals accounting system, which meant that no patients could be booked onto the system for treatment by the suspended consultant.
- Although staff told us they were supported by their managers, there was an inconsistency in staff responses about the provision of clinical supervision. However, the hospital's annual plan for 2016 included an action to introduce formal clinical supervision and reflection for staff. Work was still ongoing on this at the time of the inspection.

Multidisciplinary working

- The theatre and ward managers held a weekly planning meeting that was used to discuss the individual needs of patients who attended for treatment. Staffing numbers and equipment required were discussed during this meeting.
- We observed a theatre team huddle, which was well organised. Any issues for the day were discussed using a communication book as were the individual needs of the patients. However, on one occasion we found that an incident that needed raising was not added to the communications book. This meant that there was limited assurance that it had been communicated effectively during the huddle.
- Staff liaised with a number of different services when co-ordinating a patients discharge. This included hospitals and community services, depending on where the patient was from.
- The hospital held a daily communications meeting. A staff member from all departments attended this and it was an opportunity for information to be shared between different teams. We attended one of these meetings and we found it to be well attended and well organised.
- Staff told us there was a good working relationship between the physiotherapy and nursing teams in supporting patients on the ward during and following their treatments.
- When a patient was discharged, an electronic discharge form was sent to the patients GP. However, information about implants (including prosthesis) was not sent as part of this. This was not in line with the Review of the Regulation of Cosmetic Interventions (2014) which stated that details of the surgery and any implant used must be sent the patient's GP.

Seven-day services

- Surgery was scheduled between Monday and Saturday on a weekly basis. The inpatient ward area was open and staffed 24 hours a day, seven days a week. The hospital had a 24 hour theatre on call team available if patients needed to return for further treatment.
- The consultant and anaesthetist responsible for delivering treatment were on-call 24 hours a day if further advice was needed. In the event of them not being available, informal arrangements were made so that cover was provided by another consultant who worked in the hospital. The resident medical officer confirmed that there had been no problems contacting someone if required.
- The hospital had 24 hour on-call cover for radiography if required. Pharmacy services were available five days a week during normal working hours. Procedures were in place for the resident medical officer to access medication if it was unavailable.
- Other diagnostics such as pathology (blood testing) were also based on site and were available five days a week. Arrangements were in place to access pathology services at a different Spire hospital outside of these hours.
- Endoscopies were carried out between 8.30am and 8.30pm. Although an emergency team was on-call, there were no out of hours endoscopy emergencies in the last two years.
- Physiotherapy was provided on a seven day service to all patients, between 8am and 4.30pm. Patients were seen at least daily, with patients who had undergone hip or knee surgery being seen twice daily. Additional physiotherapy sessions were provided dependent on patients' needs and consultant requests. The team also provided an on-call out of hours service seven days a week.

Access to information

- Staff had access to information using computers that were available. This included access to the internet and intranet which included hospital policies and procedures as well the email system.
- Hospital policies and patient care pathways were accessible for staff that had access to the electronic system. Continuity of patient care was maintained as all individual patient records and medication charts were paper based, so all staff were able to use them.
- Appointments were only usually confirmed for any patient once the hospital received a GP referral, however self-funding patients did not require a GP referral to access services at the hospital. The referral formed the basis of the physical medical record, along with any available test or diagnostic results. The hospital reported that no patients were seen within the last three months without all the relevant medical information

being available. However, if for any reason the records were not available, a process was in place to obtain and print the latest copy of correspondence between the patient's consultant and GP.
- On discharge, an electronic GP form was completed. This included information about treatment that had been provided and any changes to medication. An email encryption tool was used to ensure that electronic communication of sensitive information outside the hospital was secure.
- Staff, including consultants, were not permitted to take records off site.
- Patient records were kept in the hospital for three months following a patient discharge. They were then archived at a central location. If a patient re-attended for further treatment, the hospital were able to request the old records if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a policy for consent, mental capacity (MCA) and deprivation of liberty safeguards (DoLS). This was available for staff on the intranet.
- Where appropriate to their role, staff undertook Mental Capacity Act (MCA) training. By the end of September 2016, 19 permanent ward staff (76%) had completed the mandatory MCA training; one ward bank staff member (8%) had completed the training.
- The hospital had a lead for mental capacity who was available during normal working hours. An on-call hospital manager was available for advice during evening and weekends. Staff that we spoke to had a basic understanding of MCA and DoLS and what their responsibilities were if they found that a patient lacked the capacity to make a decision. Some staff correctly identified that patients must be assumed to have mental capacity until this has been identified otherwise following assessment.
- Consultants completed consent forms at different times. Some completed them at the pre-admission stage and they were then confirmed on the day of treatment. Others completed them on admission, which included patients undergoing cosmetic surgery.
- We reviewed a sample of ten patient records, and found that consent had been obtained on all occasions. Patients that we spoke to confirmed that their treatment had been discussed with them which included any potential risks that were present as a result of their treatment.
- On reviewing a sample of eight patient records, we found that the 'two week cool off period' had been adhered to on all occasions. This was recommended practice by the Royal College of Surgeons professional standards for cosmetic surgery 2016.

Are surgery services caring?

Good

We rated Surgery as 'Good' for Caring. This is because;

- Care and treatment was delivered in a caring and compassionate way. Patients were treated with dignity and respect; their privacy was maintained when being examined.
- Staff took time to provide support to patients when required. This included spending time to help reduce anxieties and fears before and after surgery.
- Friends and relatives were kept informed of relevant information during a patients stay in the hospital.
- Patients were positive about the care and treatment that had been provided. NHS friends and family test (FFT) results between October 2015 and March 2016) were positive and showed that between 98% of patients had recommended the hospital as a place of care. This was the same as similar services nationally.

Compassionate care

- Care and treatment at the hospital was delivered in a compassionate and caring way. We observed how staff interacted with patients in a positive way. Staff introduced themselves and behaved in a courteous manner. The hospital embedded the '6 c's of care' (care, compassion, competence, communication, courage and commitment) and this was supported in staff mandatory training, which included a module on 'compassion in practice'.
- The privacy and dignity of patients was maintained at all times. This included drawing curtains or closing doors when examination was taking place.

- We observed staff in theatre ensuring that patients were treated in a caring way once anaesthetised. We saw staff taking care when moving and handling patients and they ensured that the patient was covered appropriately at all times.
- Patients that we spoke to were positive about the care and treatment that they had received at the hospital. Patients told us that they knew who was looking after them and that they had been treated in a caring way. One patient told us she 'could cuddle them [staff]'.
- Patient led assessments of the care environment (PLACE) showed that in 2016, the hospital scored 95% in the category 'privacy, dignity and wellbeing' which was better than the England average result of 87.2%.
- The hospital took part in the NHS friends and family test (FFT) survey, which assesses whether patients would recommend a service to their friends and family. Results from October 2015 to March 2016 showed that 98% of patients who took part were likely to recommend the hospital as a place of care. This was the same as those of similar services nationally.
- The hospital also requested patient feedback as part of their own satisfaction survey. Records indicated that 98% of patients had felt that they were treated with compassion and respect.
- A patient concierge greeted patients on admission to hospital and provided an escort service for private patients. The concierge was responsible for raising the profile of the patient survey and encouraged patients to complete this at the end of their stay.
- The customer satisfaction group, chaired by the acting hospital director, reviewed feedback from the patient survey. Any actions arising from this were tracked until completion; for example, any consultant that was named in the patient survey was invited to visit the hospital director to discuss any issues.

Understanding and involvement of patients and those close to them

- Consideration was given to the ongoing needs of the patient and their relatives during the pre-admission assessments. Records indicated that arrangements for discharge had often been made during the initial assessment.
- Patients told us that they felt well informed prior to their admission to the hospital. Information about their procedure including any risks had been discussed. A patient told us that they thought staff had done 'everything that was expected' of them in explaining things that had happened.
- Another patient who was undergoing infusion treatment was able to describe her condition and the treatment being provided. The patient told us her consultant gave the explanation to her. The patient told us she was 'happy with the treatment' and the 'staff are very nice'.
- The hospital's patient survey for August 2016 indicated that 88% of those patients who responded considered they were involved as much as they wanted to be in decisions about their care and treatment.
- Relatives were encouraged to visit when possible. When a patient was discharged, staff involved relatives when providing information of what to do over the next few days or if there were any concerns.
- We checked a sample of ten records. These indicated that staff had had conversations with relatives to discuss the patient's treatment on seven occasions.
- We spoke to a self-paying patient who told us that prices of treatment that they had received had been discussed and made clear prior to treatment being undertaken. The patients told us they felt able to ask questions of the consultants and nurses if they wanted further explanations.

Emotional support

- Staff provided regular support to patients by completing comfort rounds on an hourly basis. This included checking if a patient needed anything, including food and drink and pain relief.
- Staff spent time with patients, discussing any fears or anxieties that they had before, during or after treatment. We saw members of staff comforting patients on their way to theatre and in the anaesthetic room. Additionally, we saw staff providing emotional support to patients when they were recovering from anaesthetic.
- On one occasion we observed the care of a patient who had a needle phobia. The anaesthetist did everything possible when treating the patient to reduce their anxieties and fears.
- Contact details were given to patients when they were discharged. They were able to contact staff at the hospital 24 hours a day, seven days a week if they had any concerns or anxieties.
- The hospital's patient survey for August 2016 indicated that 83% of patients who responded were able to find a

staff member with whom they could discuss their worries and fears. The hospital recognised this relatively low figure and action was taken by the ward sister to discuss this with ward staff. 96% of patients who responded confirmed they were told by staff who they could contact, if they were worried about their condition or treatment after discharge.
- Chaperones were available to support patients during consultations and procedures.

Are surgery services responsive?

Good

We rated Surgery as 'Good' for Responsive. This is because;

- The hospital had considered the needs of people using the services that were provided. Facilities included a number of en-suite rooms. There was a refurbishment plan in place for rooms that had not yet been updated.
- Staff assessed whether they had the correct resources to care for patients prior to admission. The service had a clear admissions policy that was being followed.
- Records indicated that referral to treatment times between April 2015 and March 2016 had been positive. Patients had been seen within 18 weeks of referral on over 90% of occasions.
- Patient admission times were staggered and attempts were made to reduce the amount of time that patients waited before receiving treatment. On occasions when this was delayed, patients were kept informed.
- Patient stay was estimated at the time of admission. This was dependant on the individual and the type of treatment that they had received.
- Complaints and concerns were investigated in a timely manner and in line with hospital policy.

However;

- A large number of operations had been cancelled or rearranged by patients between April 2015 and March 2016 but all patients had been given another appointment within 28 days.
- The hospital had not made any adjustments to the environment for people living with a learning disability or those living with dementia.
- The hospital did not have any formal processes in recognising patients who had become delirious during their time at the hospital.

Service planning and delivery to meet the needs of local people

- Referrals to the service for NHS funded and insured patients were mainly from GP's, and this was done electronically. Self-paying patients were able to refer themselves. Once a referral had been made, an appointment was made to see the consultant for an assessment. Patients had the option to choose the date of their pre-operative assessment as well as the date of their admission.
- At the initial assessment stage, the service were able to assess whether they had the correct staff and resources to provide the care and treatment that was needed. If they did not, then the patient was referred back to the GP and treatment was provided by a different service. That meant that the hospital were able to control the level of care that was given.
- The hospital used Spire care pathways when planning and delivering treatment. This meant that things such as discharge planning and pain control were discussed at the initial assessment stage. For example, if a patient was having a joint replacement, consideration was given to the type of accommodation they lived in and how much support they had from carers, family members or friends. This allowed appropriate arrangements to be made for discharge before the patient received treatment.
- The hospital provided individual en-suite rooms for inpatients which allowed privacy to be maintained. As part of the hospital refurbishment scheme, rooms were being upgraded and showers were being fitted in en-suite rooms which still only had a bath. In the meantime, rooms with baths were only allocated to patients who were mobile and had no preference to a shower room. This meant that services had to be planned carefully to ensure that rooms with a bath were allocated correctly.
- There was one day case unit that had a total of 17 beds. The unit had been split into two areas so that the service could ensure that guidance on mixed sex accommodation was adhered to. We observed a number of occasions when the facilities were used to achieve this.
- The hospital had developed a corridor from the day case unit to the theatre area. This was used for patients

rather than using the main corridor so their privacy and dignity was protected. Patients reported that this was a 'nice touch' as they had been anxious on the way to theatre.

- In the period June 2015 to July 2016, the hospital undertook 611 endoscopic diagnostic procedures, of which 84 were NHS funded. As these were elective procedures patients were less likely to be affected by busy periods or seasonal pressures. The hospital also delivered four episodes of individually contracted rehabilitation and respite care. These were outside the hospital's existing NHS contract, which meant it was able to support local NHS services.

Access and flow

- The hospital reported that over 90% of admitted NHS patients began treatment within 18 weeks of referral for each month between April 2015 and March 2016. Elective waiting times were reviewed by staff to identify patients approaching the 18 week wait period and these patients were prioritised so they didn't go over the 18 week wait time target.
- The hospital's business development manager monitored weekly waiting times. This meant that action could be taken if a medical patient was near to breaching the 18 week waiting time. Breaches were reported on a monthly basis to the clinical commissioning group.
- Between April 2015 and March 2016, there had been a total of 6,262 attendances to theatre. 4,715 of these were day case attendances and 1,547 had been inpatient admissions.
- The Spire admissions policy provided clear guidelines relating to pre-operative assessments. As part of a patient's initial consultation, they completed a medical questionnaire which was reviewed by a member of the pre-operative assessment team. If an individual patient or the planned procedure highlighted a higher risk, patients attended a face to face consultation with a nurse. Staff informed us that they had chosen to do this rather than undertaking a telephone consultation as it reduced the risk of a mistake being made prior to admission.
- Admission times were staggered throughout the day so that patients did not have to wait for a long period of time once admitted. We spoke to a number of patients who told us that if this had happened, they had been kept informed of what was happening by a member of staff. Between April 2015 and March 2016, a small number of procedures had been cancelled as a result of surgery overrunning. The hospital patient survey for August 2016 indicated that 93% of those that responded felt that the overall admission experience, including promptness and efficiency was 'excellent' or 'very good'.
- The duration of a patient's stay was estimated during the admission assessment and was based on the individual need of the patient as well as the type of treatment that was being provided.
- On the day of discharge, the service tried to discharge patients by 11am. However, between January 2016 and June 2016, this had only been achieved on 50% of occasions. We observed during the inspection that this was sometimes difficult due to patients being admitted at the same time as patients requiring discharge, especially at times when there were high numbers of inpatients to look after.
- The service had attempted to keep the number of cancellations for treatment to a minimum. The hospital recorded all incidents of cancellations for either clinical or non-clinical reasons so that future improvements were made. Between April 2015 and March 2016, the hospital reported 84 that had been cancelled for both clinical and non-clinical reasons. All patients that had procedures cancelled were offered another appointment within 28 working days. Spire required the hospital to audit the reason for cancellations so that improvements could be made where possible. Records indicated that reasons for non-clinical cancellations included but was not limited to consultants not being available, equipment failure and staff sickness. Reasons for clinical cancellations included patients being unwell on the day of surgery or medications not being stopped appropriately. We found on some occasions, actions had been taken by the management team to make improvements.
- Between April 2015 and March 2016, there had been 10 patient transfers to another hospital which were mainly as a result of a patient deteriorating or requiring a higher level of care than the hospital was able to provide.

Meeting people's individual needs

- The hospital provided a range of information leaflets about different conditions and treatments. For example, there was a leaflet for having a hip replacement which

described what to expect before, during and after treatment. These leaflets were only displayed in English. However, we were informed that leaflets were available in other languages on request.

- The hospital had access to translation services and interpreters if required. Staff told us that the needs of the patient and family were assessed during the initial assessment and a translator or an interpreter was booked if needed.
- The hospital had not made any formal adjustments to the facilities that met the needs of patients living with dementia. Staff were able to give some examples of how a patient living with dementia would be managed and we were told that it was very rare that a patient was accepted for treatment at the hospital during the initial assessment stage. This was as a result of the capacity criteria in the admissions policy.
- The hospital had not made any adjustments to the environment for patients living with a learning disability. However, staff informed us that they always encouraged carers or relatives to provide support during their visit if needed.
- There was easy access for patients or relatives who used a wheelchair. However, there were no en-suite rooms that had been adapted for a patient in a wheelchair to use.
- There was access to psychological services that were provided by another hospital if required. If a patient was having cosmetic surgery, the consultants providing the treatment made referrals to their own preferred services if needed. Additionally, there was a cosmetic lead nurse who was part of all cosmetic surgery pre-admission assessments and was sensitive to the needs of patients undergoing this type of treatment.
- The hospital also had a bariatric lead nurse who completed a face to face consultation prior to a consultant appointment being made. This provided the opportunity for staff to ensure that the patients were fully informed about the treatment they received. This was important as patients often had misinformed ideas of what the benefits of surgery were. The hospital had adapted some facilities to accommodate patients requiring bariatric support who were undergoing treatment. This included a modified wheelchair and the inpatient ward had access to bariatric beds if needed.
- There were no formal processes in place for recognising patients who had become delirious during their stay. Staff that we spoke to had a limited understanding of this. Delirium is a state of confusion that sometimes occurs following an anaesthetic being administered, with the risk being higher for patients who are anaesthetised for a longer period of time.
- Staff were aware of the need to undertake appropriate assessments, such as mental capacity, when appropriate and to make reasonable adjustments for patients who were living with dementia or with learning disabilities. The hospital matron had delivered four dementia friends training sessions for staff within the last twelve months, which complemented staff mandatory training.
- Interpretation and translation services were available for patients whose first language was not English.
- Signs in each patient bedroom explained the differences in staff uniforms and how to activate the call bell if assistance was needed.

Learning from complaints and concerns

- The hospital had a policy for managing complaints and concerns. Staff that we spoke to were able to tell us about the complaints process and that if a complaint or concern was raised, it was escalated to the department manager.
- Spire policy stated that complaints must be responded to within 20 days of receipt. This was monitored in management team meetings, ensuring that the hospital met this target. The management team told us that if it was taking longer than this, communication was made with the complainant and a new timescale was agreed. In 2015, the hospital responded to 83% of complaints within 20 working days, which was better than the Spire corporate average of 81%. The hospital achieved 100% in the first quarter of 2016.
- The number of complaints that the hospital had received had been similar since 2013. There had been 40 complaints received between April 2013 and March 2014, 33 between April 2014 and March 2015 and 48 between April 2015 and March 2016. Records indicated that 24 of the 48 complaints between April 2015 and March 2016 had been up-held, meaning that the management team had acknowledged that improvements needed to be made.
- If the patients was unhappy with the response to the complaint, advice was given for contact to be made with the Independent Healthcare Sector Adjudication Service (ISCAS). Similarly, NHS funded patients had access to make referrals to the NHS ombudsman. Records

indicated that between April 2015 and March 2016, there had been one referral made to ISCAS for further investigation. No complaints had progressed to investigation by the Parliamentary Health Service Ombudsman (for NHS complaints).

- Minutes of meetings indicated that complaints and concerns were discussed at management team meetings and as part of the medical advisory committee (MAC) meetings.
- Complaints, learning and actions to improve for consultants were discussed at quarterly meetings attended by the local NHS trust medical director and the acting hospital director. The hospital's customer satisfaction group also reviewed complaints and any actions arising from these were tracked until completion; for example, rather than leaving discharge information in the patient's room, this was to be handed directly to the patient by staff.
- Learning from complaints and incidents was shared with staff in team meetings and in staff briefing newsletters; for example, staff were reminded of completing and signing all sections of a care pathway and documenting discussions with consultants. Newsletters were also provided to agency staff for information. One staff member told us that, although rare, learning from complaints from other Spire hospitals was also shared.

Are surgery services well-led?

Requires improvement

We rated Surgery as 'Requires Improvement' for Well-led. This is because;

- The hospital used a risk register to monitor and mitigate risks. However, not all risks had been identified and added to the register.
- We found that on one occasion an improvement was not made in a timely way to improve services once an issue had been identified. We saw that the Medical Advisory Committee had identified an area for improvement in January 2016 but changes had not yet been implemented in September 2016.
- There had been missed opportunities for potential learning following a number of incidents. As a result we were not assured that the level of risk to patients had been controlled in a way that all avoidable harm could be prevented.
- We saw an example of where a corporate policy did not reflect up to date national guidance.

However;

- The hospital had a vision and strategy. The overall strategy had been developed taking into account the departmental strategies. Staff that we spoke to were able to identify with this.
- A 'quality tree' was displayed across the hospital. The tree identified quality objectives of each department.
- There was a positive working culture and staff were able to give us examples of when they had been supported. Staff felt that the management team were approachable and supportive.

Vision and strategy for this this core service

- Spire had an overall vision and strategy. The values highlighted in this statement were caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on promises and keeping it simple. The hospital had also set its own objectives based on these values. These included delivering high quality care, enhancing relationships with partners so promote services to the local population, and improving the hospital's survey scores.
- A 'quality tree' was displayed across the hospital. The tree identified quality objectives of each department. It depicted an apple tree and the objectives were written on the apples, once these were completed the apples were transferred to the basket at the bottom of the tree.
- The hospital also recently developed a nursing strategy in August 2016 and was in the process of rolling this out to staff. The nursing strategy supported staff to reflect on the care and treatment they provided and to assess if they could do things differently.
- Staff yearly objectives for the Enabling Excellence appraisal process were designed to contribute to each department's yearly plan and therefore to the hospital's strategy.
- The clinical and balanced scorecards were displayed across the hospital to indicate progress towards the strategy.

Requires improvement

Surgery

Governance, risk management and quality measurement for this core service

- The management team held a number of meetings at different levels. At departmental level, the ward and theatre teams met monthly. Departmental quality reports had been introduced so that compliance with performance targets were highlighted. Results from these were fed to the senior management team meeting and the medical advisory committee (MAC) who had overall oversight.
- The hospital used an overall risk register which could be filtered by department. Heads of department met with the matron to discuss departmental risks and these were added to the central register when needed. Risks that were listed had an owner, had controls to reduce the level of risk and had a date for further review. Additionally, key actions for improvement were also documented.
- However, there were some risks that had not been identified. For example, the hospital did not have a clear policy for staffing and did not use a dependency tool to determine staffing levels on the inpatient ward. When we discussed this with the management team, they were unsure how many staff were needed to provide safe care and were unable to tell us on what basis the number of staff had been calculated.
- We found that health care assistants were completing venous thrombo-embolism (VTE) assessments without having achieved the competencies to do so. This had not been recognised as a risk. As a result, appropriate actions had not been taken to mitigate the level of risk posed to patients.
- A further risk that had not been acknowledged by the management team was the poor compliance with mandatory training, particularly compliance with basic and immediate life support both on the ward and in theatre.
- The hospital had developed a set of standard operating procedures and working instructions to support the Spire corporate policies that already existed. However, on one occasion we found that the provider's policy for VTE did not reflect national standards. This was because the provider's policy stated that VTE incidents that occurred within 30 days post-surgery should be investigated. Guidelines from the national VTE prevention programme (2013) state that incidences of VTE can be attributable to surgery and should be investigated up to 90 days post-surgery.
- The medical advisory committee (MAC) were involved in reviewing policies and procedures, ensuring that treatment was delivered in line with recommended guidance. However, on one occasion we found that the MAC had identified that there was no hospital guideline providing oversight of what chemical VTE prophylaxis was used following surgery. Work on this had commenced in January 2016 but was still ongoing in September 2016. This meant that improvements had not been completed in a timely way.
- The MAC had clear terms of reference which included consultants from different specialities asked to attend. We saw minutes of these meetings and found that topics such as National Institute for Health Care Excellence (NICE) guidance, incidents and complaints and mortality were discussed. The chair of the medical advisory committee was able to identify the key risks and challenges that the hospital currently faced. The MAC also had oversight for reviewing applications for consultants to work at the hospital under practicing privileges.
- The hospital ensured that all consultants working under practicing privileges had the appropriate indemnity cover. Evidence of this was documented in their individual files. Records indicated that all consultants had received an appraisal within the last 12 months. The MAC had a system where individual performance could be fed back to the consultant's employer when needed.
- Incidents and complaints were investigated by the appropriate members of staff and oversight of this process was provided by the clinical governance co-ordinator. Outcomes and learning from incidents and complaints was disseminated to staff through team meetings or by email.
- A Spire audit plan was used to monitor levels of compliance with care and treatment provided. Results of these were discussed as part of clinical effectiveness meetings and at the medical advisory committee meetings. Compliance with treatment provided to NHS funded patients was monitored through key performance indicators.

- Annual Spire quality reports were used to measure the performance of services provided against other Spire hospitals nationally. Results from this showed that the hospitals performance was similar to that of other Spire hospitals nationally.
- The hospital had not made any arrangements to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT. SNOMED-CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems. The move to a single terminology, SNOMED CT, for the direct management of care of an individual, across all care settings in England, is recommended by the National Information Board (NIB), in ' Personalised Health and Care 2020: A Framework for Action'. The framework sets out that By April 2020, the entire health system will adopt SNOMED clinical terminology.

Leadership / culture of service

- The acting hospital director was supported by a senior management team which included the matron, theatre manager, business development and commercial manager, and the finance manager. There was a clear reporting line from ward staff, through the senior ward sister to the matron. Similarly there was a clear reporting structure from theatre and sterile services staff to the theatre manager.
- Senior management staff were visible throughout the hospital. The matron also carried out regular visits throughout the hospital.
- Staff told us they felt supported by the management team at the hospital, and that they 'work well as a team'. Staff told us they 'feel happy' working at the hospital and that there is a friendly culture in the hospital.
- One member of staff spoke very positively of the management team. The staff member told us that members of the management team were approachable and that they felt supported in personal and professional issues as well as being trusted with a level of autonomy in their roles. Another staff member gave a positive comment about their manager. They said 'your job is to look after patients, my job is to look after you'.
- A healthcare assistant told us the hospital culture was supportive and they felt respected in their role as part of the wider nursing team. The same staff member told us the open culture meant they felt able to challenge colleagues if needed.
- The hospital developed a quarterly Quality Circle meeting, which included the matron and representatives of each of the departments. The aim of the meeting was to resolve interdepartmental issues, to discuss new ideas and to oversee the staff recognition programme including deciding which member of staff would receive a recognition award. The hospital was in the process of developing and introducing an employee of the month scheme.

Public and staff engagement

- The hospital developed a patient forum, which included staff and eight former patients, with a view to increasing to twelve with the recruitment of additional NHS patients.
- The patient forum met every six weeks with the aim of engaging patients and making their stay in hospital more comfortable. The group reviewed patient satisfaction results and provided feedback on improvements that could be made in the hospital from a patient's perspective. The group also considered which quality indicators were important to patients; was developing a volunteer policy; and, took part in carrying out the hospital's patient led assessments of the care environment (PLACE) audit.
- Staff involved in the delivery of endoscopy treatment were active in an endoscopy support group called Flexible Friends. This enabled the sharing of information and learning across Spire endoscopy teams.
- Staff were recognised when compliments were received from patients; notifications of thank you messages were sent across the hospital and the matron personally thanked individual staff involved.
- The hospital also had a formal staff recognition scheme, called the Inspiring People Awards. One theatre staff member was nominated for silver award for helping to set up a walk-in hysteroscopy service in outpatients. A healthcare assistant was nominated for being caring and inspirational. Recognition also extended to non-clinical staff; a catering staff member, with the agreement of nursing staff, assisted a patient to eat breakfast, as nursing staff had been particularly busy at the time.
- The hospital developed a quarterly Quality Circle meeting, which included the matron and representatives of each of the departments. The aim of the meeting was to resolve interdepartmental issues, to discuss new ideas and to oversee the staff recognition

programme including deciding which member of staff would receive a recognition award. The hospital was in the process of developing and introducing an employee of the month scheme.

Good

Outpatients and diagnostic imaging

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

Information about the service

Murrayfield Hospital opened in 1982 as a single story hospital with 57 inpatient beds, 17 of which are day care beds, 13 outpatient consultation rooms and small Physiotherapy, Pharmacy and Radiology departments. The hospital was renamed Spire Murrayfield Hospital, Wirral when it was sold to Spire Healthcare in 2007.

The hospital is located in the middle of the Wirral peninsula close to the M53 motorway. Over time there has been six development phases. Current facilities for outpatients include 13 outpatient consulting rooms including two dressing rooms and a minor operations room. Located at the front of the hospital in an L shaped environment there are two consulting rooms fitted out for ophthalmic consultations, phlebotomy general and orthopaedic dressing rooms (one fitted out for ear, nose and throat) and a colposcopy room.

The radiology department offers a magnetic resonance imaging (MRI) scanner, mobile computerise tomography (CT) scanner, fluoroscopy, digital mammography and general x-ray.

The hospital provides services for fee-paying patients and accepts NHS patients where commissioning arrangements are in place. At the time of our visit the hospital was treating approximately 30% insured and self-funded patients and approximately 70% NHS patients.

During our inspection we spoke to 16 members of staff, 10 patients and reviewed eight sets of medical records. We observed care and treatment, reviewed performance and assessed information about the outpatients and diagnostic departments. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the Outpatients and Diagnostics Imaging service as "Good" overall. This is because;

- The building was in good condition, well maintained, free from clutter and provided a relaxed environment for treating patients.
- Patients attending for a mammography or x-ray had the use of private, well equipped, individual changing rooms.
- The areas we visited were visibly clean and tidy, cleaning schedules were in place and clearly displayed.
- In the last three months all patients seen in outpatients had a full medical record. It was rare for a patient to be seen without their medical records.
- Complimentary pain relief therapies were available via the physiotherapist which included pilates classes, which were open to all members of the public.
- The hospital's staff respected the privacy and dignity of patients and cared about their wellbeing.
- A multi-disciplinary team (MDT) approach was evident across all the areas we visited. We observed collaboration and communication amongst all members of the MDT to support the planning and delivery of care in the outpatients and diagnostics department.
- The hospital met the referral to treatment (RTT) waiting time target.
- All patients were seen in a timely manner and very rarely had to wait for clinics. There was no waiting list for the scanner and appointments were easily made.
- All NHS patients we spoke to in the diagnostics department said that there was no difference between their treatment and that of a fee paying patient. One patient told us that their procedure had been talked through with them extensively and they were made to feel individual and special.
- The hospital had business continuity plans in place for major incidents, but also had departmental action cards available on the intranet for step by step advice on dealing with major incidents, e.g. electrical faults and gas leaks.

However;

- The use of bank and agency outpatient nurses was higher than the average of other independent acute hospitals for the period of April 2015 to March 2016.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging as 'Good' for Safe. This is because;

- All equipment in the radiology department had Quality Assurance (QA) checks to ensure that the equipment was running at its optimal performance and we saw evidence of QA's for x-ray equipment and ultrasound.
- In the previous three months leading up to our visit, all patients had been seen in outpatients with a full medical record. It was rare for a patient to be seen without their medical records.
- Reports for x-rays were written on-site by the relevant consultant. The consultants used voice recognition and would read the patients report into the Picture Archiving and Communication System (PACS) which was efficient and time saving.
- The imaging services had adapted the 'WHO' Surgical safety checklist for radiological interventions and this was displayed in all relevant rooms next to the equipment. The 'Who' checklist is a set of safety checks for use when carrying out non-surgical interventional radiology.
- The hospital had business continuity plans in place for major incidents, but also had departmental action cards available on the intranet for step by step advice on dealing with major incidents, e.g. electrical faults and gas leaks.

However;

- The use of bank and agency outpatient nurses was higher than the average of other independent acute hospitals for the period April 2015 to March 2016.
- A low number of staff in the outpatient department were up to date with basic and immediate life support training.

Incidents

- There were no never events reported for the outpatient department (OPD) or radiology. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were 38 clinical incidents within outpatient and diagnostic imaging services in the period April 2015 to March 2016. The rate of clinical incidents in outpatient departments per 100 outpatient attendances was lower than the rate of other independent acute hospitals CQC hold this type of data for. In the same period, there were 18 non-clinical incidents. The rate of non-clinical incidents in outpatient departments per 100 outpatient attendances was similar to the rate of other independent acute hospitals we hold this type of data for.
- Incidents were reported electronically and staff knew how to report an incident. Investigations were carried out at management level and fed back to all relevant staff.
- The imaging service ensured that radiation incidents were fed into risk management team and reported to the radiation protection advisor (RPA), under IRR99 requirements. One radiographer informed us of an incident where an x-ray of the same knee was repeated, so the patient had been double exposed to radiation. The incident was reported to the radiation protection advisor, in line with the ionising radiation (Medical Exposure) Regulations 2000 (IR (ME) R); however they were informed that the exposure was minimum and well under the requirement to report, but had shown that they were fully aware of how to report an incident.
- We saw a radiation incidents folder, which was up to date. We also saw evidence that radiation protection surveys were carried out by integrated radiology services and the last report was completed in August 2016.
- The diagnostic department also had a learning outcomes folder for the attention of staff, which they knew about and was easily accessible. The folder was kept updated and reports submitted for sharing and learning from incidents.
- We saw an incident was reported with regards to a double exposure x-ray on a patient's knee. Details of the incident and investigation were highlighted to staff to ensure that learning was identified and action taken to prevent the incident being repeated. The folder contained details about other incidents within the wider hospital and their learning outcomes.

- Staff we spoke to were familiar with the term 'Duty of candour' and told us they would always inform their line manager and patient if incidents occurred. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- We saw evidence of a communication file in the diagnostics department available for all staff. The file contained minutes from the safety briefings for staff to read. The safety briefing was a weekly meeting attended by all departments of the hospital.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and tidy. Cleaning schedules were in place and we saw that they were completed to indicate cleaning had taken place. The schedules were clearly displayed.
- The hospital had employed an infection prevention control lead to provide training and to liaise with staff so patients that acquired infections could be identified and treated promptly. They were supported by a number of departmental infection control link staff.
- There were no cases of healthcare-associated infections, such as methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C.difficile) attributed to the outpatients and diagnostic imaging departments in the 12 months preceding the inspection
- Staff that we observed followed 'bare below the elbow' guidance and used appropriate personal protective equipment (PPE) whilst delivering care, such as gloves and aprons. We also saw 'bare below the elbow' and 'hand washing techniques' information posters displayed around the departments.
- Gloves and apron dispensers were accessible to staff outside the consultation rooms which we saw being used.
- Hand sanitising gel/foam was in place in each of the patients' changing rooms in the radiology department and in outpatients.
- Patients gowns were taken away daily to be cleaned off-site.
- In the ultrasound scanning room, it was the radiologist's role to ensure the probes were cleaned after each use.
- We observed staff following infection control best practice in relation to waste management, disposal of sharps, contaminated waste and laundry. We saw a poster displayed in the ultrasound room for 'waste segregation'.
- Disinfection and detergent cleaning wipes were available in the x-ray room and were used to clean the foam pads between each patient.
- The hospitals patient-led assessment of the care environment (PLACE) score for 2016, cleanliness was 90%, which was the same as the England average.
- We saw evidence of infection control audits being carried out for OPD and the radiology department which included; handling and disposal of linen, hand hygiene benchmark audit and management of patient equipment. We saw that the hospital was measuring the amount of hand sanitiser used in clinical areas over a week period to monitor whether staff were sanitising their hands. We were provided with the results for one week which indicated it was being used but there was no observational audit of hand hygiene in the department at the time of the inspection.
- The hospital held quarterly infection control meetings, which we saw minutes of.
- Spire Healthcare had an infection prevention and control annual plan. We saw the 2016 plan and one example of the code of practice criteria was; to ensure that healthcare workers were free of and were protected from exposure to infections during the course of their work and that all staff were are suitably educated in the prevention and control of infection. The actions were to raise awareness on the treatment and management of C difficile infection with regards to appropriate hand hygiene technique, correct use and disposal of personnel protective equipment, all patients to be offered a hand wipe before meal times and compliance with the corporate/local antimicrobial guidance. The planned update showed that this had been carried out.
- We saw that the mobile x-ray machine used in theatres was cleaned before and after use and a cleaning record was attached to the equipment which we saw was completed regularly indicating that cleaning had taken place.
- The mobile theatre image intensifier was also cleaned after each patient use, before being covered and stored in the theatre corridor ready for the next patient.

- We observed that records were in place which indicated that the computerised tomography (CT) scanner had a monthly deep clean.

Environment and equipment

- The building was in good condition, well maintained, free from clutter and provided a relaxed environment for treating patients.
- Staff told us that they had suitable equipment to meet patient needs and were not in need of anything.
- Emergency resuscitation equipment was available in all areas inspected. Records indicated that checks were carried out on a daily basis with a monthly check done when a seal was broken, to monitor the expiry dates of all equipment sealed in the drawers. The equipment we looked at was found to be in date.
- We saw lead aprons hanging appropriately in the x-ray room. Lead aprons were given to members of the public who attend to hold/support a patient in x-ray. If someone had been present during an x-ray for this purpose, their details were recorded on the computerised radiology information system.
- The radiology department had assessed exposure to radiation and staff wore radiation detection badges that were sent externally to be analysed routinely to ensure safe levels were maintained.
- Records indicated that all equipment in the radiology department had Quality Assurance (QA) checks to ensure that the equipment was running at its optimal performance and we saw evidence of QA's for x-ray equipment and ultrasound.

Medicines

- Medicines were available from the on-site pharmacy department, Monday to Friday.
- Nurses did not write patient prescriptions. The consultants wrote prescriptions themselves during the appointment, or contacted the patients GP.
- Medicines were stored securely in medication cabinets within the consulting rooms. The medicines we looked at were stored correctly and were in date. The outpatients department did not hold any stock of controlled drugs.
- Some medicines required refrigeration within the consultation rooms. Records indicated the fridge and room temperatures were checked and recorded routinely.
- No radiologist was required when giving patient's intravenous contrast media as it was prescribed as patient group directions (PGD) and vetted by the radiologist. Radiologists prescribe the use of contrast during the vetting procedure which is recorded on the radiology information system. Patient group directions allow for radiographers to administer contrast using standard CT protocols. The legal requirement states that a PGD's must include a signature of a Doctor and a pharmacist. The PGD's were being signed by the dispensary manager, who was a pharmacy technician and not a pharmacist. This was raised at the time of our inspection and it was found to be an oversight by staff and there was no impact on patient safety. There were plenty of pharmacists available to sign. There were no other problems found with PGD's in how they were being used or audited and we saw that this had been rectified on our return.

Records

- Information provided by the hospital showed that all patients were seen in outpatients with a full medical record in the three months prior to the inspection. It was rare for a patient to be seen without their medical records, if for any reason there was an occasion where notes were not available for an appointment then the relevant medical secretary/ GP would be contacted for a copy of the last correspondence between the Consultant and GP which would outline current status of care. Test results (Lab test / Imaging) were available electronically for review.
- We reviewed eight sets of patient records. The notes were legible, comprehensive and contained all the relevant information. They were all signed and dated accordingly.
- Consultants reported no difficulties in accessing patients' notes for their clinics and we observed clinics where patient notes were available.
- Patient records were stored securely in the outpatient's office. The patient records were taken to the consultation room prior to the patient arriving. Records were returned to the secure cabinet immediately after the clinic.
- Reports for x-rays were written on-site by the relevant consultant. The consultants used voice recognition and would read the patients report into the Patient Archiving and Communication System (PACS) which was efficient and saved time. If no report was required the consultant

would write directly in the patient's notes. As radiographers did not write reports, if an urgent one was required for a patient referral, the staff would call the consultant directly to attend and write the report.
- GPs received the patients' notes and x-ray via post.

Safeguarding

- Corporate safeguarding policies and procedures were available to staff on the Spire intranet and all staff we spoke to were aware of how to escalate a safeguarding concern. The acting Hospital Director was the safeguarding lead for adults and children.
- Staff completed an e-learning training module as part of their mandatory training for the safeguarding of adults and children. At the time of the inspection, 71% of outpatient staff had completed level 2 safeguarding children training and 88% of diagnostic department staff. 68% of outpatient staff had completed level 2 safeguarding adults training and 88% of diagnostic staff. The hospital target for quarter three was 75%, which increased throughout the year.
- We were told that as part of a restructure in outpatients, some nursing staff had been identified to complete level 3 safeguarding adults training in the immediate future.
- Staff in radiology were made aware of the female genital mutilation (FGM) policy which was held in the clinical brief folder in the department and was easily accessible to staff. We saw the policy and spoke to staff who knew where it was to refer to.

Mandatory training

- Mandatory training was mostly completed through e-learning, which included infection control, fire safety, health and safety, safeguarding adults and children, manual handling, information governance, compassion in practice and equality and diversity. Basic Life Support (BLS) training was an annual, practical training session.
- The staff had training packages personalised to their role and their training would flag up as they logged onto their intranet.
- In radiography, a spreadsheet of staff mandatory training was displayed in the 'vision room' and staff were able to see when training was due.
- Within the x-ray department was a notice board which informed staff of what training they were due to go on, to ensure they did not overlook the course.
- All staff in outpatients and diagnostics were trained in Basic Life Support (BLS) for adults as part of their mandatory training. However, at the time of our inspection, only 47% of OPD staff were up to date with BLS and Immediate life support (ILS) training and 85% of diagnostic staff.
- 88% of outpatient's staff had completed mandatory training in; fire safety, health and safety, infection control, safeguarding children and adults and 94% had completed a manual handling training, as of 21 September 2016.
- 100% of radiology / diagnostics staff had completed mandatory training as of 21 September 2016.

Assessing and responding to patient risk

- In an emergency situation, emergency 'bleep holders' attended to treat a deteriorating patient quickly, throughout the hospital. The hospital had an arrest team who would respond, which was led by the resident medical officer (RMO). The RMO is expected to attend any resus scenarios undertaken whilst they are on duty and this is documented by the Resus lead following completion of the scenario.
- Staff were aware of managing contrast-media-induced anaphylaxis and on an annual basis attended basic life support training where anaphylaxis was discussed. The anaphylaxis algorithm was available on all resuscitation trolleys. All clinical staff also attended AIM training on a biennial basis where anaphylaxis is discussed. The resuscitation lead also undertakes bi monthly 'drop down' scenarios throughout the hospital as per Spire Resus policy. These are performed within all areas of the hospital using a variety of emergencies including anaphylaxis.
- If a patient's health deteriorated significantly, the staff knew to call for an ambulance for the patient to be taken to the local NHS hospital.
- Emergency resuscitation equipment was available in outpatients and in the diagnostic department, which included defibrillators for adults and children.
- The two x-ray rooms and the ultrasound room had nurse call emergency buttons which patients could access whilst undergoing the x-ray, in case they felt unwell or wanted the procedure to stop for any reason. The alert would be received by the front reception desk and the nursing station.

Good

Outpatients and diagnostic imaging

- There were two radiation protection supervisors (RPS) in radiology. The RPS helps to ensure compliance with the arrangements made by the radiation employer under IRR99 and in particular, supervising the arrangements set out in local rules.
- The diagnostics and imaging service had patient safety questionnaires for patients to complete before any scans. The questionnaires were first filled and then vetted by the radiologist and then further questions asked at the appointment.
- In the x-ray room patients had an emergency call bell to use from the x-ray table if there was an emergency or they needed assistance.
- The hospital confirmed staff had the appropriate training to deal with anaphylaxis in the event of a reaction to contrast media. They confirmed anaphylaxis is covered during BLS training, as part of the AIMS course and also that scenarios are undertaken bi-monthly as per Spire policy.
- The radiology service had adapted the World Health Organization (WHO) surgical safety checklist for radiological interventions and this was displayed in all relevant rooms next to the equipment. The 'WHO' checklist is a set of safety checks for use when carrying out non-surgical interventional radiology.
- We also saw Spire's own staff safety checklist, which was an adapted version of; 'PAUSE' and 'PAUSE and Ask', which was displayed in the mammogram room, ultrasound room and x-ray rooms. This was an adapted version of the 'WHO' check list.

Nursing staffing

- At the time of the inspection patients' needs were being met and there was sufficient nurse staffing in OPD. The department had undergone a recent re-structure and the management team had determined that the department was top-heavy with nursing staff. At the time of our visit there were no vacancies for outpatient's nurses or health care assistants; however, the hospital told us there were bank staff vacancies for two registered general nurses and two health care assistants, these were to cover holidays and sickness.
- The use of bank and agency outpatient nurses was higher than the average of other independent acute hospitals that we hold this type of data for in the reporting period (Apr 15 to Mar 16). The use of bank and agency outpatient health care assistants was lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period, with the exception of the last 3 months of the reporting period, where only agency staff were used in outpatients. However, in the three months prior to our visit there had been no agency staff use in the department. Also, no agency staff were used in the radiography department. At the time of our visit there were three bank staff employed, all of who had received an induction
- The hospital used bank staff who would all receive a Spire induction and shadow a Health Care Assistant (HCA) or Registered General Nurse (RGN), after four weeks they would complete a competencies check list. We spoke to one member of bank staff in the diagnostics department who confirmed they had had an induction in which they were also informed of relevant policies and procedures.
- The turnover of outpatient nurses was lower than average of other independent acute hospitals we had looked at for the period of April 2015 to March 2016.
- For outpatient and diagnostic departments at the hospital, a ratio of nurse to health care assistant was 3.6 to 1.

Medical staffing

- Medical staff were engaged to work at the hospital through practicing privileges. The hospital had a system to check competencies of consultants who had applied to work under practicing privileges. All applications had been reviewed by the medical advisory committee who ensured that they had undertaken the treatment they had applied to provide on a regular basis.
- Specific consultants had planned clinics every week and medical staffing was based on the number and type of clinics that were operating on any given day.
- If consultants couldn't attend a clinic, appointments would be rearranged.
- The hospital had two resident medical officers (RMOs) who were employed through an agency. The RMO was available 24 hours a day and were resident on site, with immediate telephone access to the responsible consultant if required.
- All of the orthopaedic surgeons working in outpatients worked well together as a team and would cover each other's clinics if required and worked well as a team.

Major incident awareness and training

Good

Outpatients and diagnostic imaging

- There were business continuity plans in place for the hospital. This covered emergency response arrangements for all departments, including evacuation procedures to follow for major incidents such as; fire, flood, bomb explosion and spillage of hazardous materials.
- The hospital had departmental action cards available on the intranet for step by step advice on dealing with major incidents, e.g. electrical faults and gas leaks.
- The hospital had a backup generator which was used in the event of a power failure. This had been tested regularly by the on-site maintenance team.
- The hospital had a contingency plan for picture archiving and communication system (PACS) downtime. PACS allows a healthcare organisation to capture, store, view and share all types of images internally and externally. We viewed the contingency plan during our visit.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

- The departments followed relevant National Institute for Health and Care Excellence (NICE) guidelines and evidence based practice guidance in their care and treatment of patients.
- The radiology department followed guidance in relation to the safe use of radiation as described in 'Ionising Radiation (Medical exposure) Regulations (2000) (IRMER) AND Recommendation from Radiology Protection Association (RPA).
- The hospital looked at alternative methods of pain prevention wherever possible and complimentary pain relief therapies were available via the physiotherapist, included pilates classes, which were open to all members of the public.
- All new corporate policies were disseminated by email and printed off and placed in the clinical briefing folder. New policies had to be read and signed by members of staff to say that they had noted the policy.
- A multi-disciplinary team (MDT) approach was evident across all the areas we visited. We observed collaboration and communication amongst all members of the MDT to support the planning and delivery of care in the outpatients and diagnostics department.

Evidence-based care and treatment

- The hospital followed the World Health Organization (WHO) and Royal College of Radiologists guidelines for interventional radiology. The guidelines were easy to access and displayed for reference.
- The departments followed relevant National Institute for Health and Care Excellence (NICE) guidelines and evidence based practice guidance in their care and treatment of patients.
- The radiology department followed guidance in relation to the safe use of radiation as described in 'Ionising Radiation (Medical exposure) Regulations (2000) (IRMER) and recommendations from the Radiology Protection Association (RPA).
- The diagnostics department had a new magnetic resonance imaging (MRI) scanner and offered patients ear plugs when using it; however, the scanner was very quiet (under 90 decibels) and they were not always needed.
- All new corporate policies were disseminated by email and printed off and placed in the clinical brief folder. New policies had to be read and signed by members of staff to say that they had noted the policy.

Pain relief

- Patients were assessed using a pain scale of 0-4 during consultation and the records indicated that pain was discussed with all patients on admission. It was also detailed in their care pathway.
- The hospital looked at alternative methods of pain prevention wherever possible and complimentary pain relief therapies were available via the physiotherapist, included pilates classes, which were open to all members of the public.
- The hospital participated in a 'pain scoring trigger to action audit'. The audit was completed when a patient had a pain score of 2 or more. We saw the audit completed for July 2016.
- The patient satisfaction survey for August 2016 showed 89% of all patients answered 'A great deal' when asked 'to what extent did staff control pain?'

Good

Outpatients and diagnostic imaging

Patient outcomes

- The radiology department actively carried out a number of audits in order for them to make improvements where required. At the time of our visit there were 14 ongoing audits in the department, e.g. Radiation protection audit. The audit for personal protective equipment (PPE) on the use of lead aprons was completed in January, which we had sight of.
- We saw a clinical audit calendar for radiology in order for staff to monitor when audits were due and who was responsible.

Competent staff

- 100% of staff in outpatients and diagnostics had received an appraisal in the current appraisal year (January 2016 to December 2016).
- All staff involved in administering radiation were formally trained in accordance with legislation set out under the ionising radiation (Medical Exposure) Regulations 2000 (IR (ME) R).
- Records indicated that some staff completed competency assessments and an induction to the department when they first started. After four weeks they were required to complete an induction test.
- We saw evidence that staff in diagnostics had read and signed the Local Rules (IRR 99).
- We saw a 'Standard operating procedure for local working' folder within the diagnostic imaging department. This folder contained information for staff on what individual clinics required when carrying out a procedure.
- We spoke to a consultant who confirmed they had received a 360 feedback and appraisal of their practice with their substantive NHS employers. The Spire biennial review involved checking the NHS appraisals.
- The consultant we spoke to collected patient questionnaires from both his NHS and private patients in order to support his appraisal and maintain a high quality of care.
- Staff we spoke to were actively encouraged and given opportunities to develop. We spoke to a member of staff who had been a bank nurse in the diagnostic department and was now a permanent member of staff.
- All ultrasounds were carried out by a consultant radiologist with the appropriate qualifications.
- Staff told us they had opportunities to conduct further training and further their careers. We spoke to a former radiographer department assistant and she told us that she was given the opportunity to become an assistant practitioner with in house training, external courses and a radiographer mentor, achieving an NVQ level 3.
- In outpatients, some staff had recently been trained in carrying out the procedure for the latest minimally invasive technique for the treatment of varicose veins.

Multidisciplinary working

- A range of clinical and non-clinical staff worked together within the outpatients department and we saw that they all worked together well.
- A multi-disciplinary team (MDT) approach was evident across all the areas we visited. We observed collaboration and communication amongst all members of the MDT to support the planning and delivery of care in the outpatients and radiology department.
- To reduce the amount of time patients were exposed to radiation, the imaging service would attempt to use previous images of the same person requiring the test first, even if these had been taken elsewhere. The referring GP would attach the scan or x-ray to Spire's e-referral system and the NHS Co-ordinator would inform the x-ray department.

Seven-day services

- Various clinics were operating between the hours of 8am to 9pm Monday to Friday with clinics scheduled on Saturdays when the demand was high, but regular clinics from 8am -1pm.
- The in-house pharmacy was open 6 days a week.
- Waiting times for patients once they had arrived at the department were short after being booked in at reception. Patients confirmed they did not wait long before they were seen and were kept informed if there were any unforeseen delays.
- The outpatients department had started auditing waiting times for patients. One clinic daily would be audited and a different clinic each day. There was no data available at the time of our visit as the audits were in their infancy.
- A Radiographer was on call 24 hours a day, seven days a week to undertake time critical diagnostic tests. The radiologist was able to perform and interpret urgent reports as required.

Access to information

Good

Outpatients and diagnostic imaging

- Staff had access to the Spire Healthcare's intranet to obtain information, policies and procedures and had personalised e-learning. They could also access reference sources such as NICE guidance and professional guidance.
- The outpatients department was a consultant led service. When patients were discharged from the hospital the patient's GP was informed electronically.
- If the staff had any concerns regarding a patient they would ask permission from the patient and inform their GP and consultant.
- GP's received the patient's notes from the hospital via the post. In the case of an x-ray not arriving in time for the patient's GP's appointment, the hospital would fax through the x-ray to the surgery to save the patient from having to make another appointment.
- The radiology service used patient archiving and communication system (PACS), a medical imaging technology which provides economical storage and convenient access to images from multiple modalities. This is a system which enables clinicians to access scans undertaken across the North West region where the system is used in the referring hospital.
- Staff in radiology had access to the radiology information system (RIS), a core system for the electronic management of imaging departments. The major functions of the RIS can include patient scheduling, resource management, examination performance tracking, examination interpretation, results distribution, and procedure billing. Radiographers could add any concerns regarding a patient to the system, to be available for other radiographers, e.g. the patient is claustrophobic.
- The hospital had an electronic referral system, tracked through the clinical commissioning group (CCG); the patient had unique reference number and password. GP's would attach their referral and any previous scans or x-rays relevant to the patient for the hospitals attention.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance for the Mental Capacity Act (MCA) when obtaining consent.
- MCA training was completed as part of staff mandatory training, figures at the time of our visit showed 59% of outpatient's staff were compliant and 62.5% of diagnostic staff.
- The Deprivation of Liberty Safeguards (DoLS) policy was easily accessible to all staff in the diagnostic imaging department as it was displayed in the clinical brief folder for all staff.
- We looked at patient records in outpatients and saw evidence that consent had been obtained where necessary.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging as 'Good' for Caring. This is because;

- We saw that patients were involved in decisions about their care and treatment and that their views and wishes were listened to.
- Patients we spoke to said that the staff treated them well and with dignity and respect throughout the process.
- All NHS patients we spoke to in the diagnostics department said that there was no difference between their treatment and a fee paying patient. One patient told us that their procedure had been talked through with them extensively and they were made to feel individual and special.
- Patients were supported throughout their treatments. We saw staff spending appropriate time talking to patients and responding to their questions in an appropriate manner.

Compassionate care

- During our inspection we observed staff interactions with patients and relatives and found theses to be friendly, respectful, polite and professional.
- The hospitals patient-led assessment of the care environment (PLACE) results for 2016 showed the hospital scored 91% for privacy, dignity and wellbeing which was better than the England average of 83.3%.

Good

Outpatients and diagnostic imaging

- For consultations for plastic surgery and gynaecological procedures, same gender chaperones were always provided.
- We witnessed a member of staff operating the magnetic resonance imaging (MRI) scanner interacting with a patient whilst they were in the scanner. They understood the apprehension that the patient may have had and reassured them periodically, informing them how long each procedure would take.
- We spoke to patients waiting in the diagnostic waiting room, who all said that the reception staff treated them well and with dignity and respect, only asking them for essential details at reception. Any confidential issues to be discussed with patients and they would be taken to one side, away from the reception desk.
- All NHS patients we spoke to in the diagnostics department said that there was no difference between their treatment and a fee paying patient. One patient told us that their procedure had been talked through with them extensively and they were made to feel individual and special.
- The NHS Friends and Family Test (FFT) is a survey which asks patients whether they would recommend the service they have used to their friends and family. The survey results we looked at were from the period of June 2016 to July 2016; 99.5% of all patients said they would recommend the service. This was better than the England average of 95%.
- A chaperone service was available when required for patients who may require an intimate examination. Posters were displayed in the waiting areas informing patients of the service.

Understanding and involvement of patients and those close to them

- Posters were displayed in the outpatients and diagnostic waiting rooms informing patients that a chaperone service was available and how to ask.
- All patients stated that their appointments slots gave sufficient time to discuss their condition in a relaxed, respectful, courteous and dignified manner.
- Patients we spoke to said they received clear and comprehensive information about their care and treatment in a way they understood. They felt this assisted them to make informed choices about treatment options.
- The hospital provided clear and unambiguous information about prices and cost for medical treatment in order for patients to be clear about what to expect when being billed for services and the price list was available on the hospital website.

Emotional support

- Patients were supported throughout their treatments. We saw staff spending appropriate time talking to patients and responding to their questions in an appropriate manner.
- We observed a patient undergoing an MRI scan who was particularly nervous; the member of staff continually re-assured them via the intercom system throughout the procedure.
- All the treatment room and consultation rooms were private and could be used to deliver any bad news.
- All outpatients attending clinics were escorted to see the consultant by a member of staff and escorted from the consulting room after the appointment. We heard staff being kind and offering support to patients.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatients and diagnostic imaging as 'Good' for Responsive. This is because;

- The waiting rooms in both outpatients and diagnostics were designed to meet patients' needs, with more than ample seating. Large flat screen televisions were in place, which provided information about clinics and services, with magazines and information leaflets available. Both waiting rooms had access to toilets and had a hot drinks machine, providing free tea and coffee.
- The hospital performed well in relation to referral to treatment (RTT) waiting times. Generally, 100% patients on incomplete or non-admitted pathways were seen in 18 weeks, with only three months being at 99% for incomplete pathways between April 2015 to March 2016.
- Clinics were available until 9pm in the evening and all day Saturday if there was sufficient patient demand for these appointments.

Good

Outpatients and diagnostic imaging

- There was no waiting list for patients awaiting a magnetic resonance imaging (MRI) scan. Private patients were seen within 24-48 hours. NHS patients were booked in over the telephone and appointments were made within three days.

Service planning and delivery to meet the needs of local people

- The waiting rooms in both outpatients and diagnostics were visibly clean, tidy, light and airy with more than adequate seating and designed to meet patients' needs. Large flat screen televisions were in place, which provided information about clinics and services, with magazines and information leaflets available. Both waiting rooms had access to toilets and had a hot drinks machine, providing free tea and coffee.
- The MRI scanner operated Monday to Friday 9am to 5pm; with late nights on Tuesday and Wednesday until 9pm and Saturdays 9am to 1pm. Staff were not on call to operate the scanner.
- Complimentary pain relief therapies were available via the physiotherapist which included pilates classes, which were open to all members of the public.
- A patient information board in the outpatient department (OPD) displayed information on; hearing loop, how to make a complaint, Deprivation of Liberty Safeguards (DoLS), the chaplaincy service, dementia, Mental Capacity Act (MCA) and informed patients that there was no cases of methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C.difficile) in the department.
- The hospital had a restaurant which offered food and drink Monday to Saturday, 8am to 6.30pm and snack machines were available for patients in the outpatients and diagnostic waiting rooms.
- There was a large free public car park for patients to use.
- All departments were clearly signposted and a map was displayed in the reception area to guide patients around the hospital.
- Clinics were available until 9pm in the evening and all day Saturday if there was sufficient patient demand for these appointments.
- In radiology, GP's received the patients' notes and x-ray via the post, we were told that if a patient attended a GP's appointment and the x-ray had for some reason not arrived, they would fax over the x-ray to prevent the patient having to make another appointment.
- Patients attending for a mammography had the use of private, individual changing rooms next to the mammography room. The changing rooms were well equipped with a lockable wardrobe, seat, mirror, hand gel and privacy curtain. The x-ray room also had two patient changing rooms with adjoining doors into the x-ray room, to maintain patient dignity.
- The outpatient department were looking to increase the services for cosmetic surgery and bariatric patients. Management saw this as a way of improving service to meet the needs of local people and this would involve employing specialist nurses.
- OPD also wanted to expand the services for ophthalmology to meet demand as they were seeing an increase in cataract patients.

Access and flow

- The hospital performed well in relation to referral to treatment (RTT) waiting times for NHS patients to be treated within 18 weeks of referral. Data showed that performance in relation to incomplete pathways and non-admitted pathways within 18 weeks was generally achieved for 100% of patients from April 2015 to March 2016. There were only three months where performance was 99% for incomplete pathways in that period.
- The hospital had no patients waiting six weeks or longer from referral for magnetic resonance imaging (MRI), Computerised Tomography (CT) or non-obstetric ultrasound.
- Waiting times for patients once they had arrived in the department were short after being booked in at reception. Patients we spoke to confirmed they did not have to wait long before they were seen. No waiting times were displayed in the waiting room, but staff told us that they would let patient's know individually if there were any unforeseen delays.
- There was no waiting list for patients awaiting a magnetic resonance imaging (MRI) scan. Private patients were seen within 24-48 hours. NHS patients were booked in over the telephone and appointments were made within three days. Outpatients department had only started auditing waiting times in the department, three weeks prior to our visit. They were auditing one clinic a day and the managers were collating the information to feed back to staff.
- At the time of our visit the outpatients and diagnostics imaging departments did not monitor Do Not Attend

(DNA) rates, however on speaking to managers of OPD it is something they intend to audit in the future. Presently if a patient fails to attend an appointment they would receive a phone call and a letter from the hospital.

Meeting people's individual needs

- The hospitals patient-led assessment of the care environment (PLACE) score for 2016 showed the provision of a dementia friendly environment was 83.85%, which was better than the England average of 77%.
- Appropriate support was provided for patients who required bariatric equipment. Specialist equipment was available such as; wheelchairs, hover mats, gel pads and a bariatric table in theatre. A service level agreement was in place with a local NHS hospital in case of any complicated bariatric cases.
- The MRI scanner was suitable for bariatric referrals and had a 32 stone table weight limit.
- Staff completed equality and diversity training as part of their mandatory training; 100% of staff in both diagnostics and outpatients had completed the training, as of 21September 2016**.**
- Patients using the MRI scanner were given a buzzer in easy reach to enable them to contact staff if they were worried whilst using the scanner.
- Patients requiring support during an x-ray were able to take a friend or relative in with them and they were able to remain in the x-ray room during the procedure, whilst wearing an issued lead apron, which we saw ready for use.
- Telephone or face to face interpreter services were available when English was not the patient's first language. Information gathered at the referral stage identified patients who would need interpretation services and translators were booked when the appointment was made.
- Hearing loops (an audio induction loop) a special type of sound system for use by people with hearing aids, were available to assist patients with hearing difficulties. The hearing loop provides a magnetic, wireless signal that is picked up by the hearing aid when it is set to 'T'. Hearing loops can greatly improve the quality of sound and reduce background noise.
- Patients with complex needs including learning disabilities and patients living with dementia were identified when the appointment was made and whenever possible would get them to attend with their carer.
- Governance leads told us that their vision for the future is for all hospital staff to receive dementia training.

Learning from complaints and concerns

- The hospital as a whole, had received 48 formal complaints in the reporting period April 2015 to March 16. No complaints had been referred to the Ombudsman Independent Healthcare Sector Complaints Adjudication Service or (ISCAS) in the same reporting period.
- We reviewed two complaints that related to outpatients and diagnostics. We looked at their investigations and outcomes and were satisfied that they were investigated and dealt with in an appropriate and timely fashion.
- In the outpatients waiting room we saw a patient information board which displayed clear information on how patients could make a complaint. We saw 'Please talk to us' leaflets available which also feature this information. There was details on the website as to how to make a complaint and for NHS patients, how to make a report to the Parliamentary and Health Service Ombudsman.
- The hospitals aim was to provide written acknowledgement within 48 hours of receipt of a complaint and provide a full written response usually within 20 working days when the outcome of the investigation was known. If the investigation was still ongoing after 20 days there would be written contact explaining what the delay was.
- All staff we spoke to knew how to refer a complaint and would report to their department manager, who would investigate it before feeding back the outcome.

Are outpatients and diagnostic imaging services well-led?

Good

We rated outpatients and diagnostic imaging as 'Good' for Well-led. This is because;

Good

Outpatients and diagnostic imaging

- A 'quality tree' was displayed in the outpatients' waiting room and at the entrance to the diagnostic waiting room. The tree identified quality objectives of the department.
- A quality improvement meeting was held quarterly which more recently had been combined with 'Drivers for change' meeting, looking at the strengths and weaknesses in the outpatients department and sharing information for improvement.
- There was a clear governance structure in place and information was shared throughout the staff structure via; outpatient's department monthly meeting, daily multidisciplinary team (MDT) meetings and monthly clinical effectiveness where the risk register and any relevant incidents were discussed.
- The hospital participated in the Spire healthcare staff survey. We looked at the engagement survey result for November 2015, when staff were asked if senior managers help them to feel well informed about what is happening in the hospital, the response was 87% positive feedback.

However;

- Staff sickness rates were generally low between May 2015 and March 2016, though during the months of April, August and October 2015 the rate was notably higher than average; average; 25% in April, 30% in October and rising to 40% in August.

Vision and strategy for this this core service

- The outpatient managers told us that their vision was to ensure that all Health Care Assistants were supported in their training and development and intended to employ a designated practice educator for HCAs.
- Staff were provided with a corporate induction that outlined the vision and values and staff had a good understanding of what they were.
- A quality improvement meeting was held quarterly which more recently had been combined with 'Drivers for change' meeting, looking at the strengths and weaknesses in the outpatients department and sharing information for improvement.
- Management for OPD told us that the vision for OPD was to train staff in different skills in order to utilise them in various roles, without diluting their expertise.
- A 'quality tree' was displayed in the outpatients' waiting room and at the entrance to the diagnostic waiting room. The tree identified quality objectives of the department. It depicted an apple tree and the objectives were written on the apples, once these were completed the apples were transferred to the basket at the bottom of the tree. For the outpatient department (OPD), the objectives were; staff recruiting, operational plan in place, staffing, and professional planning. Completed objectives shown were; huddles, debriefs monthly meetings.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place and information was shared throughout the staff structure via; outpatient's department monthly meeting, daily multidisciplinary team (MDT) meetings and monthly clinical effectiveness where the risk register and any relevant incidents were discussed.
- Risk assessments were being carried out for the radiology department. We saw a risk assessment file for radiation issues which was recorded in 2015 and reviewed in 2017.
- The hospital wide risk register highlighted key risks to the service. Actions taken to control or minimise the risks were detailed. The risk register in relation to the outpatients department highlighted a staffing issue and the action to be taken was for the department to recruit more bank staff. We were told that the staffing issue was due to 3 nurses being on long term sick.
- The most senior member of staff on duty within each department attended the senior staff 'Comm cell' (Communication cell) every morning. The meeting was an opportunity to share information relating to the hospital and across each department. As well as general hospital business it included complaints, incidents, concerns and compliments. Each department had the opportunity to report on things relating to their area. We witnessed a 'comm cell' taking place during our visit.
- The link nurses for infection control attended bi-Monthly meetings where activity and outcomes were monitored. We saw minutes and action logs for the meetings.
- A quality improvement plan spreadsheet was seen in the communication file in the diagnostics department, it was signed by staff to say they had read it. The improvement plan used RAG ratings; The RAG system is a popular project management method of rating for issues or status reports, based on Red, Amber (yellow), and Green colours used in a traffic light rating system One example was the implementation of the

Governance National Breast Register, with the aim to align with the National Breast Register Guidelines and the outcome was the commencement of education for October 2016.

Leadership and culture within the service

- There was clearly defined and visible local leadership roles in each speciality within outpatients and diagnostic imaging areas. Senior staff provided visible leadership and motivation to their teams.
- Staff morale was good and we observed staff from all specialities worked well together. The team was visibly enthusiastic about the outpatient and diagnostic imaging services. Many of them had worked in the service for many years. Staff enjoyed working at the hospital and felt the company treated then with respect and valued their opinions.
- All staff we spoke to said that the communication within the departments and between departments was good and was described it as 'Like a family'.
- Staff sickness rates were generally low (less than 10%) between May 2015 and March 2016, though during the months of April, August and October 2015 the rate was notably higher than average; 25% in April, 30% in October and rising to 40% in August.
- Staff were able to progress and develop and discuss with their managers at their appraisals their interests and what new skill areas they would like to develop. Some staff had recently been trained in carrying out the procedure for the latest minimally invasive technique for the treatment of varicose veins.

Public and staff engagement

- The hospital participated in the Spire Healthcare staff survey. We looked at the engagement survey result for November 2015, when staff were asked if senior managers help them to feel well informed about what is happening in the hospital, the response was 87% positive feedback.
- The hospital also carried out a patient satisfaction survey and the patient feedback was compared with the provider's other hospitals. Results for the August 2016 survey showed that 81% of all patients asked said that they would be extremely likely to recommend the hospital to family and friends and 85% of all patients said that the care and attention they received from nurses was excellent. The satisfaction survey asked extensive questions for individual departments, outpatient nurses and x-ray / imaging scored high throughout the survey.
- The hospital also participated In the NHS outpatient satisfaction survey. The results for the July 2016 survey showed out of 77 returns received, 59 patients said they were 'extremely likely' to recommend the hospital to friends and family if they need similar care or treatment and 17 said they were' Likely'
- The hospital held fortnightly minuted patient forums, where patients could share their experiences and put forward their views for improvements. For example at the 7 July 2016 meeting, the patients raised issues over the patient room folder stating it was out of date, needed laminating and should be smaller in size and with less information. This was then discussed at the 'Drivers for Change' meeting and with marketing and brought back to the group for review and action where necessary.
- The radiology staff meeting minutes were placed in the communication folder for staff to read.
- All of the NHS patients we spoke with told us that they had selected Spire Murrayfield hospital via the 'Choose and book' service on the internet and felt empowered at making a decision as to where to receive their treatment.

Innovation, improvement and sustainability

- OPD were also looking forward to the future of GP Led services, concentrating on improved preventative measures. They talked of improving patient care by offering time in clinic for independent GP's, allowing patients to utilise their services and avoid long waiting times in general GP surgeries.
- We were informed that at the time of our visit a business case was being developed for a new mobile 'C arm' Computerised Tomography (CT) scanner, to be used in theatre as a replacement for fluoroscopy in the department, but was not yet complete.

Not sufficient evidence to rate

Termination of pregnancy

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

Information about the service

Spire Murrayfield hospital is located in the middle of the Wirral peninsula close to the M53 motorway.

Termination of pregnancy is one of the services offered within the hospital setting. The hospital provides services that include an out – patient department and surgical facilities.

The hospital provides a range of termination of pregnancy services. They include: pregnancy testing, unplanned pregnancy counselling/consultation, medical abortion and early surgical abortion up to 14 weeks of pregnancy, abortion aftercare and contraceptive advice and contraception supply. Termination of pregnancy is offered up to 14 weeks, by one consultant with practising privileges to provide this service.

Treatments offered include, medical termination or surgical termination under general anaesthesia.

Medical abortions are usually offered as per Royal College of Obstetricians Guidelines (RCOG) with a minimum gap of 24 hours between administrations of abortifacient medication. The service is available six days a week including out of hours if requested. The hospital provides treatment for patients who self – refer and are self – funding only.

Between April 2015 and March 2016, the service carried out 16 medical abortions and four surgical terminations, “suction terminations of pregnancy” under general anaesthetic. All patients were over 18 years old.

Patients were able to call the consultant or the hospital 24 hours a day, post treatment for advice and support if needed.

We spoke to the consultant via a teleconference, the acting hospital director, the theatre manager, a senior nurse and three pharmacy staff (the manager, a pharmacist and a technician).

We reviewed care records, including prescription records for 14 patients (10 for medical termination of pregnancy and four surgical termination of pregnancy). Prescription records were further reviewed by a CQC pharmacy inspector.

This service has been inspected but not rated due to the low number of patients involved.

Not sufficient evidence to rate

Termination of pregnancy

Summary of findings

This service has been inspected but not rated due to the low number of patients involved. There were no patients undergoing a termination of pregnancy procedure at the hospital at the time of the inspection.

- There were no incidents reported, for the termination of pregnancy service, via the hospital's electronic system.
- All areas were visibly clean and free from clutter with staff using appropriate use of personal protective equipment (PPE) and hand washing.
- There was adequate equipment in place that had been maintained appropriately.
- All patients were over 18 years old; any enquiries from younger people were signposted to alternative providers.
- There had been no safeguarding concerns reported. All consultations included a chaperone.
- There were no nurses specifically employed to care for patients who attended for a termination of pregnancy. The consultant contacted the senior nurse, on the ward and the theatre manager, for a surgical treatment, not only to ensure there were nurses with appropriate training and skills available, but also to check there were staff members with no moral objections.
- The consultant was the sole provider of this service at the hospital, although there was a Resident Medical Officer (RMO) on–site in case of any complications.
- Policies were based on National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines and the Abortion Act 1967, however; there were two instances where abortifacients had been administered with less than 24 hours between each part.
- Patients were seen and treated within a timely manner. There was one patient who had waited 7 days but this was due to their own preference.
- The consultant was employed at the hospital via a practising privileges arrangement. All competencies, including scanning, were assessed, via the NHS, and monitored by the hospital.
- There was effective multi –disciplinary team working that included the consultant, nurses, theatre staff, pharmacy, ultrasound and laboratory.
- The service was available six days a week, including evenings with the exception of consultant leave.
- There had been no instances where records were not available. Results from blood tests were accessible in the electronic system.
- Patients were able to be accompanied by those close to them whilst receiving care and treatment.
- The consultant discussed options about the disposal of pregnancy remains during the initial consultation.
- Clinical psychologists provided counselling support when needed at each stage of care and treatment.
- We were told that there were no waiting times in the hospital.
- An interpreter was available for non-English speaking patients; information could be translated into Braille, for visually impaired patients or other languages. A hearing loop was available for patents with a hearing disability.
- We were told, a best interest meeting would be held for patients with a learning disability or mental health need, but we could not review this as there had been no patients accessing the service that would require such a meeting at the time of the inspection.
- There were no complaints or concerns made about the termination of pregnancy service.
- The termination of pregnancy register was maintained electronically.
- There were effective arrangements in place to make sure that the HSA1 form was signed by two medical practitioners as required by Abortion Act 1967 and Abortion Regulations 1991.

However;

- Medication was prescribed on paper prescription charts that were not always clear and duplicate charts were present in two patient notes.
- Patient records included a range of standardised forms. The consultant completed hand written notes that were difficult to read, therefore; it was difficult to ascertain what information was discussed with patients.

Not sufficient evidence to rate

Termination of pregnancy

- Although we were told that the consultant audited failure rates, the hospital did not pro-actively audit successful outcomes of a termination of a pregnancy.
- Contraception was routinely discussed at consultation and offered if requested, however; there were no audits of Long Acting Reversible Contraception (LARC) uptake.
- Pain relief was not consistently offered and included paracetamol which has been found not to relief pain as per Royal College of Obstetricians and Gynaecologists guidelines.
- We were told that routine screening for sexually transmitted infections was carried out for all patients, however; no evidence seen in records reviewed.
- The hospital risk register did not include any risks for termination of pregnancy services.
- There was no evidence, in records reviewed, that patients were informed about the statutory requirement to notify the Department of Health, via the HSA4 form or that the forms had been sent.

Are termination of pregnancy services safe?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. There were no patients undergoing a termination of pregnancy procedure at the hospital at the time of the inspection. Procedures in place related to surgery and outpatient services with many processes not specific to termination of pregnancy.

- There were no incidents reported via the hospital's electronic system. A complication identified in an audit was not reported as an incident.
- Medication was prescribed on paper prescription charts that were not always clear and duplicate charts present in two patient notes out of 14 prescription charts checked
- Patient records included a range of standardised forms. The consultant completed hand written notes that were difficult to read, therefore; it was difficult to ascertain what information was discussed with patients.

However;

- All areas were visibly clean and free from clutter with staff using appropriate personal protective equipment (PPE) and hand washing.
- There was adequate equipment in place that had been maintained appropriately.
- There had been no safeguarding concerns reported. All consultations included a chaperone.
- There were no nurses specifically employed to care for patients who attended for a termination of pregnancy.
- The consultant was the sole provider of this service at the hospital, although there was a Resident Medical Officer (RMO) on–site in case of any complications.

Incidents

- There was an electronic system in place to report incidents with triggers to alert senior management. Staff we spoke with were aware of the process and understood their responsibilities.
- From April 2015 to March 2016 there were no never events. Never Events are serious incidents that are wholly preventable as guidance or safety

recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- From April 2015 to March 2016 there were no incidents reported for termination of pregnancy. However records we reviewed showed that in July 2016, an audit of patient records included a complication four weeks following a medical termination; the complication was not recorded as an incident.
- Staff we spoke with were familiar with the term 'Duty of Candour' with some demonstrating a more detailed in depth knowledge of the process than other staff. 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.
- Feedback from incident investigations was shared at team meetings as well as safety briefing meetings that included representatives from all hospital staff. Staff had access to computers and could check emails during their shift.
- Medical Advisory Committee (MAC) minutes showed that serious incidents were discussed to share learning and standardise practise. The consultant represented gynaecology at MAC meetings.

Cleanliness, infection control and hygiene

- There were no methicillin resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA), Escherichia coli (E-coli) or clostridium difficile (C.diff) reported by the service between April 2015 and March 2016.
- Infection control meetings included the review of any infections, environmental issues and audits.
- Hand hygiene audits were completed quarterly. The audits include in the infection control minutes for January 2015 and June 2016 reported 'green' for compliance.
- An environmental audit of theatre was completed in August 2016 and scored 94% compliance (green). An environmental audit in the outpatient department (OPD) was carried out in August 2016. There was no overall score included, although; non-compliance was recorded and any necessary actions were completed.
- A Patient-Led Assessment of the Care Environment (PLACE) audit, 2016, scored 90.45% for cleanliness.
- The reception area, consultation rooms, ward, and theatre were visibly clean and well organised.
- Hand gel and sanitizers were readily available on entry to clinical areas and ward staff we observed used sanitizing hand gels and hand washing procedures prior to providing care to patients. All ward staff we observed adhered to the 'bare below the elbows' policy in clinical areas, however; there were no patients that were undergoing a termination of pregnancy at the time of inspection and therefore we could not observe infection control practice during such a procedure.
- Personal protective equipment (PPE) was readily available and included gloves and aprons. Posters displaying 'hand washing techniques' were displayed throughout the hospital.
- Cleaning schedules were in place and clearly displayed.

Environment and equipment

- The service was located in a single – storey building; there were automatic doors at the entrance. This meant the hospital was accessible for patients with reduced mobility.
- Patients could access different areas of the hospital freely through corridors to different departments.
- The building was in good condition, well maintained and free from clutter.
- Equipment and the environment were shared with other services such as out – patients and surgical areas of wards and theatres.
- Staff told us that there was appropriate and adequate equipment in place for any surgical procedure.
- Emergency resuscitation equipment was available in all areas inspected. Checks were carried out on a daily basis with a monthly check done when a seal was broken, to monitor the expiry dates of all equipment sealed in the drawers.
- Records we reviewed indicated fridge temperatures were checked daily, including the ranges, in all areas inspected.
- Equipment was checked for Quality Assurance (QA) in all areas inspected.
- An environmental audit was carried out in March 2016. There was 100% compliance with one of the patient rooms, however; there were cleanliness issues in another patient room. There were no action plans included.

Termination of pregnancy

- A hospital-wide Patient-Led Assessment of the Care Environment (PLACE) audit, 2016, scored 92.17% for condition, appearance and maintenance.

Medicines

- A policy for the administration of abortifacient medication was requested prior to inspection. The corporate Medicines Management Policy was provided that did not include any information specific to termination of pregnancy, however; a Standard Operating Procedure (SOP) for termination of pregnancy medication was reviewed on inspection.
- Medicines were by medical prescription only. There were no patient group directives (PGDs) for this service.
- Abortifacient medication was stored securely in the pharmacy department at the time of inspection.
- Medications were provided by the pharmacy department within the hospital. Out of office hours, there were on call arrangements for pharmacy and also emergency arrangements where the resident medical officer (RMO) and a registered nurse could access medication. If a patient was booked for a medical termination, the pharmacist explained that the consultant contacted them to order the first abortifacient medication (mifepristone) for the termination. The pharmacist explained that these were dispensed as temporary medication.
- Prescription charts were hand – held paper records. Of the records we reviewed, we found instances of duplicate prescription records. These were discussed with the pharmacist. One prescription included the same medication at the same time. Pharmacy records confirmed that the medication had been dispensed and administered once. One patient's notes included two prescription charts; a blank chart had 'penicillin' recorded as sensitivity. The other chart, within the notes, had medication prescribed, that did not include any sensitivity. This meant there was a risk of medication being prescribed twice and / or any allergy missed.
- The consultant carried out a consultation with the patient and a chaperone, then completed the paperwork and administered the medication in the outpatient department following the completion of the HSA1 forms. The pharmacist explained that for the first part of the treatment (mifepristone), this was labelled generically rather than a specific patient due to high numbers of did not attends (DNA's) for this initial consultation. The consultant told us that the patient would return for the second abortifacient medication (misoprostol) about 24 hours following the first dose. The pharmacist explained that the second treatment was labelled patient specific.
- When reviewing prescription charts, however; we found two out of 14 records of patients returning for the second dose within 24 hours. Royal College of Obstetricians Guidelines (RCOG) recommends a period of 24 to 48 hours between the two abortifacients. If a further dose was necessary this was administered prior to the patient's discharge. For the patients where there was less than 24 hours between parts one and part two of the medication, there was no evidence in the notes that this had been discussed with the patients.
- All patients were prescribed antibiotics as prophylaxis treatment for infection and the medication was administered prior to discharge. It was noted that these prescriptions were recorded on the take home section of the prescription charts, but were either administered by nurses on the ward or given to take home if complaining of nausea post procedure.
- In addition, we were told that for surgical treatment, antibiotics would be administered in theatre, however; there was no evidence in the four prescription records we reviewed.

Records

- Evidence showed that patient records were always available for patients for consultation or admission to the hospital.
- Records were stored securely in all areas inspected.
- We reviewed 10 medical abortion patient records and four surgical abortion patient records. All records were paper – based. There were printed patient labels and standard forms including the "termination of pregnancy" pathway, prescription chart, consent to treatment form, consent for disposal of pregnancy remains and HSA1 form. Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. The doctor completed free text records, however; we found the writing difficult to read.
- In one of the termination of pregnancy audit of records, an action plan was to introduce a 'checklist' for the

doctor, however; no evidence was seen in the records reviewed on inspection. We were provided with a blank copy of the checklist post-inspection. Patient records were audited against the Required Standard Operating Procedures (RSOPs). From January 2015 to time of inspection, records for 48 patients were audited. It was found that the consultant did not consistently document patient discussions in the patients' records. The action plan, in July 2016, proposed the development of a termination of pregnancy history sheet and a checklist, however; none seen in any records reviewed.

- There was no evidence, in the records reviewed, of screening being discussed or any results for sexually transmitted infections. We were told that all patients were tested, using swabs, for chlamydia and gonorrhoea. The information provided to patients following a medical termination of pregnancy, however; referred to testing of urine rather than swabs. There were instances were screening had been declined by the patient.
- There was limited storage space at the hospital; therefore records were stored, following discharge, with individual codes, in a central secure storage facility for eight years. These records could be retrieved in 24 hours if required.
- There were no deaths reported for the service. There were processes in place for reporting to the CQC and Department of Health.

Safeguarding

- There were no safeguarding concerns reported to The Care Quality Commission between April 2015 and March 2016.
- The corporate "Procedure for the care of children and young people" policy had been reviewed in March 2016 included reference to Female Genital Mutilation (FGM), radicalisation, exploitation and the March 2015 legislation for "Working Together to Safeguard Children".
- The corporate "Safeguarding vulnerable adults" policy had been reviewed in January 2016, however; there was no reference to Female Genital Mutilation FGM included.
- Staff, we spoke to, were familiar with female genital mutilation and would report any concerns.
- Adult safeguarding level two training was included in mandatory training. At the time of our inspection there was 64.86% compliance.
- There were no patients under 16 years old that had been treated between April 2015 and March 2016. The consultant told us that he had not treated any patient under 18 years old at the hospital. The Acting Hospital Manager told us that they had received enquiries for under 18s and directed them to alternative providers. The hospital suspended all paediatric and adolescent services in July 2016 due to a lack of suitably qualified paediatric trained staff.
- There was a lead nurse for safeguarding adults and children trained to level three. The Acting Hospital Manager also linked with the local NHS Trust safeguarding teams providing updates that were shared with staff and also access to training.
- The consultant told us he was trained to safeguarding level three for adults and children. In addition, as a consultant at a local acute NHS Trust hospital, there were good links with the Trust. Safeguarding processes were embedded such as the mandatory reporting of female genital mutilation.
- When entering the building, the reception staff presented patients with a registration form to confirm their details and maintain confidentiality.
- We were told that all consultations included a chaperone from the hospital, however; there were no patients at time of inspection.

Mandatory training

- Refer to surgery and outpatient services for compliance rates of training.
- There were no nursing staff specifically for termination of pregnancy.
- Staff received training in areas that included standard modules of fire safety, health and safety, infection control, safeguarding children, safeguarding adults, manual handling, compassion in practice and equality and diversity. Other role dependent mandatory training included managing violence and aggression, controlled drugs, incident reporting, display screen equipment, level 1 food safety, Mental Capacity Act and safe transfusion.

Assessing and responding to patient risk

- Refer to surgery as low numbers of patients for termination of pregnancy.
- Patient records included a 'short stay pathway for termination of pregnancy'. This pathway included a

venous thrombo-embolism (VTE) assessment and World Health Organization (WHO) Surgical Safety Checklist. This checklist is a system to reduce errors and adverse events for patients having surgery.

- Records, we reviewed, showed that patients' vital signs were recorded once, on admission, for medical termination of pregnancy and as required for surgical termination of pregnancy patients on national early warning score (NEWS) charts and scored appropriately.
- The hospital included an on–site laboratory. Copies of results of blood tests were included in the patient records we reviewed. These included the patients' haemoglobin and rhesus status. There was blood available, at the hospital, if needed, however; the consultant told us there had been no need for a blood transfusion for any termination of pregnancy patient at the hospital.
- Audits of 48 patient records between January 2015 and time of inspection showed that any patient that needed anti – D immunoglobulin was given it as appropriate.
- The consultant told us that there was a service level agreement with the local NHS Trust for any emergencies following procedures and that there had been no patients transferred to the local trust. The policy "Escalating concerns about the deteriorating patient" dated March 2015 (review date March 2018) was provided, on request, however; did not include reference to transferring of patients if needed.
- There were emergency call buttons available in all areas inspected as well as a process for alerting the arrest team, if needed.
- The hospital had a resident medical officer (RMO) on–site 24 hours a day, employed via an agency. The RMO was contacted as part of the escalating concerns policy, if needed. We were told that a requirement of the RMO was to be trained in advanced life support (ALS). This was monitored by senior managers.
- In the hospital 115 staff had received basic life support (BLS) training, two had attended advanced life support (ALS) and 28 staff had completed immediate life support (ILS) training.
- On discharge, we were told that patients were given a post-operative leaflet. The leaflet that we reviewed referred to medical termination of pregnancy only. It was dated as published in November 2014, reviewed July 2016 and a review date of July 2018). This leaflet included hospital contact numbers. Any other patient information leaflets were requested post inspection. The consultant provided patients with his phone number in case there was a need to contact him 24 hours a day, seven days a week. This was available in case of a need for further discharge support and advice verbally about any action required. This included, returning to the hospital or attending the local NHS accident and emergency department. There was additional information included in the hospital website: "Treatment summary Termination of Pregnancy" about what to expect before, during and after the procedure.
- Audits of 48 patient records between January 2015 and time of inspection showed that 90% of patients included evidence that discharge information had been provided that included details about a 24 hour helpline as well as physical and emotional symptoms to expect following the procedure.

Nursing staffing

- There were no staff that were specifically allocated termination of pregnancy patients, however; the consultant contacted the senior nurse and theatre manager (if surgical procedure) prior to an admission, in order to ensure staff with appropriate skills and no moral objections, were available to care and treat for a patient. There were also dedicated gynaecology staff in theatres
- Due to the small numbers of procedures, for the termination of pregnancy service, and no patients at the time of the inspection, we were unable to observe staffing in operation.

Medical and surgical staffing

- There was one consultant, experienced in obstetrics and gynaecology, who carried out termination of pregnancy service, as well as an anaesthetist for surgical procedures. The consultant was employed by a practising privileges arrangement. The consultant was also employed by a local NHS acute trust hospital. If a female consultant was requested, an alternative hospital / venue was suggested.
- We were told the consultant was available if required, should a patient need to speak with them following treatment.
- A Resident Medical Officer (RMO) was available on–site 24 hours a day, seven days a week. This doctor was

Not sufficient evidence to rate

Termination of pregnancy

included in the completion of the HSA1 form, as well as the consultant. The RMO was available to review a patient in the absence of the consultant or an anaesthetist.

Major incident awareness and training

- A business continuity plan dated March 2015 (review date March 2017) was provided that outlined actions needed for a variety of situations for this hospital such as fire, electrical failure and water failure.
- Staff we spoke to were aware of major incident plans and scenarios had taken place to practice the plan.

Are termination of pregnancy services effective?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. There were no patients undergoing a termination of pregnancy procedure at the hospital at the time of the inspection. Positively, we saw that;

- Policies and procedures were based national guidance.
- The consultant was employed at the hospital via a practising privileges arrangement. All competencies, including scanning, were assessed via the NHS, and monitored by the hospital.
- There was effective multi –disciplinary team working that included the consultant, nurses, theatre staff, pharmacy, ultrasound and laboratory.
- The service was available six days a week, including evenings with the exception of consultant leave.
- There had been no instances where records were not available. Results from blood tests were accessible in the electronic system.
- All patients were aged over 18 years. We were told that patients were assessed individually for suitability. If a patient presented with a learning disability or lacked capacity to consent, a best interest meeting would be held an alternative consent form was available, hospital-wide and would need to be completed. There had been no patients treated with a learning disability.

However;

- There was no evidence, in records reviewed, that routine screening for sexually transmitted infections was carried out for all patients.
- Contraception was routinely discussed at consultation and offered if requested, however; there were no audits of Long Acting Reversible Contraception (LARC) uptake.
- The hospital did not audit the outcomes of the treatments of a successful termination or any continuing pregnancy.
- Pain relief was not consistently offered and included paracetamol rather than non – steroidal anti-inflammatory analgesia as recommended by the Royal College of Obstetricians.
- There were two instances, out of 10 records reviewed of patients following a medical abortion, of less than 24 hours between administrations of abortifacient medications. Royal College of Obstetrician (RCOG) guidance advocates a minimum of 24 hours between doses. There was no evidence in the records that any increased risk was discussed during the consent process.

Evidence-based care and treatment

- Policies and procedures were based on national guidance.
- The consultant told us that termination of pregnancy treatments were carried out at the hospital up to 14 weeks gestation either by medical termination or surgical termination under general anaesthesia. Any patient that enquired over 14 week's gestation was signposted to an alternative provider.
- Surgical termination of pregnancy was by "suction" under general anaesthesia up to 14 weeks gestation. The pregnancy remains were collected, following the procedure, sealed and disposed of according to the patient's choice. We were told that a curette instrument was used at the end of each procedure to examine the uterus to ensure that all products had been removed. Clinical effectiveness minutes, September 2016 reported that pathology audits had been carried out with 100% compliance in April 2016 and August 2016. A minor pathology issue was highlighted in the June 2016 audit.
- We found two instances, of the 10 records for medical termination of pregnancy reviewed, where there was less than 24 hours between part one and part two of the treatment for a medical termination of pregnancy. In

these instances, we were told that patients were informed there was an increased risk of complications or continuing pregnancy. There was no evidence in the patient records that this had been discussed.

- There was a Standard Operating Procedure (SOP) in place for pharmacy supply of termination of pregnancy medication and in theatre.
- The consultant spoke to patients after referral on the phone and then a face to face – assessment was made to see if they were suitable to receive care and treatment at the hospital.
- There was an audit schedule and quality improvement programme in place at the hospital that included quarterly monitoring of the termination of pregnancy service. These audits were carried out using patients' records to check that all necessary information was evidenced in the notes.
- The consultant confirmed that failure rates were audited. We were told that the consultant asked patients to perform a pregnancy test four weeks after the procedure and inform the consultant if the test was positive. Any reported positive test would be recorded on the electronic system and monitored by clinical effectiveness /audit and clinical governance committee meetings. Between January 2015 and time of inspection, audits of 48 patient records showed that one patient had returned four weeks post procedure following a complication of retained products of conception.

Pain relief

- Records we reviewed showed that pain assessment included in the pathway for termination of pregnancy was completed following a surgical termination. However, we noted that these remained blank following a medical termination of pregnancy.
- Of the prescription charts that we reviewed, there were instances where patients had not been prescribed analgesia or had been prescribed paracetamol rather than a non – steroidal anti-inflammatory analgesia (NSAI).
- In the booklet 'Medical Termination of Pregnancy' the advice, following part one of the treatments was: "You may take paracetamol or co-codamol for pain relief. Do not take products that contain ibuprofen." This is not in line with RCOG guidelines that recommend use of NSAI pain relief such as ibuprofen. When questioned, the consultant explained the reason for this advice was the interactions of the medication. The use of ibuprofen was recommended in the leaflet following part two of the treatment.

Patient outcomes

- Policies and procedures were based on national guidance.
- We requested data about outcomes following the treatment, however; we were told that the service did not audit the outcomes for any continuation of pregnancy.
- We requested evidence of any benchmarking against Department of Health (DOH) statistics or reports regarding any failures, however; we were told that the service was not currently benchmarked.
- Discharge letters, present in the patients records that we reviewed, included that contraception had been discussed with patients choosing to seek further support or treatment from the GP. The consultant told us that the long acting reversible contraception (LARC) was available.
- When data was requested about LARC uptake, prior to inspection, we were told the service was not offered. Patient records reviewed showed that some chose to take up the Mirena contraception, however; the numbers had not been monitored. Required standard operating procedures include RSOP 13 that requires providers to supply all reversible methods of contraception, including Long Acting Reversible methods (LARC).
- Audits of 48 patient records, from January 2015 to time of inspection, showed that there was evidence that contraception had been offered to 75% of patients. Required Standard Operating Procedure (RSOP) 13 includes the requirement that "providers should be able to supply all reversible methods of contraception…..and offer testing for sexually transmitted infections."
- We were told, by the consultant, that screening for sexually transmitted infections (STI's) chlamydia and gonorrhoea was routinely carried out for all patients seen. The booklet, provided to patients: "Medical Termination of Pregnancy" referred to screening using urine test, however; the consultant who wrote the leaflet said the tests should be high vaginal swabs (HVS). There were no consultations booked or observed at time of inspection and no evidence seen in the records we reviewed that screening had taken place except where

noted 'screening declined'. We were told that if a positive result was identified, the patient would be contacted to return for treatment either at the hospital or referred either to the patients G.P. or to a sexual health service, however; there was no evidence seen in patient records we reviewed.
- Audits of 48 patient records, from January 2015 to time of inspection, showed that there was evidence that screening had been offered to 42% of patients.

Competent staff

- There were no nursing staff that were employed solely for termination of pregnancy services. We were told that, prior to an admission; the consultant confirmed with the lead nurse, that there were staff available with the necessary skills and competencies to provide care and treatment. Staff, employed for the hospital received an annual appraisal. There was a compliance of 100% across the hospital.
- The consultant who managed this service was employed at the hospital by a practising privileges arrangement. Reviews were carried out biennially with a 100% compliance of appraisals for all doctors.
- All ultrasound scans were carried out by the consultant carrying out the treatment either abdominal or trans vaginal. The consultant told us that training and on – going supervision was monitored by the Royal College of Obstetricians (RCOG) with competencies maintained through activity in the role at the local acute NHS Trust.
- The consultant told us that if counselling was required then the patient could be referred to a consultant psychologist. The acting hospital manager told us that there were three clinical psychologists, on–site that a patient could talk to at any part of the pathway of care and treatment.

Multidisciplinary working

- There was good internal MDT working between the consultant and the nursing staff. We were told that if a patient required admission, the consultant contacted the senior nurse to ensure that appropriate nurses were available. In addition, the consultant contacted the pharmacy, on site for any specific medication was required.
- There were service level agreements in place with the local acute NHS trust in case of emergency transfers as well as with the local crematorium for disposal of pregnancy remains.
- The hospital director told us that there were good links, at the hospital, with the local safeguarding team and local NHS acute trust hospital.
- There were daily MDT huddles at the hospital. We were told that if there was a surgical termination planned, the consultant attended the huddle in theatre.
- At the time of the inspection, staff were clear that the consultant held the responsibility for patients receiving treatment.
- Patients were made aware of post treatment care and support that was available 24 hours a day.

Seven-day services

- The consultant who delivered the service told us that the service was flexible to meet individual patient's requests, usually available six days a week; Monday to Saturday.
- If the consultant was not available, patients were signposted to alternative locations that included dedicated termination of pregnancy services.

Access to information

- Staff had access to policies and procedures via the hospital's intranet system.
- The consultant told us there had been no instances when patient records were not available prior to a procedure.
- The hospital had its own on site laboratory. This meant that results from blood tests were readily available. Staff could access these results through the hospital's electronic results system and then a printed copy was added to patient records.
- Information leaflets were available for patients following a medical or a surgical termination of pregnancy. Some information was also accessible on the provider's website.
- Records we reviewed included discharge letters that were addressed to GPs unless patients requested otherwise.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The consent for treatment form did not include information about unlicensed medication, however; a pharmacist told us that patients were provided with a leaflet "Unlicensed and off-label medicines."

Not sufficient evidence to rate

Termination of pregnancy

- All the records we reviewed included a form for consent to treatment that was completed by the consultant and the patient as well as a form for the disposal of pregnancy remains: "Consent for Histopathological Examination and Disposal of Products of Conception".
- All 48 records audited from January 2015 to time of inspection included evidence of consent for disposal of pregnancy remains in line with RSOP 15.
- A translation and interpreter service was available for non-English speaking patients, as part of the consent process. In one patient's record it was noted that there was a language difficulty but no evidence that an interpreter was included in the discussion about care and treatment.
- If a vulnerable patient accessed the service, their ability to make a decision as per the Mental Capacity Act 2005 was assessed. This may include a best interest meeting and completion of an alternative consent form. If assessed as unsuitable, the patient was supported to locate an alternative service.
- For the patients where there was less than 24 hours between part one and part two of the medication, we found there was no evidence in the notes that any increased risks had been discussed with the patients.

Are termination of pregnancy services caring?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. There were no patients undergoing a termination of pregnancy procedure at the hospital at the time of the inspection.

- Positive patient feedback collected could not be disaggregated to identify patients who had undergone a termination of pregnancy.
- Patients were able to be accompanied by those close to them whilst receiving care and treatment.
- The consultant discussed options about the disposal of pregnancy remains during the initial consultation.
- Clinical psychologists provided counselling support when needed at each stage of the care pathway.

Compassionate care

- On the two days of the announced inspection and the unannounced inspection, there were no terminations of pregnancy patients at the hospital, therefore we were unable to observe care and treatment or speak to any patients.
- We requested details of feedback from previous termination of pregnancy patients, however; there was no information available specifically for patients following a termination. Information was gathered collectively for the whole hospital for self-funded patients.
- In August 2016, 98% of all patients reported that they were likely to recommend the hospital to others. The response rate was 51%.
- Feedback was reviewed by the customer satisfaction group who produced the document "You said, we did". This highlighted information received from all patients.
- The hospital promoted the six C's (care, compassion, courage, communication, commitment and competence) and encouraged a person –centred approach to care.
- The hospital director told us that all consultations included a chaperone.
- A hospital-wide Patient-Led Assessment of the Care Environment (PLACE) audit, 2016, scored 91.43% for privacy, dignity and well-being.

Understanding and involvement of patients and those close to them

- Prior to the inspection, we were told that the HSA4 form was discussed with patients at the outpatient appointment, however; we found no evidence of discussions in the records we reviewed that the HSA4 form would be anonymised and sent. The HSA4 is a notification form that is sent, by the doctor, to the Department of Health, within 14 days, following a termination of pregnancy
- We were told that, after an initial consultation with the consultant, patients were able to be accompanied by those close to them if preferred. In addition, for a surgical termination of pregnancy, patients were able to be accompanied to the anaesthetic room and return to recovery, following the procedure, if requested.

Emotional support

- There were no specific nurse specialists for termination of pregnancy although the consultant contacted the senior nurse on the ward and theatre staff, if applicable,

prior to admission to ensure that nurses with appropriate skills to support patients in a non –judgemental manner were available to care and treat a patient.

- We were told that one of three clinical psychologists were available if required for counselling support at any point of the care pathway. Of the 14 records we reviewed, only one had evidence hat counselling had been offered. However, an audit of 48 patient records, from January 2015 to the time of inspection, showed that all patients had been offered counselling, at each stage of their treatment. The results also showed evidence that 88% of patients had accessed this service.

Are termination of pregnancy services responsive?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved.

- The service was available for any self-funding patients over 18 years old.
- There was one consultant that offered the service six days a week up to 14 weeks gestation.
- The building was accessible for patients with reduced mobility.
- We were told that there was no waiting times, however; these were not audited.
- An interpreter was available for non-English speaking patients; information could be translated into Braille, for visually impaired patients or other languages. A hearing loop was available for patents with a hearing disability.
- We were told, a best interests' meeting would be held for patients who may lack capacity with a learning disability or mental health need.
- There were no complaints or concerns made about the termination of pregnancy service.

Service planning and delivery to meet the needs of local people

- The hospital offered a service to any patient who was self-funded, over the age of 18 years old, as this was an entirely private service. The service was not available to NHS patients. These patients were signposted to suitable local alternatives.
- The service included one consultant doctor (obstetrics / gynaecology) who was employed by a local acute NHS trust hospital and also employed using practising privileges for this private service. The service was offered Monday to Saturday with the exception of leave by the consultant.
- Referrals were received via the hospital's self – funding hotline from patients seeking a personal service up to 14 weeks gestation. If a patient enquired with a gestation of later than 14 weeks, they were signposted to alternative local providers.
- We were told that all surgical terminations of pregnancy treatments were provided as planned day cases unless a patient chose to remain overnight. Medical termination of pregnancy patients were seen in the outpatient department for the first part of the treatment and admitted to the ward for the second part of the treatment.

Access and flow

- We were told that there were no waiting times for appointments. Patients contacted the consultant directly and a convenient time for an outpatient appointment was made. This was often requested and organised for an evening.
- If the chosen method for a termination of pregnancy was medical, the first treatment could be given on the same day as the face to face consultation, following the completion of paperwork, with an appointment to return to the hospital ward for the second part of the treatment.
- If the chosen method for a termination of pregnancy was surgical, an appointment for the procedure could be planned for the following day if that was agreed.
- The service reported that between April 2015 and March 2016, one patient waited longer than 10 days from the first appointment to the termination of pregnancy. We were told this was due to stabilisation of a pre – existing medical condition prior to the procedure.
- Details of any audits of waiting times from initial referral to outpatient appointment were requested, in addition to waiting times within the hospital, however; no data was available as not collected. Between January 2015 and time of inspection, audits of 48 patient records showed that the time difference between outpatient consultation and procedure was less than five days in all except one patient. This is line with Required Standard Operating Procedure (RSOP) 11.

Not sufficient evidence to rate

Termination of pregnancy

Meeting people's individual needs

- There were several parking areas with ample car parking spaces available to patients.
- The hospital was all on one level and was accessible for all individuals included patients or those close to them, with reduced mobility needs. The main reception doors were automatic also.
- Waiting areas were clean, tidy and light with adequate seating available.
- A patient concierge was available to support patients on arrival. There were single–patient, en–suite rooms that helped to maintain privacy and dignity.
- There was a hearing loop available, as displayed on notice boards for patients with a hearing impairment.
- Information was available in Braille, for visually impaired patients if needed.
- There were interpreter services available for patients whose first language was not English as well as access to translation services.
- Each patient was assessed on an individual basis by the consultant for suitability. The consultant told us that there were no patients that had accessed the service with a learning disability. We were told a best interest meeting would be held if needed and also that a patient may be referred to an alternative provider, either the local acute NHS Trust or other specialised organisation.
- A hospital-wide Patient-Led Assessment of the Care Environment (PLACE) audit, 2016, for disability scored 92.26%.
- As the service was provided by one consultant, if a patient requested a female consultant, they were referred to an alternative provider.
- We were told about how the hospital had provided a discreet service to individuals who preferred not to be recognised by allowing entrance by alternative doors and private waiting areas.
- Patients were provided with the opportunity of making informed choice about the disposal of pregnancy remains or burial of the fetus or pregnancy remains by completion of an additional consent form during the consultation. A service level agreement was in place with a local crematorium for disposal of pregnancy remains

Learning from complaints and concerns

- There were no complaints or concerns reported for the termination of pregnancy service.
- There were posters displayed, throughout the hospital to inform patients how to make a complaint. 'Please talk to us leaflets' were available in all patient waiting areas.

Are termination of pregnancy services well-led?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved.

- The termination of pregnancy register was maintained electronically.
- There were effective arrangements in place to make sure that the HSA1 form was signed by two medical practitioners to meet the requirements of the Abortion Act 1967 and Abortion Regulations 1991.

However;

- The hospital risk register did not include any risks for termination of pregnancy services.
- There was no evidence, in records reviewed, either that patients had been informed about the statutory requirement to notify the Department of Health of all terminations undertaken, via the HSA4 form or that the forms had been sent.

Vision and strategy for this this core service

- The service did not have a specific vision and strategy. The hospital's vision was to: "…strive to provide the highest standards and quality of care and to be the independent provider of choice…"

Governance, risk management and quality measurement for this core service

- There was a hospital risk register, in place. There were no risks were identified for the termination of pregnancy service.
- The termination of pregnancy register was in place. It had been recorded electronically for the past two years with previous records stored on paper, in the ward.
- There were effective arrangements in place to make sure that the certificate of opinion HSA1 were signed by two medical practitioners to meet the requirements of the Abortion Act 1967 and Abortion Regulations 1991. Legislation requires that for an abortion to be legal, two

doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. The consultant who carried out the consultation and examination of the patient told us that the HSA1 form was completed with the first signature by the consultant. The consultant then discussed the patient with the Resident Medical Officer (RMO) who reviewed the patient records and then signed the form setting out their opinion. All patient records we reviewed included completed HSA1 documentation.

- Audits of 48 patient records from January 2015 to time of inspection showed that all included HSA1 forms were signed, in line with RSOP 1.
- The consultant took responsibility for the sending of HSA4 forms. We were told, prior to the inspection, that the HSA4 form was discussed with the patient at the outpatient appointment, however; there was no evidence that patients had been informed about the statutory requirement to send the forms.
- We were told that the consultant posted the HSA4 form, from the hospital, following each treatment, however; the hospital did not record that the form had been sent to the Department of Health, apart from records' audits. The HSA4 is a notification form that is sent, by the doctor, to the Department of Health following a termination of pregnancy. Some records included a form to show that the form had been sent and other records included HSA4 in the consultant's notes with a tick next to it.
- Audits of 48 patient records, from January 2015 to time of inspection showed that 88% included evidence that the HSA4 had been sent within 14 days, however; this was not seen in records reviewed.
- There were processes in place for monitoring practising privileges for doctors at the hospital including sharing of information with other hospitals both independent and NHS. The acting hospital director met with the Responsible Officer (RO) twice yearly.
- The RMO was employed by an external agency. They were required to have specific skills such as being trained in Advanced Life Support (ALS) and they were present 24 hours a day, seven days a week.
- The consultant, for termination of pregnancy, represented the gynaecology team of doctors on the Medical Advisory Committee (MAC). Meetings took place every three months and the consultant was an active, regular member at the meetings.
- There were weekly Core Management Team (CMT) meetings that discussed 'hot issues' and ensured that resources were allocated appropriately.
- Senior hospital management team meetings were held that managed operational issues as well as clinical governance meetings and clinical effectiveness meetings.
- Feedback from patients was reviewed by the customer satisfaction group who produced: "You said, we did" posters to demonstrate to patients and visitors that the hospital had acted on feedback and made changes.

Leadership / culture of service

- The Certificate of Approval (issued by the Department of Health – expiry 2018) was displayed in a prominent position, at the reception desk of the hospital
- The senior managers were very visible and approachable, including the hospital director, matron and theatre manager.
- Quality and safety walk arounds had been introduced as well security walk arounds by the hospital director and MAC representatives.
- There was an 'open door' culture. Staff we spoke with felt supported and respected by their managers and they worked as a team.

Public and staff engagement

- Feedback was sought both from patients on a monthly basis.
- "Patient Forum Meetings" were held every 2 months. These included staff and members of the general public.
- Staff attended meetings in their local departments and could access a staff newsletter.
- There was a restaurant loyalty scheme for staff and also staff away days were arranged.
- Annual events, for staff, included "21 years' service award", Christmas celebrations and the presenting of Inspiring Peoples Awards.

Outstanding practice and areas for improvement

Outstanding practice

- Two members of the physiotherapy team attended a six week pilates course approved by the Australian Physiotherapy and Pilates Institute (APPI) in order to offer a complementary pain relief therapy for patients. Pilates is used as a preventative and multi-disciplinary approach to treatment. The classes were also open to patients without a referral.

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that all incidences of venous thrombo-embolism resulting in a pulmonary embolism are thoroughly investigated in line with Spire policy and national guidance. This is so that potential learning is identified and improvements are made when needed.
- The hospital must have a robust system to determine the numbers of staff required at any given time on the inpatient ward.
- The hospital must ensure that there are sufficient numbers of staff who are up to date with basic and immediate life support training.
- The hospital must ensure that all staff have the necessary competencies for the tasks they are required to perform.

In the termination of pregnancy service

- Records by health professionals must be clear and easy to read.
- Evidence of counselling offered must be included in patient records.
- Medication charts must be clear, with all prescribed medication included and only one per patient.
- The hospital must monitor the outcome of each termination of pregnancy.
- The hospital needs to audit the uptake of Long Acting Reversible Contraception.
- The hospital must evidence screening for sexually transmitted infections.
- The hospital must evidence a discussion with patients about HSA4 form and evidence that this has been sent.

Action the provider SHOULD take to improve

In Surgery

- The hospital should consider how to become compliant with building note HBN 00-09.
- The hospital should review equipment checking procedures, ensuring that resuscitation equipment on the ward is checked robustly and is in date.
- The hospital should review processes to make sure that all cleaning agents are locked away in an appropriate storage area so that they are not accessible to members of the public.
- The hospital should consider ways to ensure that all staff decontaminate their hands when required.
- The hospital should consider storing emergency anaphylaxis medication in a more secure area so that it is not accessible to members of the public.
- The hospital should consider ways to ensure that all staff are fully aware of female genital mutilation (FGM) and their legal obligation to report any identified incidences of it.
- The hospital should improve compliance with overall mandatory training.
- The hospital should make sure that consultants include their GMC number on all occasions when signing patient records.
- The hospital should make sure that 'stop before you block' signage is used in all anaesthetic rooms and should consider monitoring compliance with 'stop before you block' during procedures.
- The hospital should ensure that efficacy of administered pain relief is documented in line with Spire policy.
- The hospital should ensure that written communication is provided on all occasions when Duty of Candour is being discharged.
- The hospital should improve its performance in relation to compliance with fasting guidelines prior to patients undergoing surgery.

Outstanding practice and areas for improvement

- The hospital should consider using Q-PROMS to monitor cosmetic surgery outcomes and compare them nationally.
- The hospital should ensure that they keep evidence of all achieved competencies for staff in their personal files so that these can be evidenced when required.
- The hospital should find ways to share information about implants used during surgery to the patient's GP on discharge.
- The hospital should consider introducing guidance for staff about patients who suffer with delirium following an anaesthetic so that staff have consideration for this when managing patients.
- The hospital should ensure that all policies take into account national guidance.

In the Termination of pregnancy service

- The provider should consider ways to identify feedback from TOP patients to improve the service.
- The provider should provide clear and accurate information in patient leaflets.
- The provider should make it clear when complications should be recorded as incidents.
- The provider should ensure that analgesia is prescribed in line with RCOG guidelines.
- The provider should record evidence of all discussions about risk of complications including any increase in risk of complications.

In Outpatients and diagnostics

- The hospital should ensure that all PGD's are signed by an appropriate member of staff.

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 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 (1) (2) (a): Staffing **How the regulation was not being met:** Sufficient numbers of suitably qualified, competent and experienced persons must be deployed. Sufficient numbers of suitably qualified, competent and experienced persons must be deployed. The hospital had set an informal staff to patient ratio of 1:5 in the mornings. This had not been met on 13 occasions during August 2016. The hospital did not have a formal policy determining the number of staff required. **How the regulation was not being met:** Sufficient numbers of suitably qualified, competent and experienced persons must be deployed. The service were unable to ensure that the correct number of competent staff were available at all times to resuscitate patients in the event of an emergency. This was because a low number of staff were up to date with resuscitation training. **How the regulation was not being met:** The service did not provide sufficient numbers of suitably qualified, skilled and experienced persons. Health Care Assistants who were undertaking Venous Thrombo-Embolism assessments had not completed the competencies to do so.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Surgical procedures

Termination of pregnancies

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (1) (2) (a)(b)(c): Good governance

How the regulation was not being met:

- We reviewed 14 records and the hand written notes were all difficult to read, therefore; it was difficult to ascertain what information was discussed with patients.
- There was no evidence; recorded in patients' records that counselling had been offered at any point in the pathway of treatment for termination of pregnancy.
- Medication for termination of pregnancy was prescribed on paper prescription charts that were not always clear and duplicate charts present in two patient notes.
- We were told that for surgical terminations, antibiotics would be administered in theatre, however; there was no evidence in the four surgical prescription records we reviewed. When reviewing prescription charts we found two instances of patients returning for the second dose within 24 hours. We were told that patients were informed there was an increased risk of complications or continuing pregnancy. There was no evidence in the notes that this had been discussed with the patients.
- The hospital did not audit outcomes of the treatments of a successful termination or any continuing pregnancy. Patients were asked to complete pregnancy test 4 weeks after & inform consultant if positive.
- Contraception was routinely discussed at consultation and offered if requested, however; there were no audits of Long Acting Reversible Contraception (LARC) uptake.
- We were told routine screening for sexually transmitted infections was carried out for all patients attending for a termination of pregnancy, however this was not evidenced in patient records.
- There was no evidence, in records reviewed, either that patients were informed about the statutory requirement to notify the Department of Health, via the HSA4 form or that the forms had been sent.

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2) (a): Good Governance **How the regulation was not being met:** The service had not assessed, monitored and improved the quality and the safety of services provided. This was because reported incidents of Venous Thrombo-Embolism had not been robustly investigated in line with Spire policy or National guidance which limited the opportunity to learn and prevent recurrences.