Spire Regency Hospital

Quality Report

West Street
Macclesfield
Cheshire
SK11 8DW
Tel: 01625 501150
Website: www.spirehealthare.com/regency

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

Ratings

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

Overall summary

Spire Regency is operated by Spire Healthcare Limited. The hospital has 31 beds for inpatients and day cases. Facilities include two operating theatres, the Byron suite which has 18 en-suite bedrooms, the Coleridge suite with either single en-suite rooms or a room that can accommodate two people, and outpatient and diagnostic facilities. There is also an endoscopy unit.

The hospital provides surgery, a very small medical care service and outpatients and diagnostic imaging. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11 and 12 October 2016, along with an unannounced visit to the hospital on 19 October 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's

Summary of findings

needs, and well-led. Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with legislation

The main service provided by this hospital was surgery. Where our findings on surgery, for example, management arrangements, which also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

Services we rate

We rated this hospital as 'Good' overall. This is because;

- There were adequate systems in place to protect people from avoidable harm and learn from incidents.
- The hospital was visibly clean and well maintained. There were systems in place to prevent the spread of infection.
- There were effective systems in place to ensure the safe storage, use and administration of medicines.
- There were adequate numbers of suitably qualified, skilled and experienced staff to meet patients' needs. There were effective arrangements in place to ensure staff had, and maintained the skills required to do their jobs.
- People received nutrition and hydration that met their preferences and needs.
- Care was delivered in line with national guidance and outcomes for patients were good.
- There were arrangements for obtaining consent ensuring legal requirements and national guidance was met.
- The individual needs of patients were met including those in vulnerable circumstances such as those living with a learning disability or dementia.
- Patients could access care when they needed it and were treated with compassion. Their privacy and dignity was maintained at all times.
- The hospital management team had the confidence of patients and their team. Staff felt motivated and supported by the management team.
- There was appropriate management of quality and governance at a local level and managers were aware of the risks and challenges they needed to address.

However, we found areas of practice that required improvement across the hospital;

- Duty of candour processes were not always being followed as outlined in the hospital policy.
- Some of the root cause analysis investigation reports reviewed did not always adequately record the learning to improve standards of care.
- There was no process in place at the hospital to risk assess or check areas of non-compliance with all National Institute of Health and Care Excellence (NICE) guidance.
- There was still work to do in terms of agreeing target risk ratings and identifying actions to mitigate all risks identified on the risk register.
- Written information to patients, such as discharge letters and leaflets, was available in other languages or formats on request.
- Although there was a clear committee structure to support governance and risk management, we saw that the quality of the committee minutes and attendance was variable.

In surgery:

- The theatre and the wards did not have entrances that were locked to prevent access by unauthorised personnel.
- The hospital did not use the Q-PROM's recognised tool to collect data for patients undergoing cosmetic procedures such as breast augmentations.
- A new competency toolkit designed to support the development of staff undertaking the role of a surgical first assistant was still in the draft phase and none of the staff had started or completed an accredited qualification. However, they had been signed off by a consultant as competent to undertake the role and had a mentor.

In medical care:

- The hospital policy regarding the destruction of controlled drugs did not meet all the standards in the Safer Management of Controlled Drugs and Royal Pharmaceutical Society Guidance and the practice within the hospital was not consistent. Some areas were following hospital policy and some were following the national guidance.
- The hospital were not auditing patient outcomes undergoing medical procedures.

Summary of findings

In outpatient and diagnostic imaging:

- The turnover rate of nurses was high at nearly 40% in the outpatient department but this figure represents three staff who left in the 12 month period as a proportion of 7 outpatient staff. The turnover for healthcare assistants was low.
- The hospital did not use the World Health Organization (WHO) surgical safety checklist when undertaking minor procedures. However, as the hospital was beginning to undertake more complex procedures they were considering introducing it. The WHO checklist was designed for use in an operating theatre as a safety checklist to reduce the number of potential incidents during surgery.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Not sufficient evidence to rate 	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. • Staff were observed to be competent in their roles as they had received training and support to develop their skills. • Staff told us that there was enough nursing and medical staff to provide safe medical care and staffing levels were monitored to ensure there was sufficient staff available at all times. • Staff were able to recognise and report any concerns to management to keep people safe. • All areas we looked at were visibly clean and tidy and there was good infection prevention guidance available and followed by staff. • There was generally good medicines management and examples of staff working together to provide good care and treatment. • Patients were supported with appropriate food, drink and pain relief. Patients were consulted with regarding the decision they wished to take regarding the care that they received. • Care and treatment was given to patients in a person-centred and sensitive way and patients were involved in their care; their preferences and needs were considered. • Staff were well supported by their manager and performance was monitored to improve care. However;

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- The policy regarding the destruction of controlled drugs (denature) did not include all the standards as outlined in national guidance.
- There were no audits of patients' outcomes in any area other than multidisciplinary meetings (MDT) following a possible diagnosis of cancer.

Surgery

Good 

Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

- We rated this service as good because it was safe, effective, caring, responsive and well-led.
- There was a system in place to record incidents and investigations took place which identified learning that was shared across the hospital.
- All areas of the theatres and wards were clean and free from hazards. Patients were screened for infection.
- Records were accurately documented in line with the hospital policy and were securely stored.
- Staffing levels were planned and adequate to meet the needs of the patients. Medical cover was available 24 hours a day seven days a week.
- Medical cover was available 24 hours a day, seven days a week for patients as Resident Medical Officers (RMO) remained on site 24 hours per day.
- The hospital used care pathways that had been developed to meet best practice guidelines which staff followed to ensure patients received safe care and treatment.
- The hospital contributed to national audits including Patient Reported Outcome Measures (PROMS), and

Summary of findings

Patient-led Assessment of the Care Environment (PLACE). There was also a local audit programme in place to help improve standards.

- Staff were supported to undertake additional training and all had received a performance appraisal. There was good multidisciplinary working which included nursing and therapy staff.
- Staff treated patients and relatives with dignity and compassion. The friends and family test and patient satisfaction surveys showed positive results.
- There were risk assessments in place and staff meetings to share information and learning took place. All staff spoke positively about management staff and felt well supported.

However;

- Entrances to the theatre and wards were not locked to help prevent access by unauthorised people.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on Q-PROMs for all patients receiving cosmetic procedures such as breast augmentation. Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations.
- Whilst surgical first assistants had been assessed as being competent to undertake the role the hospital had not yet implemented the national competency toolkit and none had completed an accredited qualification.

Outpatients and diagnostic imaging

Good

Outpatients and diagnostic imaging services were a part of the hospital activity. There was only a small proportion that was children and young people. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

- We rated this service as good because it was safe, effective, caring, responsive and well led.
- There was good reporting of incidents and learning was shared across the service.
- The outpatient department was visibly clean and there was evidence of cleaning schedules and handwashing audits being completed.
- Safeguarding systems were in place and safeguarding considerations had taken into account in the pre-operative assessment process.
- Staffing levels in the outpatient and diagnostic imaging services were good
- Compliance with mandatory training was good and staff had regular appraisals and there were training opportunities available.
- There were regular audits and staff were developing outcome measures for patients.
- Patients said that staff were caring and respected their privacy and dignity.
- Waiting times for diagnostic imaging services were limited and urgent scan results could be reported on the same day.
- The department had undertaken training to support patients with dementia and there were systems to better support those living with dementia.
- There was strong leadership and a culture to continuously improve services and patient care.

However

- The service was not using the world health organization (WHO) surgical safety checklist for minor surgical procedures carried out in the department.

Summary of findings

Contents

Good

Location name here

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Spire Regency Hospital

Spire Regency is operated by Spire Healthcare Limited. The hospital is registered as an acute private hospital situated in the town of Macclesfield, Cheshire. It opened in 1991. The hospital primarily serves the communities across South Manchester, Cheshire, Derbyshire, Staffordshire and Greater Manchester.

The hospital has had a registered manager in post since 2013. At the time of the inspection, a new manager had recently been appointed and had submitted an application to be the registered manager with the CQC in October 2016. The provider nominated individual was JJ De Gorter and the controlled drugs accountable officer was Linda Robinson.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector,Jacqui Hornby, three other CQC inspectors, and specialist advisors with expertise in surgery, medical care and governance. The inspection team was overseen by Ann Ford, Head of Hospital Inspection.

Information about Spire Regency Hospital

The hospital has 31 beds for inpatients and day cases. Facilities include two operating theatres, the Byron suite which has 18 en-suite bedrooms, the Coleridge suite with single en-suite rooms and a room that can accommodate two people, and outpatient and diagnostic facilities. There is also an endoscopy unit. The hospital is registered to provide the following regulated activities:

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

During the inspection, we visited the endoscopy unit, outpatient and diagnostic services, theatres, Byron suite and Coleridge suite.

We spoke with 45 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, physiotherapists, admin staff and senior managers. We spoke with 22 patients and six relatives. We reviewed 21 sets of patient records and 16 medication records. We held two focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital.

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We observed care provided in the outpatient and imaging department, in operating theatres and on the wards.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

In the reporting period July 2015 to June 2016 there were 4,098 inpatient and day case episodes of care recorded at the hospital; of these 50% were NHS-funded and 50% other funded; 25% of all NHS-funded patients and 30% of all other funded patients stayed overnight at the hospital during the same reporting period. There were 33,174 outpatient total attendances in the reporting period; of these 47% were other funded and 53% were NHS-funded.

The surgical procedures undertaken at the hospital were varied and included knee and hip replacements, hand and spinal surgery, cataracts and cosmetic procedures.

There were 132 doctors with practising privileges at the hospital and 11% of these carried out over 100 procedures during July 2015 to June 2016. 56% of doctors did not carry out any procedures during the same period but these were mostly Consultant Anaesthetists, Radiologists and Cardiologists who would not have a

Summary of this inspection

direct patient caseload. There were 28.3 full time equivalent (FTE) registered staff employed, including nurses, and 104.8 FTE support staff, including care assistants and administrative staff. There were high levels of staff stability and there was no turnover for nurses and healthcare assistants in surgical and medical service between July 2015 and June 2016. In the outpatient department the turnover rate for nurses was around 40%, however this was only three staff who left for personal reasons. There was no staff turnover for healthcare assistants in the outpatient department.

Sickness rates were less than 10%. Although there were low vacancy levels for most staff, there were 1.9 whole time equivalent care assistant vacancies at July 2016.

Between July 2015 and June 2016 CQC did not receive any direct complaints or whistle-blowing contacts. The hospital received 34 complaints which was a decrease on the previous two years.

Between July 2015 and June 2016, there were no serious incidents or never events at the hospital. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers. There were 311 other clinical incidents during the same time period; of these, 206 caused low or no harm. During this time there had been no safeguarding concerns reported and no unexpected deaths. There were no reported cases of hospital-acquired infections such as methicillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile (C.diff).

Services provided at the hospital under service level agreement:

- Audiology
- Blood transfusion
- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Pharmacy
- Pathology

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as 'Good' because;

- There was a positive incident reporting culture within the hospital, with the majority of incidents being no or low harm. We saw good evidence of shared learning from incidents in the ward and department meeting minutes. Staff were also able to provide examples of changes in practice following incidents.
- The governance team routinely analysed trends in incidents. For example the team had supported a consultant to review their own clinical practice following a number of surgical site infections. The learning had resulted in them amending their incision technique which had significantly reduced the number of surgical site infections.
- We saw examples of shared learning across the hospitals in the Spire group during the inspection with 'key learning summaries' distributed from the corporate team.
- There was an annual infection control plan and there was an infection control lead nurse in place. There was a clear training plan in place and a monthly newsletter was circulated to all staff which contained key information.

However;

- There were carpets in ward areas(corridors) which could increase the risk of infection and there was only one hand wash basin in each patient bedroom which was not in line with national guidance..
- The root cause analysis investigation reports that we reviewed were not always of an adequate quality.
- The hospital had a process for duty of candour included in its incident reporting policy. However, when we reviewed the incidents it appeared that duty of candour had not always been applied. On our unannounced inspection a review, of recent incidents had been undertaken and duty of candour applied where required. There had also been a review of the procedures and changes made to ensure the process was robust.

Are services effective?

Good

We rated effective as 'Good' because;

- A clinical scorecard was in place at the hospital which allowed benchmarking with all the hospitals in the group. Overall the hospital performed well on this scorecard with very few areas not meeting the targets.

Summary of this inspection

- There was a corporate audit programme across all hospitals. The hospital performed well when compared to other hospitals in the Spire group. We were provided with examples of additional clinical audits undertaken locally in response to incidents, such as a consent audit. Examples of actions taken and subsequent improvements were also seen.New, applicable National Institute of Health and Care Excellence (NICE) guidance was discussed at the Clinical Governance Committee following review by a clinical member of the governance team. The guidance was then disseminated to services. However, staff said there was no process in place for checking compliance or risk assessing any areas of non-compliance for all NICE guidance at the hospital'
- The hospital had arrangements to ensure that doctors and nurses were compliant with the revalidation requirements of their professional bodies. All consultants had clear practicing privileges agreements which set out the hospital expectations of them and ensured they were competent to carry out the treatments they provided.

Are services caring?

Good

We rated caring as 'Good' because;

- We observed that patients were treated with dignity, respect and their privacy was maintained.
- Staff offered appropriate emotional support to patients.
- Patients who shared their views with us said they were treated well, with compassion and that their expectations were met.
- The results of the friends and family test and other patient satisfaction surveys demonstrated that patients would recommend the hospital to others. Whilst feedback was positive, the response rates were poor.

Are services responsive?

Good

We rated responsive as 'Good' because;

- Services were planned to meet the needs of patients and some services operated at the weekends to give patients flexible access to these services.
- We saw examples of systems to support patients living with dementia and learning disabilities. The environment allowed for patients with physical disabilities to be appropriately cared for.
- The hospital was performing well in the referral to treatment times and patients were assessed prior to admission to ensure that the hospital could safely meet their need.

Summary of this inspection

- There were a number of systems in place or planned for obtaining patient views.

However;

- We found a case where a complaint had been raised by a relative, and a response given directly to them without obtaining consent from the patient. On the unannounced inspection a review of the processes had been undertaken and there was a robust recording system in place for obtaining consent in relation to complaints.

Are services well-led?

Good

We rated well-led as 'Good' because;

- The hospital strategic direction was well described by the senior management team.
- The improvement priorities in the Quality Accounts were recognised by the matron and examples were given of how they had been progressed.
- There was a clear committee structure to support governance and risk management.
- There was a risk register in place which identified appropriate risks for the hospital but there was still work to do in terms of agreeing target risk ratings and identifying actions to mitigate all identified risks.
- There was a positive working culture at the hospital. All staff were friendly, open and honest with the inspection team.
- The 2015 staff survey identified a number of areas for improvement. There was an action plan in place and there were no concerns raised by staff with the inspection team during the course of the inspection.
- The hospital had a staff recognition scheme, 'Inspiring People'.
- NHS patients received the same level of care as private paying and insured patients.
- The Spire group website had information about the cost of procedures so that patients were aware of costs before they agreed to treatment. We were told that information packs were sent out with appointment letters which gave clear instruction about cost and payment. Costing information was given in order to make sure that patients were fully aware of any costs involved.

However;

- The medical advisory committee (MAC) was poorly attended and this was not monitored by the hospital.

Summary of this inspection

- There was limited evidence of discussion and challenge around risks at both the clinical governance committee and the health and safety and risk committee. At the time of the inspection there wasn't a clear system for tracking actions from the meetings and monitoring completion against these.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Not sufficient evidence to rate

Medical care

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

Are medical care services safe?

Not sufficient evidence to rate

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

Incidents

- See information under this sub-heading in the surgery section.
- We looked at how incidents related to medical care were managed. The hospital kept a log of all incidents throughout the service in order to investigate and learn from them. Incidents related to medical care were not logged separately. We looked at all the incidents logged and saw two incidents related to endoscopy. There were records to show that both of these had been investigated and the learning passed to staff in order that they could improve and prevent a recurrence.
- All staff we spoke with demonstrated an understanding of how to recognise and report patient safety incidents. They said senior staff investigated incidents and shared information to help provide safer care to patients.

Duty of Candour

- See information under this sub-heading in the surgery section
- From April 2015 all providers were required to comply with the duty of candour Regulation. 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.
- All staff we spoke with understood their responsibilities under the duty of candour to inform patients honestly, give them reasonable support and apologise to them in writing if there had been mistakes in their care that had led to significant harm.

Clinical Quality Dashboard

- See information under this sub-heading in the surgery section.

Cleanliness, infection control and hygiene

- Records showed that there were no reported incidents of hospital-acquired infections for medical care within the hospital.
- The room used for endoscopies also contained endoscopy equipment not in use and was also used for cleansing (decontaminating) endoscopes after use
- Hospital guidance we looked at did not set out clearly how endoscopy equipment should be cleaned (decontaminated) without risk to patients. Although the practice observed did make sure that patients were not at risk by ensuring that any cleaning of equipment was undertaken after the patient left the room.
- On the last day of our inspection, the hospital management team described the appropriate steps they were undertaking to minimise any infection risks in the endoscopy room. They updated the service's risk register and set out the steps staff should take to minimise risk when decontaminating equipment in order to reduce any risks.

Environment and equipment

- See information under this sub-heading in the surgery and outpatient department sections.

- Equipment in the endoscopy unit we looked at was well maintained. Records showed that contracts for maintenance and repair were in place for the equipment used. We reviewed maintenance records and these were all up to date.
- Equipment had portable appliance test (PAT) records that indicated electrical equipment had been tested which indicated that it was safe for use. The hospital held a register of equipment that detailed maintenance contract information so the service could identify when equipment needed testing.

Medicines

- Overall there were good systems in place for the safe management of medicines.
- A review of the management of medicines was undertaken. This showed that prescription pads were stored securely but there was no system in place that logged when a prescription was used. Without logging whom, when and why a prescription was given to a patient there was no way for the service to monitor that they were safely managed. Within 10 minutes of discussing this with staff they had created a record to do this. The record logged which consultant prescriptions were given to, the unique number and the relevant patient.
- The hospital did not have an on-site pharmacy. There was a contract arrangement with a pharmacy to supply, audit and review the management of medicines within the hospital. We looked at a sample of eight medication charts and saw that these were checked daily by the pharmacist in order to maintain the safety of patients.
- All the medication charts we looked at were accurately written and included information regarding risks such as allergies in order to assist staff in giving medicines safely.
- We saw that medicines on Coleridge and Byron suites were correctly stored, including controlled drugs (strong drugs that have legislation in place to maintain their safe management). The storage arrangements were suitable. We also reviewed the controlled drug stock book which recorded the stock of controlled drugs available. Controlled drug records were complete and made sure that patients had records about the medicines they had been given and the amounts.
- We saw that the drug fridge was locked and contained only relevant items. Records indicated that staff checked and recorded the fridge temperature daily; with appropriate action taken if the fridge temperatures were too high or too low.
- We looked at how medicines that were used for eight patients receiving medical care in the outpatients department were managed. The medicines were stored safely and securely. When medicines were prescribed by the consultant a record was kept. We saw that the amount given to the patient was not always recorded. All the records we looked at showed the strength of the drug available but not how much was given to the patient. On speaking with staff they were sure that the records were accurate that there was no wastage of medicine but agreed this could happen on rare occasions. It is essential that staff record the amount of medicines given to a patient and not just the strength of the medicines made available in order to keep an accurate record of medicines given.
- The written policy within the hospital stated that there was no necessity to denature (destroy) controlled drugs under 10 ml that had been wasted. We spoke with staff who confirmed that this was the practice in the endoscopy unit.
- However, staff working on Coleridge and Byron suites denatured all controlled drugs wastage regardless of the amount. The practice of not denaturing all controlled drugs wastage did not follow Safer Management of Controlled Drugs, Royal Pharmaceutical Society Guidance and was not consistent throughout the hospital.

Records

- See information under this sub-heading in the surgery section.
- We looked at the records for five patients receiving endoscopy treatment and six patients who had received medical care following breast surgery. All the records were clearly written and up to date making sure that staff had the information they needed to support patients safely.
- We spoke with staff throughout the hospital who described how records were managed. Patients' records we reviewed showed that they contained information relevant to the patients care such as test results,

treatment and the care provided by nursing and medical staff. We saw that patients' records were stored securely in an area only accessed by staff until they were needed.

- Patient records also held the patient referral letter and the discharge letter. A copy of the discharge letter was given to the patient and a copy sent to their GP electronically. The discharge letter was sent to the GP in order to make sure that they had up to date information about the patients' medical needs.

Safeguarding

- See information under this sub-heading in the surgery section.
- The hospital had policies that applied to all Spire Hospitals. These detail what a safeguarding concern was and what actions staff were to take in relation to any concerns.
- There were no recorded safeguarding concerns in relation to medical care and none had been reported to the CQC. Staff we spoke with explained in detail how they recognised and reported any safeguarding concerns.
- Staff were clear that there was a safeguarding lead available in the hospital that monitored all safeguarding concerns. Staff and minutes of meetings confirmed that the safeguarding lead provided feedback as necessary in order to improve the safety of patients.

Mandatory training

- See information under this sub-heading in the surgery section.
- Staff we spoke with told us that they received ongoing training including mandatory training such as safeguarding, health and safety and moving and handling. Several staff described training they had beyond the basic training. They spoke of the support they had received in order to undertake personal development training.

Assessing and responding to patient risk

- See information under this sub-heading in the surgery section.
- We saw that there were systems on both suites to ensure that patients received prompt medical care should their condition deteriorate. Staff told us and all records we looked at indicated that staff undertook observations using the national early warning score (NEWS) system. The NEWS chart was used to identify and record action taken for patients whose condition was at risk of deteriorating.
- Records showed that consultants checked patients who had an endoscopic procedure before they went home; this was so that they could ensure patients were fit for discharge.
- We were unable to observe the World Health Organization (WHO) five steps to safer surgery checklist in use for endoscopy during our inspection. We did see copies of the WHO safer surgery checklists available in all the 11 patient records reviewed. The checklists were clearly written and correctly completed. These checklists were available for all endoscopy patients. Staff in the outpatients department informed us that they had a checklist within patients' records. We looked at the records and saw that there was a checklist that assisted in making sure patients' undergoing procedures had their safety needs checked.

Nursing staffing

- See information under this sub-heading in the surgery section.
- We were informed by staff that there was no specific nursing team working in the endoscopy unit but were allocated daily from theatre staff. A computerised system recorded what endoscopy procedures were arranged that day so that suitable staff numbers could be planned in advance.
- There were at least five staff in the endoscopy room at any one time to maintain the safety of patients.

Medical staffing

- See information under this sub-heading in the surgery section.
- Records we reviewed showed that all patients were admitted under the care of a named consultant. All the consultants had been assessed by the hospital as suitable to provide services. As a result the hospital had granted them practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. Records showed that patients were reviewed by their named consultant before treatment was started. Staff and patients told us that consultants provided patients with telephone advice if needed.

Not sufficient evidence to rate

Medical care

- We saw that consultants provided medical support and dealt with any routine or emergency situations with the support of the patients' consultants. The consultants were also available for advice out of hours via telephone if needed.
- All nursing staff we spoke with said they felt supported by medical staff.

Major incident awareness and training

- See information under this sub-heading in the surgery section.
- Staff we spoke with confirmed that they had access to policies and procedures relating to major incidents and were able to explain what actions they would need to take to maintain the safety of patients.

Are medical care services effective?

Not sufficient evidence to rate

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

Evidence-based care and treatment

- See information under this sub-heading in the surgery section.
- We saw staff followed policies and guidelines that were based on recognised best practice such as National Institute for Health and Care Excellence (NICE) and relevant Royal colleges. Staff told us that they could access locally developed standard operating procedures that supported their practice.
- The hospital had applied for accreditation from the Joint Advisory Group (JAG), which would provide independent assurance of the safety standards in the endoscopy services.

Pain relief

- Staff told us in detail how pain relief was discussed with patients at the time of the pre-assessment before endoscopy procedures. They explained that they offered patients pain advice booklets after surgery.
- The Clinical Nurse Breast Specialist explained how they provided ongoing support for patients which included management of any pain.
- Patients' records showed that following endoscopic procedures, pain scores were recorded along with clinical observations. If patients had pain control issues, nursing staff spoke to medical staff, who then reassessed the patient's medicines.
- Pain scores were documented in all of the 11 patient records we reviewed. Records showed that staff asked patients to describe their pain on a scale of 0-4; 0 for "no pain" to 4 "being the worst possible pain". Further action was taken dependent on the patient's response and needs.
- The hospital sent discharge letters to the patient's GP, documenting pain relief medicines given to patients. This was done to ensure that the GP was kept informed of the patient's care and treatment.

Nutrition and hydration

- There were records of patients' food and drink intake. This was done to make sure that patients undertaking endoscopy had eaten and drunk something before going home.
- We saw that patients were given a choice of food and drink; hot and cold drinks were available throughout the day.
- A selection of hot and cold food was seen to be provided on the suites at meal times. Patients we spoke with were complimentary about the quality of the food available.

Patient outcomes

- See information under this sub-heading in the surgery section.
- The majority of patient outcomes were monitored with surgery as there were less than 1% of patients receiving medical care from the hospital at the time of the inspection.
- The hospital management team informed us that they received copies of patients Multidisciplinary Team meeting (MDT) in order to monitor these outcomes. An MDT is undertaken after test results indicate a possibility of cancer treatment being suitable and discusses the potential treatments available for patients. As such they do not monitor outcomes of medical care but do provide patients with information as to how their treatment will be managed. The hospital did not supply chemotherapy with the exception of a single procedure for bladder cancer undertaken in theatre.

Not sufficient evidence to rate

Medical care

- The Clinical Nurse Breast Specialist told us that staff worked with them to co-ordinate and monitor the care provided in order that patients received the best outcome possible. This was confirmed in patient records. They also told us that patients were never discharged from their care and could access support in a twice-weekly drop-in clinic available in the NHS. This support was available external to the hospital via the Clinical Nurse Breast Specialist until the patients felt they no longer required the additional service. This information was given directly to the patients along with the relevant telephone numbers and email address.
- For medical care there was limited participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials for endoscopy.
- We did not find any information about outcomes of patients' care and treatment as it was not routinely collected and monitored for medical care other than MDT meetings. There were outcomes that were monitored within surgery but it was not possible for outcomes for medical care to be separated from surgery.

Competent staff

- See information under this sub-heading in the surgery and outpatients section.
- All staff we spoke with told us that they received an induction that met their needs when they started working in the hospital.
- Nurses we spoke with were aware of the requirements of the Nursing and Midwifery Council (NMC) revalidation scheme. The hospital checks yearly that nursing staff had a current registration with the NMC (Nursing and Midwifery Council) to practice as a nurse. Staff told us that the hospital had been very supportive in assisting them to maintain their registration to practice as nurses.
- Staff said they had undergone an annual appraisal and they told us they found useful to discuss their progress and career aspirations. Staff also completed competencies relevant to their role and this was monitored by their line manager. As the staff involved in medical care work in surgery and outpatients there was no specific monitoring of staff competency directly in this area. Information regarding appraisal rates and staff competencies is available within both the other sections of this report.

Multidisciplinary working

- See information under this sub-heading in the surgery and outpatients section.
- The majority of staff we spoke with described how they effectively worked with other staff in the hospital. They told us that that they were a "family" and worked well together. Whilst the majority of comments were positive, a few staff stated that they would like closer working between the different teams.
- There was a supportive culture of working between nurses, specialist nurses, doctors, and allied health professionals within the hospital. All breast care patients received a clinical multidisciplinary team meeting (MDT) review of their care attended by the Clinical Nurse Breast Specialist who was involved with the patient from their first appointment. The MDT was coordinated via the NHS with a copy of the treatment plan and findings sent to the hospital in order to maintain continuity of care.

Seven-day services

- See information under this sub-heading in the surgery
- Staff told us they had access to out of hour's services for radiology, pharmacy, and non-clinical support via an on call system. Patients' records reflected that out of hours services to assist with patient care were available.

Access to information

- Guidance was available on the hospitals' intranet to assist staff to deliver consistent care. For example infection prevention and control, medicines management and endoscopy guidelines were all available to guide and support staff.
- Staff were able to show how they obtained results of blood tests and x-rays and how this information was made available to consultants. Patients' records included copies of test results that informed the care and treatment decisions.
- We saw that staff in the endoscopy service provided a wide range of information both verbally and in leaflets. The information supported patients and their relatives to make decisions about their care and treatment and the services available to them.
- The service employed two Clinical Nurse Breast Specialists on a nurse bank system. Neither nurse was directly employed by the hospital but worked closely with the consultants who accessed their services as and

when needed. The Clinical Nurse Breast Specialists where involved with patients at the start of their care. They made sure that all information related to the patients care and treatment was co-ordinated and the patients were given information. Records we reviewed supported that the Clinical Nurse Breast Specialists were available for patients and offered support to them after they have been discharged from the hospital.

- All the records we looked at contained copies of discharge letters sent to the patients' GPs with details of the treatment provided. The letters detailed follow up advice, arrangements and medicines provided. These were also copied to the patient to keep them informed of their treatment and any further needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- See information under this sub-heading in the surgery section.
- Staff we spoke with understood how to support patients to make a decision that that was appropriate to their needs. In discussion they explained their understanding of relevant consent and decision-making requirements such as the Mental Capacity Act 2005 (MCA). The MCA is legislation to support people with fluctuating or limited capacity to receive care and treatment in line with their known wishes and their best interests.
- During the inspection there were no patients who attended the service that were subject to a deprivation of liberty safeguards order in line with the MCA. Staff accurately explained their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in place to maintain patients' rights.
- All the records we looked at showed discussions with patients and consent was documented. The majority of consent was in writing and copies of this consent was available in patient's records. Staff recorded confirmation that the patients was given appropriate information regarding the charges and treatment before they underwent the treatment they had been offered.

Are medical care services caring?

Not sufficient evidence to rate

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

Compassionate care

- See information under this sub-heading in the surgery section. Information regarding friends and family test (FFT) is available in that section of the report.
- We observed staff and patient interactions in the outpatient department, Coleridge and Byron suites. We observed that staff were welcoming and treated patients with care and compassion. It was clear that some patients frequented the service and they were greeted with knowledge and understanding of their individual needs.
- Staff were observed taking the time to talk with people who used the services in a respectful and considerate manner. Patients were asked about their preferences for sharing information with family members. Records reflected that patients' wishes had been obtained and respected.
- We saw and heard examples of compassionate care. Of the twelve patients we spoke with they were clear about the compassion they had been treated with. Comments included "I cannot fault the care I have received. Staff are so kind and always have time for me I've rung up between my appointments and again they have been supportive and caring".
- Patients told us that there was no difference between being a private patient and an NHS patient. One person we spoke with was clear they were treated as well and given the same support regardless of how the treatment was funded.
- Patients we spoke with said the nursing staff were: "brilliant", "absolutely the bees knees" and "extremely good". All comments from patients and their relatives were complimentary about the staff and the service they provided.

Understanding and involvement of patients and those close to them

- See information under this sub-heading in the surgery section.

Not sufficient evidence to rate

Medical care

- Staff gave examples of how they involved patients in their own care and treatment. Patients we spoke with described how each step of their care was discussed with them and their relatives. Patients and relatives were complimentary about the support they received from staff stating; “Everything was explained fully” and “I was grateful for how much information I was given. Even when I got a little stressed by it all the nurses were so helpful”.
- Patients across both of the suites, the outpatients department and surgery had a named consultant and named nurse available to them Named staff were allocated to patients to assist in coordinating their care and to provide consistent individualised care.
- Patients we spoke with told us that staff always introduced themselves and made them feel involved. We observed this to occur frequently throughout the inspection. We observed that all staff introduced themselves to the patients and families. One person was assisted in a warm manner by the reception staff to confirm their appointment and make arrangements for a translation service to be available.
- Patients and their families told us they felt supported and were given appropriate and timely information. For example insured patients were told what was and what was not covered by their insurance and arrangements were made if they wanted care they were not insured for by directing them to NHS services.
- All the patients we spoke with told us they were included in their care and kept informed about their treatment. Records reviewed showed that treatment options were discussed with patients.

Emotional support

- We spoke with the customer care team who described how patients were supported from their first call to the hospital. The team made sure that all messages left and or email contact was answered as a priority each day. If the person was contacting the hospital for concerns related to medical care such as breast lumps this was prioritised and an appointment was made as soon as possible usually within three days in order to assist in reducing patient’s anxiety. Staff told us and records confirmed that all patients needing appointments for breast lumps were seen within two weeks of their initial contact.
- All patients we spoke with told us that they were able to telephone and speak to relevant staff after discharge, for help and advice.
- Staff told us how the emotional and social needs of a patient were a part of their care. Any patient concerns or worries were included in how the patients care and treatment was managed.
- We spoke with the Clinical Nurse Breast Specialists who described how they made sure that patients were given emotional support during their treatment. We saw records where emotional support had been made available
- Where patients required an overnight stay visiting times were not restricted. We were informed by staff and patients that family and friends were encouraged to visit their relative for emotional support.
- Staff who worked on the endoscopy unit described ways in which they reassured patients who were anxious. For example, staff talked to patients throughout procedures giving explanation and reassurance.

Are medical care services responsive?

Not sufficient evidence to rate

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

Service planning and delivery to meet the needs of local people

- See information under this sub-heading in the surgery section.
- Records showed that medical care was available for insured (private), NHS funded and self-paying patients. Staff told us that priority was assessed for their care needs and referral dates.
- Staff and managers explained how they worked with the local community. Examples included attending local GP clinics and providing training to GPs in order that the service they offered was suitable for the local community. A review of the Coleridge and Byron suites showed that consideration had been made to patients with specific needs. All bedrooms, with the exception of one double room on Coleridge Suite, were single occupancy. Where the double room was utilised, patients would be of the same gender to make sure same-sex accommodation was provided. All bedrooms

had en-suite bathroom facilities available. One bedroom had been adapted to make it more suitable for patients living with dementia. We also saw equipment available for specialist areas such as patients with a bariatric need. Bariatric needs are assessed for patients with a weight in excess of 25 stone, or with a Body Mass Index (BMI) of over 30. All rooms we looked at were fitted with call bells to alert staff when assistance was required by patients.

- There was not sufficient parking near the facilities for patients and very limited spaces for patients with a mobility disability. This had been recognised by the management team and plans were in place to increase access to parking. Information was given to staff and patients regarding other nearby parking facilities.
- All areas we visited had good access for people with physical disabilities, including wheelchair users. We saw that the suites had rooms to accommodate bariatric and wheelchair patients; these rooms were wider and staff had access to specialised equipment. All rooms we visited had extra seating for families and magazines were provided in the waiting room.

Access and flow

- See information under this sub-heading in the surgery section.
- Records we reviewed showed patients were all referred by their own GP or insurance company before receiving treatment. All patients who were booked to undergo an endoscopy procedure were asked to complete a pre-admission questionnaire. Review of this by the pre-operative assessment nurse was used to determine the level of pre-operative assessment required. Copies of the assessment and care plans were available in all the patient records we looked at. This meant patient' needs could be planned for in advance. Consultants undertook endoscopy procedures within two to four weeks of the initial referral.
- The Clinical Nurse Breast Specialists told us that they maintained links with each patient and monitored the delivery of the care; to make sure that their care and treatment was planned in advance. This could also include referrals back to the NHS for on-going support.
- We saw that where patients attended the outpatients department for the removal of a skin lesion, the treatment room was also booked by the outpatient booking staff in order to make sure that treatment could be done the same day if needed.
- The hospital did not report data on specific waiting times for medical care, however we were told by staff that no patients experienced any delays and patients normally had immediate access to a consultant. We spoke with five patients undergoing medical care who all reported that they had access to a consultant and they had not waited for long periods of time.

Meeting people's individual needs

- See information under this sub-heading in the surgery section.
- Awareness and knowledge of cultural needs was observed between staff and patients. As an example staff understood the cultural importance of specific dietary requirements. Relevant meals were offered and records kept of patient's cultural needs.
- We observed that patients who needed it were asked if they required an interpreter before they were booked for treatment. This was done so that staff could arrange for an interpreter. The hospital did not provide in house interpreting services, but staff knew how to access the translation services available. However, we saw that patient letters and information leaflets were normally written in English even when English was not the patient's first language. However, these were available when requested.
- Staff told us that they were trained to recognise when patients living with a learning disability or dementia needed support. We saw that a bedroom had been adapted to assist people living with dementia. The room was larger to allow families to stay with the person if needed.
- Very few patients with learning difficulties or living with dementia attended the hospital but when they did, staff told us they would always try to ensure these patients were not left waiting long.
- Breast care patients were given contact details of the Clinical Nurse Breast Specialist; this was so that patients were supported throughout their care.
- Patients were offered therapies as needed by the Clinical Nurse Breast Specialist; this could include psychological support directly from them or referrals back to the NHS for more structured counselling services if needed.
- Staff we spoke with told us they were able to address people's religious and cultural needs regarding food and patients' records confirmed this.

Not sufficient evidence to rate

Medical care

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.
- Staff told us that patients were encouraged to discuss complaints, so that local resolution could be achieved. We saw leaflets were available throughout the hospital that requested feedback on the care that patients' received. Copies of these leaflets were also included in the information pack given to patients at their initial appointment.
- The hospital did not separate complaints regarding medical care so it was not possible to determine how these complaints were dealt with.

Are medical care services well-led?

Not sufficient evidence to rate

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

Vision and strategy for this this core service

- See information under this sub-heading in the surgery section.
- There were just over 1% of patients a year given treatment and support in the hospital for medical care.
- Records showed that meetings were in place for key areas such as clinical governance, health and safety, medical advisory committee, infection control and medicines management. The learning from these meetings was shared in order to assist in improving the quality of care provided. Copies of team meetings minutes were available which showed key points from the meetings were disseminated to staff including any lessons to be learnt
- All staff we spoke with were clear that they understood the improvement that the management wished to make and were kept informed.

Governance, risk management and quality measurement for this core service

- See information under this sub-heading in the surgery section.
- There was a risk register in place that included risks in the endoscopy unit. The unit was not Joint Advisory Group (JAG) accredited for endoscopy procedures at the time of the inspection. We raised this with the hospital as it was unclear initially what actions were in place to reduce the identified risks. During the inspection the risk register was updated to include decontamination (cleaning) risks, progress and arrangements in place to achieve JAG accreditation.

Leadership and culture of service

- See information under this sub-heading in the surgery section.
- All staff we observed were friendly, open and honest with the inspection team. They told us that they felt well supported by the management and team leaders.
- The 2015 staff survey showed improvements of in all areas surveyed regarding staff satisfaction. The survey did show areas where improvement was needed. The main one was titled, 'working together'. The results showed staff thought that they needed to work closer with each other in order to understand and appreciate different job roles, In their response to the inspection report were told that the hospital was working hard to address these concerns.
- Staff we spoke with generally felt that they worked well together. Four staff said that they would like closer working with other departments. All staff we spoke with told us that overall they worked well with each other; they gave examples of social events that they felt helped them in being a team.
- Staff told us that there had recently been recognition for compliments. When a compliment was received about a member of staff, they were informed of this. Staff were pleased about this as it helped them feel they were appreciated.
- Staff said that they felt well supported by the matron who was described by staff as "exceptional" and "always available". They explained that if they had any questions or were unsure about anything they could contact the matron who operated an "open door" policy and was always "happy" to assist them.

Public and staff engagement

- See information under this sub-heading in the surgery section.

Innovation, improvement and sustainability

- See information under this sub-heading in the surgery section

Good

Surgery

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

Are surgery services safe?

Good

Incidents

- The hospital had an up to date corporate adverse event /near miss reporting policy for staff to follow, which was available to them through the hospital intranet.
- All staff we spoke with had a good understanding of the reporting system and could access the system. All incidents, accidents and near misses were entered onto an electronic system. The theatre manager reported that a paper system could also be used and then uploaded once the information had been reviewed. Staff gave examples of the type of incidents they reported, such as delays in theatre and missing patient details.
- Following a medication error we were informed that a staff member wrote a reflective practice document and re-completed the controlled drugs training to ensure their competence.
- Data we received from the hospital showed between June 2015 and July 2016 there had been 315 near miss and adverse incidents reported across the hospital. Of these 234 (74%) occurred within theatres or inpatients.
- Incidents were reviewed and investigated by the appropriate manager to look for improvements to the service. Moderate and severe incidents were also investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We saw six RCA reports which had been completed, with recommendations, action plans, and lessons learnt which confirmed the process. We saw the findings of RCA's were shared with all staff across the hospital through team briefings and meetings.
- We saw evidence that hospital learning reports were shared across the Spire group. These reports highlighted errors in practice and key learning points. We also saw evidence that key learning with regards to incidents and adverse events were discussed in team meetings.
- Staff told us they either received feedback directly, if they were involved in an incident or during monthly team meetings and newsletters where incidents and complaints would be discussed. We saw evidence of this in the team meeting minutes we looked at.
- We reviewed the incident recording logs and found that there was a broad spread of incidents recorded. These included cancellation of surgery and wrong patient details identified. This showed that staff were reporting appropriate incidents that occurred at the hospital.
- The hospital had reported no 'never events' from June 2015 to June 2016. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers.
- The hospital reported no serious incidents between June 2015 and June 2016.
- All incidents and adverse events were discussed at the quarterly Medical Advisory Committee (MAC) and Clinical Governance Committee (CGC) and the monthly Senior Management Team (SMT) Meeting. Minutes of the MAC, CGC and SMT meetings confirmed this.
- Clinical score cards were used across all Spire hospitals. These score cards provided information against a set of key performance indicators. We saw from the scorecard

dated April to June 2016 that incidents relating to patient safety were audited and reported. This included the time taken to close incidents within 45 calendar days. The hospital scored 97% of incidents closed within 45 days against a target of 75%.

- The hospital did not carry out specific mortality and morbidity review meetings, due to the low number of patients treated and the resulting low numbers of patients who would fall into this category. However, we were informed that where a death did occur, a mortality and morbidity meeting would be established with the relevant multi-disciplinary team members.
- From April 2015 all providers were required to comply with the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of the duty of candour regulation, and we saw a hospital news brief had been circulated in March 2016 to help and remind staff of their obligations under the duty of candour regulation.
- The hospital process for duty of candour was included in its incident reporting policy. The policy included descriptions of incidents that should trigger duty of candour to meet the legislative requirements of moderate harm and above. Timescales were clearly detailed within the policy. However, when we reviewed the incidents it appeared that duty of candour had not always been applied meaning that not all patients received an apology if harm (classed as moderate and above) was caused through care and treatment received at the hospital. We saw that the hospital had scored 52 adverse events to patients as moderate and above, and only two had triggered a duty of candour, and letters of apology sent to patients.
- We reviewed the 52 adverse events and found that only 27 should have been scored as moderate or above. This meant that there was not a robust system for scoring harm to patients. We raised this with the senior management team. On our return for the unannounced inspection we saw that a review of recent incidents had been undertaken, and where applicable, duty of candour applied and further letters were sent to patients. We also found that there had been a review of the procedures and changes made to ensure the process was robust.

Clinical Quality Dashboard

- The safety thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data was collected on each month to indicate performance in key safety areas, for example, new pressure ulcers and falls.
- The hospital monitored the incidence of pressure ulcers, falls, and venous thromboembolisms (VTEs). VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients.
- From July 2015 to June 2016 three patients acquired a VTE whilst at the hospital. A full RCA investigation was carried out by the hospital to ensure that appropriate measures had taken place. Following the investigation a lecture was provided by a haematology specialist to improve knowledge and skills of staff.
- 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. Data provided by the hospital indicated that between April 2016 and June 2016, 95% of patients had a VTE risk assessment performed. This was in line with the hospital target of 95%. In the three months previous, the hospital reported that 100% of patients were assessed for VTE.
- Risk assessments were completed to identify those patients who would benefit from wearing anti embolism stockings following surgery. We saw patients had anti embolism stockings fitted to help reduce the risk of them acquiring VTE.
- From January to June 2016 the service had no inpatient falls which was better than the Spire average of 2.6 falls per 1,000 bed days.
- For the same time period the service had no pressure ulcers grade two or above. The service had performed better than their safety tolerance levels which was 0.1%.They also performed better than the Spire average of 0.12% pressure ulcers per 1,000 bed days.

Cleanliness, infection control and hygiene

- The hospital followed their corporate infection control manual which included hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, to prevent the potential spread of infection.
- At the pre-operative assessment stage, staff screened patients for Methicillin-Resistant Staphylococcus Aureus (MRSA) and Meticillin-Sensitive Staphylococcus Aureus

(MSSA).This is in line with Department of Health: Implementation of modified admission MRSA Screening guidance for the NHS (2014). MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated.

- If a patient was identified at the preoperative assessment with carrying an infection such as MRSA or MSSA, they received treatment for the infection in the five days leading up to the surgery. The scheduling of theatre lists allowed for patients who had infections to be last on the theatre list. Patients identified with MRSA could be isolated in their rooms to prevent cross infection risks. All patients had individual rooms with en-suite facilities.
- Data provided by the hospital showed that between July 2015 and June 2016 there had been no reported cases of MRSA and MSSA at the hospital.
- All areas of the hospital we visited appeared visibly clean. Some areas of the ward (corridors) had carpet which could not be as easily cleaned when spillages occurred. Managers informed us that there were no current plans to replace carpeting with easy clean surfaces. The Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment states 'Carpets should not be used in clinical areas. Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. However, we saw carpets were visibly clean and free from stains, and managers reported that carpets were regularly cleaned.
- We observed that spill kits were available on the wards and theatres to effectively clean up spillages.
- The hospital had two operating theatres which had laminar flow theatre ventilation, which was considered best practice for ventilation within operating theatres, particularly for joint surgery to reduce the risk of infection.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk. We saw that all staff in theatres wore the correct attire; piercings were removed and we saw that hair including facial hair was covered. We saw that at the end of surgery gowns were removed and laundered by an external company.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations.
- A COSHH audit was completed in September 2016 that showed 96% compliance against the audit. We saw that actions were recorded and actions taken.
- We saw appropriate facilities for disposal of clinical waste and sharps such as needles located in theatres and ward areas.
- We found equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection prevention. Clean equipment had 'I am clean' stickers on them which indicated the date the equipment had been cleaned.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Hand gel was readily available in all clinical areas and we observed staff using it. Posters displaying hand washing techniques were observed above handwashing sinks.
- We saw Personal Protective Equipment (PPE), and hand sanitising gel was available across theatres and the ward. Posters were displayed which explained the '5 moments for hand hygiene' in line with World Health Organization (WHO) guidance. We found that staff were compliant with 'bare below the elbow' guidance and that PPE was used on a regular basis in line with hospital policy. PPE was also provided for visiting relatives when needed.
- Hand hygiene compliance was monitored by measuring the usage of hand sanitising agents every quarter. The results for April to June 2016 showed a score of 17, which was below the corporate target of 18. The audit of hand sanitising agents measured how much agent was in the bottle and after a specified time it could be re-measured to provide data on how much liquid had been used. This form of hand sanitiser audit could not provide assurances that all staff were compliant with hand hygiene, and instead showed that hand sanitiser was being used. Observational hand hygiene audits had

recently been introduced to monitor staff compliance. The ward and theatres had achieved100% compliance in September 2016. We observed that staff were compliant with hand hygiene during the inspection.

- There were large red signs on the walls next to hand sanitisers to remind staff and visitors to use the hand sanitisers.
- There were no dedicated clinical hand wash basins in patient bedrooms, staff and visitors used the basin in the bedroom's en-suite bathroom as the washing facility. This is not in accordance with Department of Health's Health Building Note 00-09: infection control in the built environment. The guidance states 'healthcare providers should have policies in place ensuring that clinical wash-hand basins are not used for other purposes'. We saw the hospital had a corporate prevention and control of infection manual (November 2015) which provided guidance for the requirements of separate hand wash basins in each single bedroom within new build and refurbished hospitals. The manual also included guidance on the use of dual purpose sinks in patient bedrooms which were, for example, too small for separate sinks. We saw that the hospital had followed the corporate guidance, as lever taps were being used to minimise the risk of cross infection and a risk assessment had been completed.
- The hospital monitored the incidences of surgical site infections (SSI). Data provided by the hospital showed that between July 2015 and June 2016 there had been a total of 16 surgical site infections following surgery at the hospital. This is above the rate of other independent hospital for which the CQC hold data. However, the rate of infections during primary knee procedures was below the rate of other independent acute hospitals and there were no surgical site infections resulting from hip revision, knee revision, spinal, upper GI and colorectal, urological or vascular procedures. Full RCA's were completed and changes had been implemented to reduce the reoccurrence of SSI's. This included, changes to advice to patients on washing prior to laparoscopic procedures and the use of skin disinfectants. Managers informed us that all infections that had been reported were superficial site infections and there had been no deep tissue infections. We saw that surgical site infections had been categorised at moderate by the hospital on their recording system even if the infection was superficial.
- The matron was the sepsis lead to oversee the hospital sepsis management. We saw that sepsis audits were completed and a sepsis pathway with clear flow charts for staff to follow were available and plans in place to ensure all relevant staff had completed sepsis training. This ensured that any patients who were suspected of sepsis received a timely response to treatment.
- The hospital had a sterile services department that sterilised all reusable medical equipment and devices and was SGS accredited. This showed that they were compliant with national guidelines on sterile services.
- We saw evidence that external audits were being completed to meet standards in the Sterile Service Department (SSD) as part of their SGS accreditation. The last audit in 2016 showed no major points for consideration. We saw evidence of an action point with regards to auditing had been implemented following the inspection from SGS.
- The SSD also completed their own internal audits to ensure compliance with their SGS accreditation. We saw evidence that the audits were completed which covered all areas of the department including dress code, decontamination process, through to transportation of sterile equipment.
- The hospitals Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed the hospital scored 91% for cleanliness which was below the England national average of 98%. We saw that action plans had been developed to address all areas of the PLACE audit and a care setting improvement tool provided an audit of the environment to ensure standards of cleanliness were maintained.

Environment and equipment

- The ward and theatres were tidy and well maintained; they were free from clutter and provided a suitable environment for patients, visitors and staff to move around freely.
- All doors were unobstructed and fire escapes were clear.
- The hospital undertook quarterly inspections of the environment to ensure all areas were clean, and free from defects. We reviewed the quarterly inspection report for the ward and theatre and saw that each inspection contained actions required for compliance and all actions had been completed.
- The wards were split over two floors with lift access. The ground floor provided eight private patient bedrooms

with en-suite facilities and one double room. The first floor provided 18 en-suite bedrooms for patients who required an inpatient stay following surgery. We saw that all inpatient bedrooms had level access showers.

- The theatres were located on the first floor next to the inpatient ward which meant that patients on this ward did not need to go up and down using the lift from ward to theatre.
- The theatre and the wards did not have entrances that were locked to prevent access by unauthorised personnel. To access the theatre there was a push button access that meant anyone could access the area. Although all areas could be freely accessed, there were nurse stations at the entrance to the ward and there was an office area at the entrance to theatre to stop and check visitors on arrival. We were informed that a business case had been authorised for controlled entry doors to theatre and that in the meantime, a risk assessment was in place. The hospital also adhered to safety procedures such as CCTV and panic buttons.
- The ward provided two extended recovery beds for those patients who required further monitoring following surgery. We found that the two extended recovery rooms had extended recovery trolleys that contained a difficult airways drawer, a sepsis drawer and a haemorrhage drawer. The stock in the drawers were all in date and records indicated they were regularly checked by staff, however, the drawers were not locked potentially leaving them accessible to the public. We saw that a risk assessment had been completed for this in April 2016 and the manager informed us that the trolley could be removed from the area if required.
- The extended recovery beds provided level one care. Patients who required level two care could be transferred back to the post anaesthetic recovery area in theatres if required. We saw that at lunch time one of the extended recovery rooms, which was not currently being used for patient care, was being used as a dining area for staff. We were informed that this had been utilised due to staff wanting to be on hand if a patient or visitor required support. However, this was not an appropriate area for staff to use for such a purpose and could potentially present an infection risk. A staff canteen was available in another area of the hospital.
- Records indicated that equipment was maintained and used according to manufacturer's instructions. There was sufficient equipment to maintain safe and effective care. We saw service schedules were kept for all electrical equipment with service dates for scheduled servicing.
- We saw that all portable oxygen cylinders were stored on the ward and attached and locked to the wall to prevent unauthorised removal.
- We saw evidence that in 2016 the servicing of air ventilation in theatres had been carried out. The verification process comprised a number of tests to ensure compliance with the relevant Health Technical Memorandum (HTM). Information supplied by the hospital showed that the service was compliant with the HTM.
- Daily morning surgical meetings were held to ensure that all staff had the required equipment for the surgeries planned for that day.
- Records indicated that resuscitation equipment for use in an emergency in operating theatres and ward areas was regularly checked, documented as complete and ready for use. The trolleys were secured with tags, which were removed and replaced following checking the contents of the trolley. However, we did find that within theatres one serial number on the checklist did not match up with the serial numbers on the tags. We raised this with the theatre manager and was rectified immediately.
- Records indicated that the four anaesthetic machines were checked on a daily basis to ensure readiness for use and disposable circuits were changed on a weekly basis. The log book contained the reference numbers of the anaesthetic circuits.
- There were systems to maintain and service equipment as required. Records indicated that equipment had been tested appropriately to ensure that it was safe to use. Most medical devices we saw had up to date portable appliance testing (PAT) but we found four items on the ward that showed their PAT testing had expired. PAT testing is a process by which electrical appliances are routinely checked for safety once a year. We saw a database for PAT testing was kept and showed dates for when electrical items needed testing.
- The hospital had two laminar flow theatres (where air is moved at the same speed and in the same direction, to avoid contamination). The laminar flow theatres operated Monday to Friday 8am to 9pm and ad-hoc on

Saturday and Sundays to meet the needs of the patients. Theatre staff undertook a close down procedure at the end of routine theatre lists to ensure readiness for if a patient required a return to theatre.

- Theatre staff had completed medical device competencies for specialist equipment used in particular procedures. This ensured that staff were able to use specialist equipment competently and ensured patient safety.
- There were arrangements in place for managing waste. We saw no waste being stored in theatres or the ward areas. Waste was removed immediately and not carried through the theatre areas. Sharp bins were used to dispose of needles and appropriate bins were used for clinical and confidential waste.
- Recording systems were in place to ensure that details of specific implants and equipment could be provided rapidly to the health care products regulator. An implant register was kept within surgery of all cosmetic implants and prosthesis. Serial numbers were also noted. We reviewed the register and found that it was legible, up to date and contained the necessary serial numbers of implants or prosthesis used.
- We visited the theatre stock room and saw that it was well organised and the stock had been rotated. The theatre employed staff to work in the stock room to ensure that stocks were well maintained and to ensure adequate daily supplies of stock.

Medicines

- There were arrangements in place for managing medicines, medical gases and contrast media. Nursing staff were able to explain the process for safe administration of medicines and were aware of policies on preparation and administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management. We saw that there was an up to date policy for the safe storage, recording of, administration and disposal of medicines. This was available for staff on the intranet.
- Records on the ward and theatres indicated that controlled drugs were checked twice daily and were signed as correct by two staff. We observed that medicines were in date.
- We observed that all medicines were appropriately stored in suitable locked cabinets. Patient medication could be locked in small cabinets in their rooms and staff held the keys.
- The hospital ward completed a controlled drugs audit in July 2016. The findings showed that the ward was 88% compliant with controlled drug record keeping. We saw that an action plan had been developed to improve performance with a review date.
- We reviewed seven prescription charts and found them all to be legible, dated and signed, allergies documented and saw antibiotics were administered appropriately.
- Fridge and room temperatures were all within normal ranges which meant that medicines were stored at the correct temperature. Records indicated that staff completed daily fridge and ambient room temperature checks in line with the hospital policy.
- The theatre had a blood fridge which was maintained by an external provider. The fridge had keypad entry and appeared visibly clean, and temperature records were maintained. Blood supplies were not routinely kept on site and were ordered as needed. We were informed that blood for emergencies could be received within 10 minutes from a neighbouring trust if required. We saw that a service level agreement was in place for this.
- The hospital had a service level agreement for pharmacy cover within the hospital. The two pharmacists provided cover on a daily basis and at weekends and operated a 24/7 on call service to meet the demands of the hospital. Managers we spoke with confirmed that they received adequate support from this service.
- A missed dosage, medicine management and prescription audit was carried out in July 2016 to ensure compliance with medicines management. The audit highlighted areas for staff training and an action plan to improve.
- We saw that prescription pads were kept in a locked cabinet; however there was no tracking system to record their use. This was highlighted to managers and rectified during our inspection to ensure that records of prescription pad usage were recorded.

Records

- The hospital staff followed their corporate information lifecycle management and patient records policy, which included confidentiality of patient records, documentation by clinicians, length of time records were to be kept and patient records on discharge or transfer. The policy was issued in August 2013 and had passed its review date in August 2016.

- At the time of inspection we saw patient personal information and medical records were managed safely and securely, in line with the data protection guidelines. We observed no records left out on the ward or theatre and were stored in lockable cabinets once used.
- We saw that separate bins were in use for confidential waste. This ensured that sensitive data and patient identifiers were destroyed securely.
- We observed eight patient records and found each patient that attended for surgery was placed on a pathway that ensured they received the appropriate care and treatment. Pathways were available to staff on the intranet for printing as required.
- All eight records we viewed were signed and dated with no loose filing, and were legible which was in accordance with the hospitals documentation policy.
- A hospital records audit completed for April to June 2016 showed 100% compliance with records being fully signed and dated by consultants.
- Patient records we viewed were integrated to ensure that they contained all information from pre-assessment, through to surgery, to the ward. We also saw evidence of consultant letters showing costs for surgery. From the three sets of notes relating to cosmetic surgery we saw evidence that there was at least two weeks 'cooling off' period between patient consultation and surgery. A cooling off audit was competed between June 2015 to May 2016.Results showed that the service had taken into account the Royal College of surgeons professional standards for cosmetic surgery 2016 as the shortest cooling off period for patients had been 17 days.

Safeguarding

- The hospital had a senior named nurse lead for safeguarding for both adults and children. All staff we spoke with were aware of their safeguarding adults and children responsibilities and who to contact if guidance was required.
- There was safeguarding policy which staff were able to locate on the intranet and staff were aware of safeguarding adults and children from abuse. This included an awareness of female genital mutilation (FGM). However, we found that FGM was not included in the adult safeguarding policy.
- We saw evidence that the hospital shared information with all staff with regards to important patient safety through hospital briefings. These included PREVENT (prevent vulnerable people to exploitation by radicalisers) and FGM. The briefings were placed on noticeboards to remind staff and raise awareness. We saw that a notice with regards to FGM was displayed in the manager's office.
- The hospital had not reported any safeguarding issues to the CQC in the reporting period from July 2015 to June 2016.
- Staff received mandatory training in the safeguarding of adults and children, as part of their induction followed by safeguarding refresher training yearly.
- The hospital data provided at inspection showed that 71% of staff in theatres and the ward and completed safeguarding children level 3 training and 100% of staff had completed safeguarding adult's level 2. We were informed that assessments for children were carried out by staff that had completed children's safeguarding level 3 training.
- The hospital did not perform any surgery on children under the age of 16. All children between the ages of 16 to 18 were assessed at a preoperative assessment and if a registered children's sick nurse was required then surgery would not take place. From July 2015 to June 2016, the hospital performed nine surgical procedures on children aged between 16 to 18, of which two were inpatients. There were no children admitted for surgery during the inspection

Mandatory Training

- Mandatory training was made available to all staff to enable them to provide safe care and treatment to patients. Some of the training was completed through e-learning which staff could access at a time to best suit their needs. Staff we spoke with told us that they were given time to complete training.
- Mandatory training modules included equality and diversity, manual handling, infection control and information governance. Other training was role specific, for example medical gas training and blood transfusions.
- We saw evidence of training records on a database that indicated that 100% of theatre and ward staff had completed their mandatory training.
- Staff training was co-ordinated and monitored by the ward manager and by a theatre department administrator to ensure staff training was completed.

We were informed following the inspection that the hospital has ranked amongst the top five achieving hospitals in terms of all online mandatory training for the past 2 years leading up to the inspection.

- Additional role specific training was provided to staff based upon their clinical practice. This included basic life support (BLS), immediate life support (ILS) and advanced life support (ALS). Data provided by the hospital indicated that, 76% of staff in theatres, 70% of staff on the ward had completed BLS. The ward had achieved 83% of staff completing immediate life support (ILS) skills and 16 staff on the ward and five in theatres completing adult advanced life support (ALS). We were informed on inspection that all registered nurses on the ward and in theatres had now either completed or booked to complete ILS training. We saw from the governance improvement objectives plan that ILS training was an objective for completion in 2016 and staff had been booked to complete the course.
- Mandatory training for the resident medical officer (RMO) was completed by their agency. The management team kept training records for the RMO and monitored the training for consultants as part of the appraisal process.

Assessing and responding to patient risk

- The hospital had an admission criteria that was based upon the level of risk associated with the procedure and the health of the patient. If a patient was at high risk due to complex co morbidities then the patient may be referred to another service. Such a risk factor would include patients whose Body Mass Index (BMI) was above 40 although this was risk assessed in each individual case. By screening patients the hospital was able to reduce the risks to patients and the probability of emergency transfers to NHS hospitals.
- A preoperative assessment was completed for each patient either face to face or via the telephone for simple procedures. The assessment was a clinical risk assessment where the health of a patient was considered to ensure that they were fit to undergo an anaesthetic and therefore the planned surgical operation.
- Allergies were checked as part of the pre-operative assessment and were checked again once the patient was admitted and rechecked again prior to anaesthetic.
- As part of the pre-operative assessment process, patients completed a comprehensive Pre-Admission Medical Questionnaire (PAMQ). These were reviewed at pre-assessment appointments to assess the suitability of patients for surgery and to carry out health assessments such as blood tests and swabs if required. The pre-admission assessment also gave an opportunity to ensure that patients were fully informed about the surgical procedure and the post-operative recovery period that included discharge and post-operative care.
- Risks to patients were assessed and monitored at pre assessment, and then checked again prior to treatment by either a registered nurse or health care assistants who had completed associated competencies and had completed NVQ level three in healthcare. The assessment included risks relating to mobility, medical history, last menstrual period, bleeding risk, pressure ulcer risk and VTE. During our inspection we looked at eight sets of patient records, which showed all risk assessments had been completed correctly.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies. The service used the National Early Warning Score system (NEWS). This is a national standardised approach to the detection of a deteriorating patient and has a clearly documented escalation response, in line with National Patient Safety Agency (NPSA) 2007 guidelines. On the NEWS chart, staff recorded observations including oxygen saturations, blood pressure and temperature and collated a total score. We saw that guidance was available on the NEWS charts to show what escalation was required for each trigger score.
- We reviewed eight patients' NEWS charts and found that all observations had been completed appropriately and at the appropriate time required.
- A NEWS score audit had been carried out in the first quarter of 2016 and the results showed 100% compliance in NEWS recording across a sample of 20 patient records.
- Patients were risk assessed for venous thromboembolism (VTE), which is where blood clots form which have the potential to be fatal. The service audited its compliance with completing the VTE assessment and we saw that 95% of patients had fully completed VTE risk assessments, meeting the hospital target of 95%.
- Data provided by the hospital showed in the second quarter of 2016, 100% of patients eligible for chemical

VTE prophylaxis (a preventative measure for patients at risk of developing VTE) had it prescribed, exceeding the target of 95%. We also saw that 100% of patients were prescribed the prophylaxis for the correct duration; 10 days for knee and 28 days for hip replacements, which was better than the target of 95%. The data also showed 90% of patients were given the prophylaxis within the recommended timescale, better than their target of 80%.

- A sepsis screening tool was used to help identify sepsis in those patients presenting with associated signs and symptoms. There were flow charts to support staff, with the procedures to follow, and patients were required to be immediately reviewed by the RMO. Managers informed us that 80% of qualified nursing staff on the ward had received this training and plans were in place to ensure all qualified staff were trained. We saw evidence of guidance for staff to follow that included recognition of sepsis, screening, escalation and clinical guidelines to follow.
- The hospital used a 'quality round form', to ensure their patients were safe and comfortable. The quality round form included pain control, nutrition, falls risk and NEWS score. Quality rounds were undertaken at least every two hours for all patients to ensure patient safety. Records we looked at indicated that the quality round forms were being completed at the required times and included a range of measures to ensure patient safety.
- A theatre team brief was held three times daily before each theatre list 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. We observed that the briefing was well attended by theatre staff and a member of the ward staff.
- Nursing handovers were taped to ensure that all the staff had the right information available to them. We were informed that the process involved the night staff taping the handover for the day staff and vice versa. This enabled all staff to receive a handover even if they attended late.
- The theatre used the world health organization (WHO) surgical safety checklist which 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 in the two surgical procedures we attended, the three phases of an operation were completed, with all members of the team participating appropriately.
- A WHO audit was completed in the second quarter of 2016 and the results showed a compliance rate of 83%. The reason for the observational compliance score was due to consultants wandering in and out of theatre during post-op WHO checklist. The audit found the theatre team still performed checks and asked questions to relevant individuals. The hospital developed an immediate action plan to improve performance which included theatre staff to identify champions to ensure adherence to new Spire policy.
- Patients were recovered by recovery nurses on a one to one basis to ensure patient safety, and minimise complications following surgery. For patients who were not ready to return to the ward following a procedure, they were moved to the extended recovery unit that was able to provide nurse staffing on a one to one basis if required.
- For patients undergoing elective surgery, there was appropriate equipment and procedures in place such as diathermy mats and pads to reduce risk of burns to patients.
- Patients remained under the direct care of their consultant following surgery. The consultants remained on-call following the surgical procedure or named deputies were available if the consultant was not going to be available to ensure patients had access to a consultant if required.
- Medical cover was available 24 hours a day for patients as a Resident Medical Officer (RMO) remained on site 24 hours per day.
- Cosmetic surgery was performed at the hospital. The service ensured that the pre-admission consultation took account of the Royal College of Surgeons' recommendations, which included ensuring psychologically vulnerable patients were identified and referred for assessment. The service had a referral system to a psychologist who was available for psychological assessments. We were also informed that there were two psychologists who worked at the hospital under practicing privileges who were able to provide assessments if required.
- 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).

Nursing and support staffing

- Staffing levels and skill mix were planned and reviewed so that patients could receive safe care and treatment at all times, in line with relevant tools and guidance. The ward used the Nursing Hours per Patient Day staffing tool (NHPPD) to determine the numbers of staff that were required on a daily basis to provide safe care and treatment to patients. The staffing ratio of staff to patients was usually 1:4 during the day and 1:5 at night. The service provided four shifts; a long day, an early shift, a late shift and a night shift to ensure adequate numbers of staff and continuity for patients. We saw that nurse staff numbers were displayed at the entrance to the ward so patients and visitors could see how many staff were on shift.
- Theatres were staffed in accordance with the Association for Perioperative Practice (AfPP) safe staffing guidelines. This ensured that there were adequately trained staff to provide safe surgical care to patients. We saw from the two surgical procedures we attended that there was appropriate staffing levels for each theatre. This included a circulating nurse, an operating department practitioner (ODP), two scrub practitioners, a recovery nurse and a surgical first assistant (SFA), who was supernumerary. We were informed that theatres provided two SFA's in theatres if it was required due to the complexity of the procedure.
- The theatre and ward manager held a weekly planning meeting that was used to discuss the individual needs of patients who attended for treatment so that staffing numbers could be arranged.
- We reviewed rotas for staffing in theatres, and saw that they included which staff had been trained in advanced life support. This supported the planning of rotas to ensure there was the correct skill mix at all times.
- During our inspection we saw that planned numbers of nursing staff had been met. We saw that from April to June 2016 there no unfilled shifts at the hospital.
- There was no turnover for nurses and no turnover for healthcare assistants within theatre from July 2015 to June 2016. We were told by several staff that they had worked at the hospital for many years and people did not usually leave the service.
- The rate of inpatient nurse turnover was below the average of other independent acute hospitals during the reporting period from July 2015 to June 2016.
- There were no vacancies for qualified nurses in theatres or on the wards.

Medical staffing

- Between July 2015 to June 2016, 132 consultants had been granted practising privileges at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at NHS trusts in the area. They included consultants with specialities such as cosmetic surgery and orthopaedics.
- All treatment was consultant led at the hospital. Following surgery the continued care of the patient remained the responsibility of the surgical consultant. If the consultant was not available then consultants were required to have a named deputy. We saw that records of consultants and their deputies were kept on the ward and in theatres. The RMO informed us that consultants were easily contactable and provided a quick response if they were needed to attend the hospital out of hours.
- We saw the Spire Consultants Handbook, which included practicing privileges for consultants. The handbook required the consultants to be available by telephone, and in person if required, 24 hours a day, whenever they had a patient in the hospital. This ensured inpatient recovering from surgery over the weekend had 24-hour access to consultant input if needed. If a consultant was not available, the handbook required them to arrange for another consultant to provide cover. We saw that this practice was being adhered to.
- There were plans to ensure there was medical staff available should an unplanned return to theatre be needed. Surgeons and anaesthetists remained on call 24 hours per day and were required to be able to attend the hospital within 30 minutes if required. The RMO's we spoke to reported that medical advice or attendance was available to them quickly if needed.
- The hospital used an agency that provided a RMO on site 24 hours a day, seven days a week, on a rotational basis. This meant a doctor was on-site at all times of the day and night in the event of an emergency. The RMO's worked one week on followed by at least one week off.

There were three RMO's employed to ensure adequate medical cover to the ward. We spoke with two RMO's who reported they were well supported by the consultants.

- There was no formal patient handover from the consultant to the RMO. RMO's attended the nursing handovers and were given a handover sheet so they knew which patients had been admitted and the care and treatment they required. We also saw that consultants were available on the ward if required.
- RMO's followed the care and treatment plans set out in the patient records. We saw from the records we reviewed that patients were reviewed daily by a member of the medical team.

Emergency awareness and training

- The hospital had a business continuity plan in place in the event of potential emergencies. The plan covered major incidents such as, how to respond in the event of loss of power, loss of staffing, adverse weather or flood. Staff were aware of the plans in place. We saw on the ward that the manager kept a sealed envelope that contained staffing telephone numbers to contact in the event of an emergency.
- Table top training scenarios were held regularly to ensure staff responded appropriately to emergency situations. Staff told us the most recent scenario involved training for a major bleed and were planning another scenario around needle stick injuries.
- The hospital had back up emergency generators for if the power failed. We were told that these were regularly tested to ensure continuity of service if the power supply failed.

Are surgery services effective?

Good

Evidence-based care and treatment

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) guidelines. For example the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50. Staff also assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines CG92.
- NICE guidelines were reviewed centrally by Spire corporately and were cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. We saw evidence through corporate key learning summaries and through departmental team meetings that changes in practice and guidance updates were discussed. For example, in the theatre team meeting, policies were discussed to ensure staff compliance with the latest guidance.
- The hospital used care pathways that had been developed to meet best practice guidelines which staff followed to ensure patients received safe care and treatment. Care pathways were in place for all treatments provided and staff were able to access them from the hospital intranet. The pathways incorporated pre-assessment through surgery to post-operative care. The records we reviewed showed that the pathways were being used for all patients.
- The face lift pathway for cosmetic surgery included a range of assessments and processes that staff were to follow to maintain the safety of patients. This included bleeding risks, VTE risks, Last Menstrual Period (LMP), medication, and discharge planning. The pathways followed National Institute for Health and Care Excellence (NICE) guidance. For example, all patients were risk assessed on admission for their risk of VTE, and this was in line with the NICE QS3 – statement 1.
- We saw that the hospital received bulletins to inform and educate staff in relation to a number of topics, such as dementia awareness.
- An enhanced recovery programme was used by the hospital to reduce the amount of time patients remained in hospital following a surgical procedure. The care pathways provided staff with guidance on the usual length of stay for patients. We saw that following surgery patients worked with the therapy team to actively start their rehabilitation and were provided with exercises to follow to aid their recovery and discharge home.
- Discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was

avoided when making care and treatment decisions. A corporate Spire policy was in place regarding equality and discrimination. We observed that staff treated patients individually and without prejudice.

- The hospital contributed to national audits including Patient Reported Outcome Measures (PROMS). These audits were published nationally to provide evidence of outcomes of the service provided.
- The hospital had taken action to implement the Royal College of Surgeons (RCS) professional standards for cosmetic surgery by ensuring that all cosmetic surgeons only carried out procedures within their scope of practice and were appraised yearly. A preoperative assessment was carried out and we observed from records that a two week cooling off period prior to surgery was in place, and access to psychology services were available to patients if required. However, we were informed that the two week cooling off period was not a formalised policy.
- In theatres, a medical device implants register was kept to ensure there was a system to record all implants used. The current register was paper based. However, they had registered with the health and social care information centre (HSCIC) to be involved in the national breast and implant register once an electronic data base was developed. We reviewed three discharge summaries and found clear documentation of the implant used was included on the summaries.
- We saw evidence of an audit programme that scheduled the audits to be completed for the year 2016. The programme included audits relating to patient safety and health and safety.

Pain relief

- Pain relief was discussed during pre-operative assessments and patients were provided with pain advice booklets to be used post-operatively. We saw that pain leaflets were displayed on the wall and patients informed us that they were regularly asked if they were in pain.
- Pain scores were recorded as part of the NEWS. We saw that pain scores were documented and that pain relief was given to patients at the specified times. We reviewed eight patient records and found pain had been recorded appropriately in all records.
- We saw that pain scores were recorded by nursing staff as part of the two hourly intentional rounding. Intentional rounding was used to ensure that patients were checked on a regular basis and that their needs had been met.
- The hospital audited that pain scores were recorded with every set of observations. From April to June 2016 the data supplied by the hospital showed 98% of patients had pain scores recorded with every set of observations, which was better than the hospital target of 95%.
- The pain relief audit that was completed between March and May 2016 showed from the patients sampled that 40% of patients received analgesia immediately following pain being recorded, 30% of patients received analgesia within 10 minutes, 20% within 15 minutes and 10% within the hour. We saw that an action plan had been developed to improve and a re-audit was scheduled within six months.
- In the June 2016 patient satisfaction survey, 100% of patients reported that they were satisfied that staff controlled their pain.
- Patients we spoke with did not raise any concerns about pain relief.
- We saw from the discharge summaries we reviewed that pain medication was included in the discharge summary which was sent to the GP.
- For patients who were not responding to pain relief, there was access to 24 hour medical support, and consultants and anaesthetists remained on call 24 hours per day.

Nutrition and hydration

- We reviewed eight patient records and found that Malnutrition Universal Screening Tool (MUST) scores had been recorded appropriately. The MUST score is a five step screening tool to identify adults who are at risk of malnutrition. We saw that the MUST screening was part of all pathways that we reviewed including those for cosmetic surgery.
- Staff followed guidance on fasting prior to surgery which was based on the recommendations of the Royal College of Anaesthetists, (RCA) which states that food can be eaten up to six hours and clear fluids can be consumed up to two hours before surgery. We saw that

ward staff also attended the theatre pre surgery briefing to discuss starve times for patients. This ensured that everyone in the briefing was aware of the starve time status for each patient.

- The hospital monitored the patient starve times as a key performance indicator. Data provided by the hospital showed that between April and June 2016, 65% of patients were fasted within the guidelines. This was better than the hospital target of 50% and the same as other hospitals within the Spire group. This was an improvement over the previous three months where the patients who were fasted within the guidelines was 40%.
- Admission times were staggered throughout the day so that patients did not have to wait for a long period of time once admitted to the ward. By staggering admission times the hospital was able to ensure those patients with the most urgent needs were prioritised. For example, patients with diabetes were placed at the beginning of the theatre lists so that they had their surgery as quickly as possible.
- The hospital did not have a dietician on site, but managers explained that a referral system was in place to access dietetic services if required.
- The hospital had a five star rating in the local authority 'Food Hygiene Certification Scheme'. This gave assurance that all best practice in food hygiene standards were adhered to.
- We saw that menus were available in all patient rooms to allow patients to choose a meal to best suit their needs and snacks were available throughout the day.
- We observed that on the day ward, tea, coffee and fresh drinking water was available to all patients and visitors.
- All patients we spoke with reported that they enjoyed the food at the hospital.
- Nausea and vomiting was assessed using a scoring system with the associated pathway and recorded. We reviewed eight sets of patient records, which showed these had been completed correctly.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored by the hospital. Managers we spoke with were aware of their responsibilities to collect and disseminate the findings. We saw from meeting minutes that audit data was shared with staff.
- The hospitals within Spire compared the patient outcomes regionally and nationally as part of their key performance indicators. For example, the hospital compared scores against corporate targets for recording pain scores, patient temperature, and theatre starve times. Hospitals were able to benchmark themselves across all other Spire hospitals and take action to improve results. Results from the clinical score cards showed that the recording of pain scores and patient starve times were in line with the rest of the spire network and temperature recording exceeded the spire network results.
- The hospital collected patient reported outcome measures (PROMS) and had participated in audits undertaken by the National Joint Registry (NJR). Data provided by the hospital showed between April 2014 to March 2015 outcomes for primary knee replacements and primary hip replacements were in-line with outcomes reported by services nationally.
- From April 2014 to March 2015 Patient Reported Outcome Measures (PROMS) data was collected for total hip and knee replacements using the Oxford Hip and Knee score. Data for the Oxford Knee Score showed that out of 56 patients, 94.6% reported an improvement. Data for the Oxford Hip Score showed that out of 50 patients, 98% reported an improvement. These results were in line with the national average.
- For the 32 NHS funded patients treated for groin hernia between April 2014 and March 2015, 43.8% of patients reported (using the EQ-5D measure Generic health status measure) their health had improved following surgery, 12.5% felt their health had worsened. This was above the England average. Under EQ VAS for the 32 patients, 34.4% were reported as improved and 40.6% as worsened. This was above the national average. The EQ-5 profile asked patients to report on their health based on self-assessed levels of problems ('no', 'some', 'extreme'). The EQ-VAS questionnaire asked patients to describe their overall health on a scale that ranged from 'worst possible' to 'best possible' health.
- 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. Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations.
- At the time of inspection the hospital did not use the Q-PROMs recognised tool to collect patient satisfaction with the operation. However, patient satisfaction was collected routinely for patients who had under gone

cosmetic surgery. Data provided by the hospital showed that type of procedure, consultant name, with a range of quality indicators including approximate waiting times for surgery, the quality of the information, clear and helpful consultant, privacy and respect and overall quality of the service was been collected and monitored. From the information supplied comments were all positive with regards to the quality of care and treatment. Negative comments included more parking and the need for more information leaflets. We saw evidence that these areas were being addressed by the hospital.

- Data provided by the hospital showed that from April to June 2016 the hospital exceeded the targets for recording temperature and theatre starve times.
- The hospital had a service level agreement with the local NHS trust for transferring patients if their condition deteriorated at the hospital. Between July 2015 and June 2016, 12 patients had been transferred out to an NHS hospital because of post-operative complications. The assessed rate of unplanned transfers (per 100 inpatient attendances) was not high when compared to a group of independent acute hospitals that submitted performance data to CQC.
- There were five cases of unplanned readmission within 28 days of discharge in the reporting period of July 2015 to June 2016. The assessed rate of unplanned readmissions (per 100 inpatient and day case attendances) was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- There were five unplanned returns to the operating theatre in the reporting period July 2015 to June 2016. The clinical score card key performance indicators showed that from January to June 2016 the unplanned return to theatre rates were below the 0.20 hospital target rate for quarter one and quarter two at 0.10 and 0.18. The hospital also performed better than other hospitals in the Spire group during this time period.
- Female patients of child bearing age were tested for pregnancy prior to surgery. This was audited, as part of Spire's clinical key performance indicators. Compliance rates between January to June 2016 was 100%. This was better than the hospital target of 95%.
- 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). The hospital was fully engaged in the process and was ready to supply data to PHIN once officially launched by Spire. We were informed that readiness for PHIN was being centrally led and has been trialled in other Spire hospitals before being rolled out nationally across the group.
- We saw from team meetings from the ward and theatres that audit results relating to patient outcomes were shared with the teams.

Competent staff

- Staff were able to access training internally and externally. There was an online learning system across Spire hospitals where staff could access additional training opportunities. All staff we spoke with reported that they were encouraged and able to access training to improve their skills and knowledge.
- All qualified nurses (100%) who worked within theatres or the ward had recorded validation of professional registration. This meant the hospital conducted annual checks to make sure all the nurses are registered with the Nursing and Midwifery Council (NMC) and is considered good practice. We were informed that all nurse validation was monitored by the human resources co-ordinator and cross checked with the NMC. One nurse who was currently on maternity was required to revalidate prior to returning back to work.
- Hospital data showed that 100% of staff had received a performance appraisal. Appraisals were linked to the hospital and corporate vision and values. Staff told us, their objectives were set at the appraisal and learning needs and further training was discussed and planned.
- Staff competencies folders were kept on each department. We reviewed competency folders for three members of the theatre staff and saw that competency files were well presented and contained competencies for example, for medical devices, pain management, controlled drugs, medical gases and immediate life support (ILS).
- The hospital had a new draft copy of a policy for safe standards in the perioperative environment which included the introduction of a SFA competency toolkit. The toolkit was developed to support the training and competency of staff. However, although the competency toolkit had been implemented for staff we were told the new policy and had yet to be introduced corporately.

- We reviewed seven competency records for scrub practitioners who had gained additional competencies to act as Surgical First Assistants (SFA). Each member of staff had been signed off as competent by a consultant and had a mentor to ensure continued development.
- 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. We saw from the records these additional skills had been completed. A log book was also kept by managers which recorded the frequency and type of SFA skills used for internal and external staff. Each member of staff also had a job description detailing the roles and responsibilities of an SFA.
- The PCC position statement regarding the SFA (2012) recommends that the role of the SFA must only be undertaken by a practitioner who has successfully completed a nationally recognised competency training programme, such as the AfPP SFA Competency Toolkit. This can be used in combination with an SFA in-house training course developed by an individual healthcare organisation or an award or module run by a higher education institution. However, although the staff were signed off as being competent with records kept of their skills, and a competency toolkit had been implemented, none of the staff employed at the hospital had yet started or achieved a nationally recognised accredited qualification by a higher education institution.
- There was a clear process for the granting of practising privileges for new consultants. This required consultants to send in a CV, a formal application, an interview and have an endorsement from a Medical Advisory Committee (MAC) representative.
- The role of the medical advisory committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document. Registration with the General Medical Council, relevant specialist register, Disability and Barring Service (DBS) and appropriate indemnity insurance were checked by the Regulatory Compliance Administrator and compliance confirmed to the MAC.
- Practising privileges for consultants were completed biennially. The review included all aspects of a consultant's performance. The review included an assessment of their annual appraisal, volume and scope of practice, plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges.
- We saw from data provided by the hospital that 11 consultants had their practicing privileges removed in the last 12 month reporting period due to non-adherence to the consultant handbook. A total of 20 consultants had their practicing privileges removed in the last 12 month reporting period for varying reason including retirement.
- The hospital employed three RMO's through an agency. The agency was responsible in ensuring that the employed RMO's had the necessary training to complete their role. Information provided by the hospital showed that the RMOs were trained in advanced life support (ALS), Paediatric ALS, Safeguarding, cannulation and venepuncture; catheterisation both male and female, IV drug administration, ECGs, prescribing medications, and infusion pump training. RMO's we spoke with informed us that they also received mandatory training which was carried out annually.

Multidisciplinary working

- We observed good multidisciplinary working with effective verbal and written communication between staff. Staff confirmed that there were good working relationships between staff that included physiotherapists, nurses, and consultants.
- We saw that the physiotherapy team worked closely with the ward staff to ensure that patients were seen quickly following surgery to further enhance their discharge.
- We observed nurses working alongside consultants. Interactions were positive and professional.
- We observed a theatre briefing and saw that it was well attended by all levels of staff and included ward staff.
- All theatre lists were consultant led and did not employ specialist nurses. Referral to specialist nurses in the community could be made if required for patients.
- The pharmacist attended the ward daily to rotate medication stock and top up any medications which had been used during the previous day. The pharmacist was involved in decisions about medication, along with the RMO.

- We observed positive working relationships between managers and the staff groups. We observed managers across the department to have close professional relationships with the staffing groups and provided them with advice and guidance as required. In theatres the deputy manager provided mentorship to the SFA's.
- Ward staff liaised with a number of different services when co-ordinating a patients discharge. This included hospitals, community services, and social services depending on the area the patient was from.

Seven-day services

- Theatres were scheduled to operate between Monday and Friday on a weekly basis and ad-hoc over the weekend to best suit the needs of patients. 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.
- Consultants and anaesthetists responsible for delivering treatment were on-call 24 hours a day. They were required under their practicing privileges to have a named deputy in the event of them not being available. The resident medical officer confirmed that there were not normally any problems contacting consultants if required and both the ward and theatres kept lists of contact numbers.
- There was an on-call system for theatre staff that would be called if a patient needed to return to theatre out of hours.
- There was a radiographer available 24 hours a day on an on call basis to provide diagnostic imaging.
- Pharmacy operated a 24hour a day on call service to ensure continuity of service.

Access to information

- There were comprehensive care pathways available to staff via the hospital intranet that contained all of the information staff needed to deliver safe care and treatment. These included risk assessments for falls and nutrition. We reviewed eight sets of patient records, which showed these had been completed correctly.
- Staff told us they had access to policies and procedures and felt they were kept informed by the management team. Staff told us, and we saw evidence in team meeting minutes that they all received monthly governance newsletters which updated them about events and incidents at the hospital.
- 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 records if required. We were informed that records could be available within 24 hours. Data provided by the hospital showed that between April and June 2016 only 1% of records were not available when a patient attended for a pre-operative assessment.
- In theatres we saw that there were working instructions for staff to follow. The instructions provided step by step instructions in areas such as disposal of clinical waste, and positioning of patients. The instructions ensured that staff maintained the safety of patients at all times.
- Computers were available in the wards and theatre areas. All staff had secure, personal log in details and had access to e-mail and all hospital systems. We observed that no computer terminals were left unattended displaying confidential information.
- An information governance audit took place in July 2016 to provide assurances that all areas of the hospital complied with data protection. The audit found four areas that required immediate attention. These included a computer terminal left unattended displaying information and an office door left unlocked. We saw that actions were taken to remediate the issues found.
- Care summaries were sent to GPs on discharge to ensure continuity of care within the community. We saw evidence that when a patient was discharged from hospital they were given a copy of their discharge form and a copy was forwarded to the GP. However, although the patient copy included the type of implant used, we were informed by managers that the GP summary did not include this information about the implant. 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 should be sent to the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a current policy for consent, mental capacity (MCA) and deprivation of liberty safeguards (DoLS). This was available for staff on the intranet.

Good

Surgery

- Staff were able to demonstrate their knowledge of consent and mental capacity and staff told us if there were concerns over a patient's capacity to consent, they would seek further advice and assistance.
- The matron was the lead for mental capacity and DoLS and further advice regarding DoLS was available from a neighbouring NHS trust.
- The hospital used a two-stage consent process, which included a 'cooling off' period to allow patients time to consider the benefits and risks of surgery. From the records we reviewed and from reviewing the cosmetic surgery patient satisfaction survey we saw that the two week 'cooling off' period was being adhered to, and the shortest time between consultation and surgery was 17 days. However, we were informed that the two week 'cooling off' period was not a formalised process, and there was no formal policy to ensure that consultants adhered to the two week 'cooling off' period.
- We saw evidence of two DoLs applications that had been made by the hospital to the local authority. The matron was able to provide us with details relating to each application and explained how the pre assessment document has been changed to ensure that mental capacity of patient to consent to treatment was ascertained prior to admission.
- We reviewed eight sets of records and tracked two patient journeys through to surgery and found that consent was discussed and recorded appropriately in all cases.
- A consent audit was completed in July 2016. The audit examined 20 sets of patient records that included to examine if the consent form was signed, evidence of advised risks given to the patient, advice on additional procedures, and anaesthesia type. The results showed 100% compliance with the consent forms being signed, however only 80% of consent forms were re-completed to confirm consent immediately prior to treatment (second stage check). The audit also found that the type of anaesthesia was only documented in 55% of patient agreements to investigation or treatment. In all other areas the audit scored 100%. We saw that an action plan had been developed to address the findings and re-audit planned to ensure full compliance.

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Are surgery services caring?

Good

Compassionate care

- We spoke with five patients and relatives who all told us that that they were treated with dignity and respect by all members of staff. Patients told us they found the staff polite, friendly and approachable. Comments included. "Staff are fabulous and lovely".
- We observed staff greeting patients on their arrival and introducing themselves. Staff were polite friendly and helpful in their approach.
- We observed that staff respected patient confidentiality and ensured discussions took place in treatment rooms for privacy. All patients we asked reported that their dignity and privacy was maintained throughout their hospital stay.
- Staff made sure that patients' privacy and dignity was respected, including during intimate care. We saw that patients in recovery area of theatres had the curtains pulled around and were nursed on a one to one basis. We saw that the nurses spoke calmly and introduced themselves to reassure the patients following a surgical procedure.
- Patient led assessments of the care environment (PLACE) showed that 73% of patients thought that their privacy and dignity had been maintained during their time at the hospital. This was below the national average, however our observations and patient feedback highlighted that privacy and dignity was being maintained at the time of the inspection.
- Staff supported patients to be mobile and independent post-operatively. We saw that Physiotherapists encouraged patients to mobilise soon after surgery and promoted independence. Patients informed us that they were seen quickly after surgery and rehabilitation started soon after surgery.
- We observed many positive interactions between staff and patients during out inspection. We saw staff approach people rather than waiting for requests for assistance. Staff introduced themselves and were professional and friendly. Patients we spoke with were very positive about the way staff treated them. Patients told us staff were 'excellent', 'friendly', 'fantastic' and 'I have nothing to complain about".

Good

Surgery

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understand their care, treatment and condition. Patients confirmed that staff explained their care and treatment and kept them up to date with any required information.
- Patients and those close to them told us that they were involved in planning and making decisions about their care and treatment.
- Visiting times were flexible on the ward to take into account the needs of the patient's relatives. One patient told us that her family were unable to visit until 9pm and that the ward accommodated this.
- In the June 2016 patient satisfaction survey, 92% of inpatients reported that they were satisfied that they had been involved in decisions regarding their care and 95% reported that they had someone to talk to about their worries or fears.
- The service ensured that advice was given to patients about all possible costs that would be incurred. We saw in the medical notes we reviewed, that all patients received a written quotation for the treatment they were going to have before they decided on the treatment.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment. This was highlighted in the preoperative assessment so reasonable adjustments could be made. For example, an adapted room was available for a patient who was living with dementia.
- Additionally there was a wide variety of information leaflets available in all areas of the hospital to help support patients with particular problems, including pain management.

Emotional support

- In the June 2016 patient satisfaction survey 100% of all patients reported that they were satisfied with the care and attention from nurses.
- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.
- We saw and were told that staff had more time to spend with patients, getting to know them and understanding their anxieties or fears. 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 an anaesthetic and hand holders were present for people having eye surgery to provide additional support.
- 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.
- All patient rooms were private. This allowed for private and sensitive conversations to take place away from other patients or visitors. This also assisted in maintaining patient's dignity but also allowed space and time if the patient required it.
- The psychological wellbeing of patients was discussed as part of the pre-operative assessment for cosmetic surgery. Following discussions with the consultant any patient deemed to require further psychological assessment could be referred to psychology services.

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital followed their corporate admission and discharge policy which outlined the clinical risk assessment criteria for patients. As part of the preoperative assessment process, patients with high risk medical conditions or special requirements would be identified via the Pre-Admission Medical Questionnaire (PAMQ). This helped the service plan care and treatment or identify those patients who may need further assessment or be declined for surgery at the hospital.
- The services provided at the hospital reflected the needs of the population they served, and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including cosmetic surgery, and general surgery. Where the hospital delivered NHS services, the procedures carried out were determined in conjunction with the local clinical commissioning groups to best serve the

local population. The procedures carried out were determined in conjunction with the local clinical commissioning groups to best serve the local population.
- Although the theatres mainly operated Monday to Friday 8am to 9pm, further operating lists were held on Saturdays and Sundays to best meet the needs of patients, and to reduce waiting times.
- The service offered patients access to consultants of their choice, who had practising privileges at the hospital.
- Senior ward staff held weekly bed management meetings, to assess the number of expected patients, ensure sufficient bed space and staffing numbers to meet their individual needs.
- The hospital used care pathways when planning and delivering treatment. This ensured that patients' needs from preoperative assessment through to discharge were taken account of.
- All patient bedrooms were well presented and decorated. All bedrooms had toilet facilities suitable for use with a wheelchair and private bathing facilities. However, although not all bathrooms on the lower floor had walk in showers, there was a separate wet-room available for patients with reduced mobility to bathe on the ground floor if required.

Access and flow

- There were 4,098 overnight and day-case patients admitted to the hospital between July 2015 and June 2016.
- Between July 2015 and June 2016, approximately 50% of all patients were NHS funded, and the remaining 50% were privately insured and self-paying patients.
- The NHS patients were either referred to the hospital via their general practitioners (GP), via the 'choose and book' system, or their care was transferred directly to the hospital from the local NHS trust as part of a local contract to reduce waiting times for patients.
- Patients accessed care and treatment at a time to suit them. Patients we spoke with told us they were given a choice of dates for their procedure, and reported they did not wait long for their surgical procedure to take place.
- The hospital audited the average times it took from admission to theatre which showed the effectiveness of the staggered admissions. The average length of time from admission to theatre was 132 minutes which was significantly better than the Spire average of 155 minutes.
- During our inspection the theatre lists generally ran on time. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements. Staff explained to us that they gave apologies to patients if theatre schedules were running late.
- There were 4,103 visits to the operating theatre between July 2015 and June 2016. Hospital data showed there had been a small number (14) of operations cancelled due to non-clinical reasons. However, all patients were offered another appointment within 28 days. We saw evidence that cancellation of surgery was being monitored by the hospital which included an action plan to improve performance. This included improvements to the pre-operative process with additional take-home instructions regarding starve instructions and medications.
- Between July 2015 and June 2016, referral to treatment times (RTT), within 18 weeks of referral was 94% on average. We were told that waiting times were reviewed by staff, to identify patients approaching the 18 week wait period so that these patients were prioritised.
- The duration of a patient 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. We saw from the care pathways being used that they indicated the usual number of days a patient would remain in hospital following a surgical procedure. Staff informed us that length of stay for patients varied, and that some patients returned home sooner than others.
- In the reporting period July 2015 to June 2016 there had been 12 unplanned transfers of care to other hospitals. The hospital was in very close proximity to a neighbouring NHS trust so transfers could be facilitated quickly if required. The number of unplanned transfers was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- The hospital aimed to discharge 55% of inpatients before 11am to ensure adequate bed space for new patients attending, and to aid flow through the hospital.

Data supplied by the hospital showed that from January 2016 to June 2016 the hospital exceeded the target for morning discharges and performed above the average of other Spire hospitals.

- The hospital also performed better than the Spire average in ensuring patients were discharged before 10am. Performance from June 2015 to June 2016 showed an average discharge rate of 40.6%. This was significantly better than the Spire average of 27.6% for the same period.
- The hospital monitored the number of day case patients who had surgery, and were discharged home within six hours. There was no performance target for Spire hospitals at the time of inspection; however performance figures showed that Spire Regency performed better than the Spire average.

Meeting people's individual needs

- Services were planned and delivered to take account of the needs of different people. Individual needs were considered at preoperative assessments to ensure their needs could be met prior to surgery.
- We saw from records and our observations that staff completed regular observational checks of patients in their care, to ensure that they were comfortable, and to answer any questions they may have. These observational checks also ensured that patient personal hygiene, nutritional, hydration, and pain needs were addressed regularly.
- Patients living with dementia were identified during the pre-assessment stage and a room had been subtly adapted to cater for their needs. For example, the room had a bathroom with a coloured toilet seat of a contrasting colour from the walls, a clock and clear signage. The room also included space for a relative to stay over with them to support their individual needs if required. There were also other resources available such as different coloured towels and pictures of bygone days.
- There were a number of link nurses to help support patients on the ward. These link nurses were trained and had a special interest in a specific area. For example, there were link nurses on the inpatient ward for dementia, diabetes, cancer, pain, cosmetic surgery, and blood transfusion.
- All areas of the ward were wheelchair accessible, and all inpatient bathrooms had level access showering facilities.
- There was an interpreter service available for patients for whom English was not their first language. Staff were aware of the service and how to access it.
- The hospital provided a range of information leaflets about different conditions and treatments and there was a discharge booklet that was given to all patients. The information was in English; however we were informed that other language formats could be available if required.
- The hospital had adapted some facilities to accommodate bariatric patients who were undergoing treatment. This included a modified commode, and a hoist if required.
- The hospital had acknowledged the views of patients following feedback. Patients had requested better parking facilities. The hospital had responded positively by building an additional 17 parking spaces and planning permission had been submitted to build a further 24 spaces to address patient feedback. In addition, 14 off-site parking spaces were also rented for staff to park, to maximise the parking available for patients. We saw that this information was displayed on notice boards in the hospital.
- For those patients who had received facial surgery, the service had introduced a system to ensure the housekeeper met with the ward sister to discuss patient dietary requirements. This was introduced following feedback from patients who had under gone facial surgery and reported it was difficult to chew.
- Upon discharge, nurses gave patients a direct telephone number to the ward in their discharge pack. Patients could call this number and speak to a nurse, if they had any concerns.

Learning from complaints and concerns

- Patients were advised on how to make a complaint or raise concerns. We saw that information for raising issues was included in the patient folders in each room.
- There was a Spire leaflet entitled 'Please talk to us'. These leaflets explained to patients how to raise concerns or complaints. There were also posters on display which asked for feedback. Patient discharge surveys were available where patients could raise concerns. A review of the discharge survey had taken place and we saw that actions had been taken to

improve. This included the ward to provide pain leaflets to patients and free post envelopes for patients who wished to post inpatient satisfaction surveys to increase the number of respondents.

- Patients we spoke with reported that they knew how to complain if they wished to do so.
- From July 2015 to June 2016 the hospital had received a total of 34 complaints. This was a reduction year on year from 2013.
- The assessed rate of complaints (per 100 inpatient and day case attendances) is similar to the rate of other independent acute hospitals that CQC hold this type of data for.
- There was a Spire corporate complaints policy. The hospital director had overall responsibility for the management of complaints. All complaints were investigated by the head of department or senior managers of the hospital.
- Complaints were acknowledged within 48 hours of receipt of the complaint, in writing. The complaints process and what the complainant could expect was explained within the acknowledgment. The service then had 20 working days to investigate the complaint. If the complaint was complex and would not be completed within 20 working days a holding letter was sent to the complainant so that they were kept informed.
- The hospital 20 day timescale in responding to individual complaints was measured via a performance indicator. The data supplied by the hospital showed that from January to March 2016, 89% of complaints were completed in the timescale. This was better than the hospital target of 75% and the Spire group average of 71%. From April to June 2016 compliance in responding to complaints within the 20 days improved to 100%. Again this was better than the hospital target and above the Spire average of 88% for the reporting period.
- Complaints, in terms of the timeliness of the acknowledgement and response, were well managed. However, we saw limited learning as a result of complaints, and raised some concerns about the transparency of the responses to some patients. We reviewed six complaints and found a case where a complaint had been raised by a patient's husband, and a response given directly to him without obtaining consent from the patient. We asked about the normal procedure for obtaining consent but staff were not able to provide any recorded evidence demonstrating this, as outlined in the hospital policy. On the unannounced inspection we found a review of the processes had been undertaken and a robust recording system in place for obtaining consent introduced.

Are surgery services well-led?

Good

Vision and strategy for this this core service

- The hospital had a clear vision and strategy which set values, with quality and safety as top priority. The hospital's vision was to be recognised as a world-class healthcare business, with a focus on developing excellent clinical environments and delivering the highest quality patient care. We found the hospital strategic direction was well described by the senior management team.
- We saw that the vison and strategy was displayed around the hospital and staff we spoke with were aware of the vison and strategy. Staff appraisals were linked to the hospital values that included caring is our passion, succeeding together and driving excellence.
- Alongside the corporate vison and strategy the hospital had set its own objectives based upon areas of improvement. We saw that these included improvements for teams to work well together resolving challenges, and supporting each other to deliver excellent patient care, embedding best practice.
- There was a clear corporate statement of purpose that set out the core values and what patients could expect during a visit to the hospital. These included access to a doctor 24 hours a day if required, and being treated with respect, privacy and dignity irrespective of gender, colour, race, ethnic or national origin, religion or belief, sexuality, disability, marital status or age.
- There was a strategy for continuous improvement in infection prevention and control. We reviewed the 2016 annual plan and saw that action plans were in place as part of their ongoing strategy. Each action had an assigned lead, a due date and updates where relevant. The devised plan had a multi-disciplinary approach and included microbiology consultants and pharmacists.
- We discussed the production and implementation of the Quality Accounts and associated improvement

priorities. We were told that this was largely co-ordinated by the group corporate team. The priorities, however, were recognised by the matron and examples were given of how they have been progressed.

Governance, risk management and quality measurement

- There was a clear committee structure to support governance and risk management. The quality of the committee minutes and attendance was however variable and did not always provide evidence learning to be shared.
- The medical advisory committee (MAC) was poorly attended. The committee chairman told us of the difficultly in challenging the poor attendance of the consultants.
- There was limited evidence of discussion and challenge around risks at both the clinical governance committee and the health and safety and risk committee. There wasn't a clear system for tracking actions from the meetings and monitoring completion against these. However, on the unannounced inspection we saw that the management team had developed a system to monitor actions and timescales from meetings to ensure they were tracked effectively.
- There was a revised risk register in place which identified appropriate risks for the hospital. There was still work to do in terms of agreeing target risk ratings and identifying actions to mitigate all risks. Senior managers were aware that this was an improvement area and felt that they were well supported to do this. Senior managers reported the next stage for the hospital was to start embedding the process at committees, followed by the clinical teams. On the unannounced inspection, there was evidence that the risk register was now included as a standard agenda item at the MAC meetings and an action plan had been developed to ensure that all risks specific to the hospital were completed.
- Patient safety alerts issued by NHS Improvement were circulated for local action by the National Clinical Governance and Quality Committee. New safety alerts were also discussed during theatre departmental meetings and displayed on the staff notice board.
- Managers at all levels understood their responsibilities to ensure and protect the safety of patients from harm. Local safety standards for invasive procedures (LocSSIPs) were in place to ensure staff were competent; records kept of procedures carried out, and patient records reflected the procedures completed. We saw that effective team working had been developed and staff were aware of their roles and responsibilities. We also saw that checklists were performed to protect against wrong site surgery and auditing took place to check performance and compliance.
- We saw evidence that the ward and theatres had risk assessments in place. On the ward we saw the top three risks were displayed for the staff to refer to. Team meeting minutes highlighted risk assessment updates and adverse events so to share learning. For example the theatre team meeting minutes highlighted ten new risk assessments and discussed 12 adverse events with learning points.
- 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. The hospital did not currently use electronic patient records for patients undergoing cosmetic surgery, so was not yet considered relevant at this time to the hospital.
- The hospital had a clear set of performance indicators that were used to measure quality. The clinical score cards were collated quarterly and disseminated and referenced against other Spire hospitals. From the quarterly scores areas of improvement could be identified and action plans developed. From our discussions with the departmental managers and senior managers, we saw that there was a good understanding of their department performance.
- We saw evidence on the unannounced inspection that the hospital management had taken action that all incidents were appropriately categorised to ensure duty of candour legislation was being met.
- A clinical governance and quality report was produced by Spire to report findings from all hospitals which aided

benchmarking. We saw that the report was set out using the five CQC domains and reviewed performance of each hospital. The report highlighted areas for improved practice and areas of learning.

- We saw evidence from clinical governance meetings that a set agenda item included discussions with regards to patient transfers, unplanned readmissions and unplanned returns to theatre. The minutes documented discussions with actions and lessons learnt. We saw that key learning points and lessons learnt were also discussed in theatre and team meetings to ensure all staff were aware of adverse events.
- The hospital had a schedule of annual audits with associated timescales. Audit reports were reviewed locally at clinical governance meetings and Medical Advisory Committee (MAC) and the results were shared with staff through the heads of department.
- Staff were clear about their roles, and understood what they were accountable for. Staff were aware of the limits of their practice and escalated issues that arose which were beyond their professional competencies. We saw that the management teams of theatres and ward worked well. The manager of theatres was of a non-clinical background and the deputy was from a clinical background. There were clear lines of role and responsibilities and the working relationship was positive.
- We saw that actions had been taken to improve performance in the PLACE audit. These included enhanced facilities for patients living with dementia and an improved menu for patients to choose from.
- Working arrangements with partners and third party providers were well managed. Each Service Level Agreement (SLA) had a process of review which was monitored. We saw that SLA's were held for pharmacy, pathology, blood transfusion and emergency transfer of adult critically ill patients to NHS.
- Meetings with the clinical commissioning groups (CCG) were held quarterly. Senior managers informed us that meetings were positive. The CCG meetings were also used as a forum to explore how the hospital could support local hospitals and community services, reducing waiting times and making improvements in community health. For example we were told that consultants attended local GP clinics and provided training to GPs in order that the service they offered was tailored to the local community.
- Managers we spoke with were conversant in understanding that all staff working under practicing privileges were required to provide evidence that they had the appropriate level of indemnity insurance, which included external first assistants and deputies in their absence. Senior managers informed us the Medical Advisory Committee (MAC) had oversight for reviewing applications for consultants and external assistants.
- Action was taken to ensure that consultants working under practicing privileges adhered to the consultant's handbook and operational policies. Their practising privileges were formally reviewed every two years. The review looked at compliance with the consultant's scope of practice, satisfactory annual appraisal and revalidation, and compliance with the consultants' handbook. We saw evidence that from the 132 consultants working under practicing privileges, 20 had their practising privileges removed. Seven of these were due to consultants not complying with working to the consultants' handbook and operational policies.
- The hospital undertook an external health and safety audit in 2015. Results from the audit found a compliance rate of 97.7%. The audit found two areas for improvement which included the need for emergency table top exercises and the necessity to date risk assessments. We saw evidence that the two learning points had been addressed by managers of the hospital.

Leadership / culture of service

- The senior managers had the skills, knowledge, experience and integrity that they needed to lead effectively. The hospital was led by a senior management team, the hospital director was new to the hospital, however he was aware of the current performance and direction of the hospital.
- We saw during the inspection that there was a board to ward assurance system in place. Staff were aware of the management structure and who they were accountable to. The hospital had a new hospital director; there was a senior management team and departmental managers who managed specific areas of the hospital.
- The matron that provided the overarching management to the ward and theatres was skilled, knowledgeable and professional. Views from all staff we spoke with highlighted that staff found her supportive, visible and approachable.

- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.
- We saw that leadership of the service was extremely good; there was excellent staff morale and all staff told us they felt supported at ward level. Staff told us the management team had an 'open door' approach, and were available to provide advice and guidance as needed.
- All staff we spoke with felt respected and valued. Staff told us that the service was 'like a family' and that everyone was supported and respected. Through regular appraisals staff were encouraged to develop and maximise their potential.

Public and staff engagement

- There was a system in place to obtain patient views, for example patient surveys. Whilst feedback was overwhelmingly positive, the response rates were poor for the friends and family test at 15% overall (July 2016). The hospital had recognised this and was currently recruiting to a patient experience position with one of the aims being to improve response rates.
- Patients' views and experiences were gathered and acted on to shape and improve the services and culture. We saw that posted on the wall were 'you said, we did' notices. The hospital had actively listened to feedback from the patients and we were informed that due to issues raised around parking an additional 17 parking spaces had been built and planning permission had been submitted to build a further 24 spaces to address patient feedback. In addition, 14 off-site parking spaces were also rented for staff to park, to maximise the parking available for patients.
- We saw that the hospital had a website that captured the views of patients following an appointment. Views on the website showed both positive and negative view points from patients. A negative comment was posted with regards to parking issues and positive comments included thank you messages left for staff and consultants.
- The service used the friends and family survey and patient-led assessment of the care environment (PLACE) audits to gain feedback on patients' experiences. The friends and family test is a survey designed for NHS patients to gauge feedback from patients about the quality of service and whether patients would recommend the service to their friends and family. The hospital was in the process of appointing a customer experience manager to further improve the patient experience.
- A staff survey had been completed in 2015. The results showed that there was a response rate of 59%. The report showed that 86% of staff felt fully engaged in their work which was a 7% increase from the survey completed in 2014. The report also highlighted areas for improvement. For example the survey showed that only 42% of staff felt that they worked together. We saw an action plan had been developed to address areas for improvement. This included addressing improvements with teams working together.
- The hospital had an inspiring people nomination and awards programme to celebrate and reward those staff members who had worked above and beyond their role. We saw from the awards in September 2016, four staff had been nominated. The nominations included for the devotion and care given in supporting a patient with dementia and his wife.

Innovation, improvement and sustainability

- When considering developments to services, the impact on quality and sustainability was assessed and monitored. The hospital held regular quarterly meetings with the Clinical Commissioning Groups (CCG) to discuss current performance and to discuss future direction of the hospital. We were informed by senior managers that the hospital was looking at ways to deliver care closer to the patient's home. This would involve consultants running satellite clinics from GP surgeries to provide services closer to home for patients.
- The hospital had a programme of education with local GP's to enhance knowledge in three identified specialities through a series of interactive learning events throughout 2016/2017. The three identified speciality areas included Ears Nose and Throat (ENT), Gynaecology and Urology. The educational events were to be delivered by specialists in the identified fields and tailored towards the enhancement of GP knowledge with a view to improving current processes and pathways.
- We were informed by senior managers that there were no examples of where financial pressures had compromised patient care. There was evidence that maintenance and replacement schedules were in place

for equipment and through regular engagement meetings with the CCG's they were able to understand the changing patterns of care needed for the future direction of services required.

- In theatres the manager informed staff of the costs for repairing equipment following breakages. This was to raise staff awareness of the service costs following accidental breakages. We saw evidence in the theatre team meetings that costs of repairing items such as a microscope were discussed.
- We saw that leaders and staff strived for continuous learning, improvement and innovation. Many of the staff we spoke with had worked at the hospital for many years in junior positions, and had worked their way up to more senior roles. All staff we spoke with reported that the hospital developed staff and supported their training needs

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- There were 57 clinical and five non-clinical incidents in the outpatients department (OPD), diagnostic imaging and physiotherapy departments which were recorded as low harm or no harm incidents. The rate of clinical and non-clinical incidents was similar to the rate of other independent acute hospitals we hold this type of data for.
- There was an electronic system for the recording of incidents. Staff were aware of how to use it and were happy to do so. Staff told us that they received feedback following incidents during team meetings and through newsletters.
- Staff talked about an incident that had occurred and how they had changed practice as a result. A patient was asked to stop taking a specific medicine before a procedure but they had not stopped taking it. To prevent such an incident recurring, the hospital introduced a checklist which patients had to sign to say that they had complied with instructions given at the surgery pre-assessment.
- There was a monthly safety bulletin that included shared learning from incidents from other Spire hospitals. This was shared with staff in the OPD and in diagnostic imaging. It also contained any new National Institute of Health and Care Excellence (NICE) guidelines, corporate policy updates, medical device alerts, and drug and safety alerts.
- Staff had an understanding of the duty of candour and how it applied to them. 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.
- There had been one reportable radiation incident to CQC when a patient had been over-exposed to radiation during a procedure. The incident was reported immediately through the electronic incident recording system and the patient had been asked to return to the hospital. An explanation and an apology was given and a letter was sent to the patient, so the duty of candour was followed. Lessons learned from the incident were shared with other Spire hospitals.
- The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor (RPS), who in turn would log the incident on the hospital's electronic incident reporting system. The rules and policy set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive. We saw that these had been signed and dated appropriately.

Cleanliness, infection control and hygiene

- The environment in OPD, diagnostic imaging and physiotherapy was visibly clean and tidy. There were daily cleaning schedules in every room that were signed and dated.
- The OPD, diagnostic imaging and physiotherapy departments performed handwashing audits every three months and were 100% compliant in the period

April – June 2016 and July – September 2016. The infection rates for the OPD were 0%. This included methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-Sensitive Staphylococcus Aureus (MSSA).

- There was an appointed lead for infection prevention in the OPD who attended hospital meetings and communicated information to staff. There were link staff for infection control in each area and the radiographer infection control link was also the radiation protection supervisor.
- Hand gel was available in all areas of OPD and diagnostic imaging including the patient waiting areas and at the front reception desk. Personal protective equipment was also plentiful in all appropriate areas.
- Procedures were in place for any patient with an infection such as methicillin resistant staphylococcus aureus (MRSA.) These included booking the patient into the last appointment in the clinic so that the room could be cleaned following treatment. There was also information available on the cleaning procedures for the different infections.
- Equipment in diagnostic imaging had "I am clean" stickers. All the curtains in the department were disposable and were appropriately dated.

Environment and equipment

- There were resuscitation trolleys available in the treatment areas of the OPD and diagnostic imaging. There was also a trolley on the second floor for patients attending the physiotherapy services. Records indicated that trolleys were checked daily, signed and dated. The expiry dates for medicines and equipment were highlighted with marker pens to make them easier to read.
- There were trolleys for the resuscitation of children and young people which contained appropriate equipment and medicines. These were available in areas where children and young people were treated and records indicated these were checked daily.
- Minutes of senior management team meetings showed that servicing and maintenance contracts were in place for equipment in the OPD, diagnostic imaging and physiotherapy departments.
- The OPD nurses had put together a book which listed the requirements for each consultant; this included the equipment needed in each clinic room, the room set up and any equipment or anatomical models needed in the room. This helped staff who might not have worked with that consultant before and ensured that clinics ran smoothly.
- Sharps boxes were stored appropriately and there was an audit of sharps which was done every six months. This showed 100% compliance for the period April 2016 to September 2016.
- There were radiation protection measures in place in the diagnostic imaging department. There was a radiation protection supervisor (RPS), the RPS is appointed by the employer and the role of the RPS is to ensure compliance with the ionising radiation regulations.
- During the inspection we saw that staff were wearing dosimetry badges and that lead aprons were available.These protect the staff when they undertake diagnostic radiological procedures.
- We looked at equipment arrangements for mammography in the outpatients department. Mammography is a technique using x-rays to diagnose and locate tumours of the breasts. Records indicated that mammography equipment was checked in order to maintain its safety and reliability.

Medicines

- Medicines were stored appropriately in OPD and diagnostic imaging. We checked fridge temperature records and saw that they had been appropriately completed and that checks had taken place. There were records of daily fridge temperatures and room temperatures. If the temperature went above 25°C, the air conditioning could be turned on to reduce the room temperature. If the room temperature increased or there was a fridge failure there were protocols in place for staff to follow. This information was kept in a folder in each room. Most medicines should be stored at a temperature below 25°C but some medicines require special storage and need to be kept in fridges, this is because they can become toxic or less effective at higher temperatures.
- We checked medicines in the treatment room and all the medicines that we checked were correctly stored and in date.
- NHS prescription forms, used by consultants, were securely stored in a locked cupboard.
- There were no controlled drugs stored in the OPD, diagnostic imaging and physiotherapy.

Good

Outpatients and diagnostic imaging

Records

- Records were paper based and were never removed from the hospital site by clinical staff. Records management was part of the mandatory information governance training for all staff including consultants.
- Patient records were stored securely in lockable trolleys in the OPD, radiology and physiotherapy when in use. At other times, records were stored securely in the hospital and records not in use were stored at a national distribution centre. Records were obtained 48 hours before the patient's appointment in clinic, but could also be transported overnight if necessary to arrive at the hospital by 7am.They could also be securely faxed to the hospital if absolutely necessary.
- In the three months before the inspection, 1% of medical records were unavailable for patients being seen in the OPD. This meant that for the vast majority of the patients seen in the OPD clinics the consultant had the patient's full medical history available.
- The hospital had a tracking system for patient records and the location of medical records was recorded at all times. Any correspondence such as clinic letters produced internally were copied and filed onto a secure central computer drive and could be retrieved by the medical secretaries if necessary. These could be made available for consultations if the full record was unavailable.
- We looked at patient records, in one set we saw that safeguarding considerations at pre-operative assessment had been noted and there were pre-surgery patient instructions. Allergies were noted and medicines recorded with an appropriate alert sticker. Consent was recorded and the record was legible, dated and timed and signed appropriately. In another set of records, allergies were recorded and the records had been followed up post–operatively with outcome forms completed. The record was legible and dated and timed and signed appropriately.

Safeguarding

- There were no safeguarding concerns reported to CQC in the reporting period (July 2015 to June 2016).
- The matron was the responsible person for safeguarding vulnerable adults and children and young people. The responsible person takes the lead for safeguarding in the organisation. The matron was also the safeguarding children's lead who would receive a concern from an alerter and on receiving information they would immediately review it and begin any necessary action. The matron reported to the hospital director who was the safeguarding manager. They were the designated persons who managed the safeguarding process. The deputy safeguarding children's lead was the clinical support services manager and the lead registered children's nurse was the bank registered sick children's nurse (RSCN.)
- Staff knew how to make a safeguarding referral and there were safeguarding link staff in each department who attended meetings and disseminated information down to departments. These staff were a point of contact for other staff who had any safeguarding concerns.
- There were monthly meetings, led by the safeguarding lead and they had invited outside speakers to the meetings to show how the organisation could play its part in safeguarding in the local community.
- In the OPD and diagnostic imaging there was 100% compliance with level three safeguarding training for children and young people for all eligible staff; in physiotherapy there was 71% compliance with the level three training.
- All staff were trained to level two for safeguarding of children and young people in OPD, diagnostic imaging and physiotherapy.
- The consultants were also undergoing training for level three in safeguarding for children and young people, 56% of them had received training and all the other consultants were booked onto training before the end of December 2016. If they did not complete this training, their paediatric practising privileges would be suspended until evidence of training was provided. The paediatric consultants both had level three training in safeguarding for children and young people.
- The paediatric consultants said that they were well supported by matron and would speak with them if they had any issues.
- The hospital had links to the local safeguarding board through the safeguarding children's lead and the matron attended appropriate meetings.
- There was a folder in the OPD containing relevant safeguarding information about children for staff.
- The matron told us that female genital mutilation (FGM) was introduced into mandatory training every year for all staff when the new reporting requirements came into

place in November 2015. .FGM had been a topic at one of the lunchtime safeguarding meetings. Information had been disseminated to the consultants though FGM was not yet included in the adult safeguarding policy.

Mandatory training

- All staff in OPD, physiotherapy and diagnostic imaging had completed their mandatory training before the inspection. This included fire, manual handling, safeguarding training, information governance training, and health and safety. This training was done through e-learning.
- The life support training (basic, immediate, advanced and paediatric) was done face to face. Diagnostic imaging staff were trained in immediate and paediatric life support skills and all staff were up to date with this training.
- The physiotherapists had undergone training in the use of medical gases and there was 100% compliance with this training.

Nursing staffing

- There were 6.2 full time equivalent (FTE) nurses and 4 FTE health care assistants which gave a ratio of nurse to health care assistant of 1.6 to 1. This meant there was always a qualified nurse in the outpatient department who was supported by the health care assistants. We saw staffing rotas which supported this and staff told us that there was always a qualified nurse in the outpatient department.
- The use of bank and agency nurses working in outpatients was below the average of other independent acute hospitals that we hold this type of data for during the reporting period (July 2015 to June 2016). There were no bank or agency nurses working in outpatient departments in the last three months of the reporting period (July 2015 to June 2016). The hospital had its own bank staff including a registered sick children's' nurse (RSCN) who completed pre-surgery assessments on young people aged 16-18 years.
- The sickness rates for nurses working in outpatient departments was higher than the average of other independent acute hospitals that we hold this type of data for in the reporting period (July 2015 to June 2016) apart from in June 16.
- The sickness rates for outpatient health care assistants was variable during the same period. The rates were higher than other independent acute hospitals we hold this type of data for in three of the months in this period.
- Staff turnover for nurses working in outpatient departments was above the average of other independent acute hospitals during the reporting period (July 2015 to June 2016). There was no staff turnover for health care assistants in outpatient departments during the same period.
- One of the staff nurses completed the staffing rota to accommodate the needs of the OPD clinics. Many staff were flexible and worked as required.
- Nurse staffing was planned appropriately so that the skills and competencies needed to support the clinics were available. For example, staff told us that a nurse trained in paediatric trained life support would always be on duty if there was a paediatric clinic and a breast care nurse would be available if there was a breast clinic running.

Medical staffing

- See information under this sub-heading in the surgery section.
- There were 132 consultants, including a number of radiologists, with practising privileges at the hospital. All OPD clinics were consultant led.
- The diagnostic imaging service saw very few paediatric patients though a paediatric radiologist was available if necessary. There were two consultants with practising privileges to treat children in the outpatient department. One was a consultant dermatologist who performed the minimally invasive procedure cryosurgery; and the other was a consultant paediatrician who performed allergy testing. The patients treated were private patients.

Allied Health Professionals (AHP) staffing

- There were four radiographers in the diagnostic imaging department; one had recently been appointed whose skill set included dual energy x-ray absorptiometry (DEXA) scanning to measure bone density.
- There were five physiotherapists. The manager of the service was full time and the other physiotherapists worked varying hours. Two bank staff were available to work at weekends dependent on demand.

Assessing and responding to risk

Good

Outpatients and diagnostic imaging

- Staff knew how to contact the consultants or the resident medical officer (RMO) if there was an emergency in the department.
- The hospital did not use the World Health Organization (WHO) surgical safety checklist in OPD when undertaking minor procedures. However, as the hospital was beginning to undertake more complex procedures they were considering introducing it. The WHO checklist was designed for use in an operating theatre as a safety checklist to reduce the number of potential incidents during surgery. The OPD used a care pathway for pre-operative assessment. This contained information on the procedure, post-operative follow up, discharge information, RMO and consultant instructions, multi-disciplinary progress notes and a record of any variance or problems.
- There were emergency call buttons in each OPD room and treatment area so that help could be summoned if necessary.
- Paediatric environmental risk assessments were carried out for each room and kept in the files with the folder for each room which showed that measures were in place to reduce the environmental risks to children. For example, there where radiator covers in the OPD rooms and in places were children were treated to prevent them burning themselves.
- Adrenaline was available in diagnostic imaging if patients had an allergic reaction to contrast media. This was appropriately stored and was found to be in date.
- There were signs in the diagnostic imaging department asking patients to inform staff if they thought that they might be pregnant. The staff also asked patients their pregnancy status before delivering any radiological testing. This was audited by the hospital and in the previous three months before the inspection there was 95% compliance, which was in line with the 95% target for the hospital. In the previous six months there was 100% compliance with this target. Staff gave examples of how they had minimised dosage to patients who were pregnant.
- The radiographers told us that very few mobile x-rays were undertaken on the ward to reduce the radiation risk to staff and patients.
- To stop patients and staff entering rooms where diagnostic imaging was taking place there were clear, illuminated; “radiation in use” warning signs in place by doors leading into any area where radiation equipment was used.
- Staff described how they had supported a patient who had an asthma attack and telephoned for an urgent GP appointment for the patient.

Major incident awareness and training

- See information under this sub-heading in the surgery section.
- Staff we spoke with were aware of the policies and procedures that related to major incidents and had been involved in evacuation exercises on at least two occasions in the last year.
- The hospital had a visit every year from the local fire and rescue service who gave advice on fire safety and evacuation procedures.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

- We saw a monthly bulletin that highlighted new clinical guidance including guidance from the National Institute for Health and Care Excellence (NICE)
- We were told by the clinical support services manager for the outpatients department (OPD) that NICE guidance was disseminated by email and was then discussed at staff meetings; there was a voting button on the email so that managers could acknowledge that they had received new guidance.
- The physiotherapy department and diagnostic imaging department participated in a number of audits including an audit of imaging referral forms, a pregnancy test audit before exposure to radiation, a mammography peer review and an audit of record keeping in physiotherapy. The pregnancy test audit showed that the diagnostic imaging department achieved 100% or 95% in this audit which was every three months. The target for this audit was 95%.
- The physiotherapy manager told us that new guidance was fed down to the team and incorporated into operational policy. This was done within seven days of receiving the new guidance. Staff told us that standard operating procedures were regularly reviewed by consultants and physiotherapists.

- The department had done an audit on fainting following hysteroscopy procedures as staff had observed that this had happened to a number of patients. The audit had shown that the fainting was not linked to one consultant but the hospital was going to increase the numbers of patients audited because they felt that the sample size for the audit was not big enough to give enough evidence for the cause of the fainting.
- The manager of OPD and diagnostic imaging said that the consultants were keen to develop new services in minor surgery and were using appropriate guidance to develop these services. These included the removal of lymph nodes less than a centimetre in diameter.

Pain relief

- See information under this sub-heading in the surgery section.
- Pain relief was discussed with patients at the pre-operative assessment and patients were provided with information leaflets about pain control following surgery and 24 hour contact details so that they could contact the hospital if they were in pain.
- Patients could discuss their pain control with their consultant when attending their review clinic in the OPD. Pain control was part of the patient survey and patients were asked "to what extent do you think that staff at the hospital did everything they could to control your pain". The results of the survey showed that patients needed written information and the pain leaflets had been produced as a result of the survey.

Patient outcomes

- The physiotherapists were working with the pre-assessment nurses for patients requiring orthopaedic surgery to assess their rehabilitation needs and any equipment needs that they may have. Patients received a standard package of equipment and staff worked with voluntary sector agencies to ensure that patients received appropriate equipment or could purchase appropriate equipment.
- Staff in physiotherapy had audited patient records and found that the measurement and recording of patient outcomes was low. They had put in measures to address this and were using the Oxford scale to record the assessment and progress of treatment. They were also using SMART goals, where patients worked with staff to identify targets and goals and to work towards them. This showed whether or not the physiotherapy treatment had made a difference to the patient following surgery.
- Pain measurement was also used as an outcome measure before and after surgery and the use of functional performance in activities was also used as an outcome measure. This showed whether or not surgery had reduced the pain experienced by the patient before surgery and if they were able to partake in more activities following surgery.

Competent staff

- See information under this sub-heading in the surgery section.
- There were training opportunities for staff in the OPD who could request external training as part of the appraisal process. These training opportunities had to meet the aims and objectives of the hospital and support the development of existing and new services. An example of this was where a nurse had completed a three day first aid course. This was to support staff and patients in the OPD and diagnostic imaging department if they had a minor injury.
- The link nurse system was part of development for staff who had an interest in a specific area. For example, safeguarding, dementia, infection control.
- The health care assistants (HCA) were undertaking national vocational qualifications (NVQ) to level two. One had now done training to level three in pre-operative assessment, and now performed pre-operative including the completion of venous thromboembolism assessments prior to admission.
- Consultants working in the department were doing so under the practising privileges of the hospital (see surgery report for details).
- Appraisals and completion of mandatory training were linked to the pay review process and at the time of the inspection all appraisals had been completed. The appraisal system was called "enabling excellence."
- There was a revalidation folder in the OPD to support nursing staff in the revalidation process. The folder contained documentation relevant to the process, a copy of the code of the Nursing and Midwifery Council (NMC) and advice on how to gather the evidence required for revalidation. It also contained information on networks and websites where nurses could find

useful information. In the OPD, 22% of the nurses had revalidated their registration in 2016. This was the total number who were required to revalidate at the time of inspection.

- Staff undertook phlebotomy training at the nearby NHS hospital trust and all staff had completed their training there. A new starter in the department was booked on the training for December 2016. The physiotherapy staff said that there were good training opportunities for staff and that the organisation was good at developing people.
- Diagnostic imaging staff reported good clinical development. They said that they were able to access external training and attend meetings with other radiographers from NHS trusts.
- There had been training for the completion of risk assessments at departmental and at hospital level.
- All the qualified staff we spoke with in the diagnostic imaging department and physiotherapy department told us they were registered with the Healthcare Professionals Council (HCPC).

Multidisciplinary working

- All staff described good working relationships with the consultants and staff said that they felt able to ask for advice or information if necessary.
- The physiotherapists were working with the pre-assessment staff in the OPD to assess patients' requirements before surgery took place.
- Consultants had been asked to complete a satisfaction survey about the physiotherapy service. This was positive as there had been good feedback from the consultants about the service.
- Radiographers described good working relationships with the radiologists.
- The hospital had started to do ultrasound guided joint injection procedures and radiographers were working with surgeons to facilitate this.
- The radiographers told us that they attended the multi-disciplinary team breast meetings for patients with breast lumps if they felt it was appropriate.

Seven day services

- There was a physiotherapy service on Saturdays which was run by the physiotherapy staff till 4pm. If patients required physiotherapy on Sunday following surgery on Saturday, this was provided by bank physiotherapy staff.
- The diagnostic imaging service ran from 8am to 8pm with an on-call service at night and weekends.

Access to information

- In the OPD there was a daily communication diary to cascade information to staff; this was a useful communication tool for staff who may not have been on shift the previous day.
- There were computers available around the departments so that staff could access the hospital intranet and other information. Consultants we spoke with had access to the records and information that they needed including diagnostic imaging test results.
- There were computers available in diagnostic imaging for the viewing of images through the electronic system. These could be shared with other hospitals and medical practitioners as necessary.
- Radiology images were digitally recorded and stored and were available at all times to appropriate members of staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Clinical staff had undergone training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). This was part of role specific mandatory training and there was 100% compliance in the OPD and in physiotherapy. There was 88% compliance in the diagnostic imaging department.
- There was a safeguarding link within each department who met monthly and discussed issues including DoLS and the Mental Capacity Act. This was then fed back to staff in the department.
- Following an incident in surgical pre-assessment staff had devised a form called "safeguarding considerations", this was in response to a patient presenting for surgery who was subject to a DoLS and the hospital had not been informed.
- In the two records that we reviewed consent was recorded appropriately and patients received a duplicate copy of their consent form. At the time of the inspection, the department did not audit consent for minor surgery but this was due to begin in January 2017.
- Staff told us that face to face translation was always used when consenting patients for treatment where English was not their first language.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- We observed good interactions between the nursing staff and the health care assistants (HCA's) and patients. Staff were friendly but respectful.
- Reception staff were very caring towards patients; they were patient and courteous and respected confidentiality, privacy and dignity. There was customer care training for front line staff which had been completed by all the appropriate staff.
- Patients we spoke with said that the care was excellent and that they were glad that they had attended the hospital. A patient we spoke with said that it had been recommended by a friend and they were happy with the service.
- We saw cards and letters from patients thanking staff and there was positive feedback on social media and NHS choices.
- The department were using the 6C's – care, compassion, courage, communication, commitment and competence as values in the department. The 6C's are values and behaviours that were part of "compassion in practice" a vision and strategy for healthcare staff, an NHS document. Part of mandatory training included a module called compassion in practice, all staff in the OPD, physiotherapy and diagnostic imaging departments were 100% compliant with this training.
- The changing rooms in radiology supported privacy and dignity as patients had very short distances to walk to the treatment areas from the changing areas and each area was curtained off. The changing areas contained a lockable cupboard for patients' belongings.
- Diagnostic imaging staff said that they were able to take a holistic view of their patients and there was good continuity of care, one patient said that it was "like having a spa day" when visiting the department.

Understanding and involvement of patients and those close to them

- Staff in the department communicated with people about their care and treatment in a way they could understand and carers were involved in any discussions as necessary.
- The hospital used a number of patient satisfaction surveys, refer to surgery core service.
- There was a questionnaire to follow up patients who answered that they could have been more involved in decisions about their treatment; or who answered that they did not find someone on the hospital staff to talk to about worries or concerns. This information was used at relevant committee and departmental meetings.
- If a patient was considering bariatric (weight loss) surgery they were given a consultation with the lead nurse for this type of surgery. Patients could then make an informed decision about future treatment. This was provided free of charge. This surgery was provided for private patients only.
- There was a paediatric questionnaire to ask both children and their parents if the child's consultant spoke to each child with respect and explained their condition and/or treatment in a way they could understand. We saw feedback from this was positive.

Emotional support

- Some clinical staff had received additional training in cancer support and breaking bad news. We saw rosters that showed that these staff were always available in appropriate clinics, for example, breast clinic to support patients if necessary.
- There was good continuity of staff in the OPD, diagnostic imaging and physiotherapy and patients generally saw the same members of staff, staff liked this and said that patients found this reassuring.
- If patients became upset there was a quiet room where they could sit and have refreshments until they felt able to leave. The hospital would provide a taxi if necessary to get the patients home. One patient had returned to the hospital to thank them for their support when they received bad news.
- All patients we spoke with told us that they were able to telephone and speak to relevant staff after discharge, for help and advice. Appropriate literature was provided to patients with telephone contact details at the hospital. This was available 24 hours a day.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- The waiting areas in the outpatient, diagnostic imaging and physiotherapy departments were comfortable and the environment was calming; there was raised seating for orthopaedic patients and patients were able to be seated close to their consulting room. Tea, coffee and water were available for all patients. The waiting areas were the same for NHS and private patients.
- The department strived to continually improve their services, the hospital was engaged with the commissioners to increase the range of services that they could offer to NHS patients. They were also working with consultants to deliver new services to all patients including additional minor surgery procedures performed in the OPD.
- Some of the OPD rooms were designated to a clinical speciality as they had specific equipment in them for treatment, this included ear nose and throat and ophthalmology.
- The staff who were on duty for the day were named on a board in the OPD and there was a chart of uniforms that indicated the job title of the individual wearing that uniform. This meant that patients knew what the roles and titles of the staff treating them were.
- There was a one stop service for orthopaedic patients so that they could have their consultation, pre-operative assessment and physiotherapy review carried out on the same day. Patients would then be listed for surgery and did not have to return to the hospital until the day of their surgery.
- The paediatric OPD service was limited to outpatient consultation and non-invasive treatment for children from 3-16 years, though there were two exceptions to this – a consultant paediatrician was permitted to perform allergy testing in outpatients on children aged from birth onwards and a consultant dermatologist was permitted to perform cryotherapy on 3-16 year olds. Both consultants were supported by a nurse who had paediatric life support training in clinic. One of the paediatricians would undertake phlebotomy on children. These services were for fee-paying patients.
- A physiotherapy service was provided by the hospital. It operated from 8.00am every morning except Sunday to 7pm on a Monday, Thursday 4pm on Tuesdays, Wednesdays and Fridays and till 4pm on a Saturday. There was a service available on Sundays if patients needed it.
- Most of the physiotherapy activity was following surgery (80%) though there were some private patients.
- The physiotherapy manager told us that the consultants were trying to engage with private physiotherapists in the surrounding area by putting on talks every two months, this was to try to reduce the number of upper limb patients undergoing surgery by using conservative treatment first.
- Diagnostic imaging services included general x-ray, fluoroscopy, mobile x-ray, an image intensifier located in theatre, ultra sound/scanning, digital mammography, dental x-rays and dual energy dosimetry scanning, (DEXA). There were four radiographers who worked in the department. A Spire healthcare mobile magnetic resonance imaging (MRI) scanner service visited the site two days per week providing MRI scanning and there was a service level agreement with a nearby trust for the provision of computerised tomography (CT) scanning and daily slots were available.
- The diagnostic imaging department were upgrading their x -ray equipment at the end of 2016 and new digital equipment was due to be installed which would produce better imaging for patients. The hospital had also put together a business case for a magnetic resonance imaging (MRI) scanner to be built on site.
- The digital mammography equipment had recently been installed and was situated in a newly decorated room. The service was for private patients and provided a choice of location for this diagnostic imaging.
- The diagnostic imaging department had employed an additional member of staff whose skill set included DEXA scanning which was available for NHS and private patients ; the service was very popular and prevented some patients having to travel a distance to receive a scan. Staff said that they had the resources to do more of this scanning.

Good

Outpatients and diagnostic imaging

- There were open evenings for patients considering cosmetic surgery where they could receive a free consultation; this was supported by nurses.
- There was free car parking on site but staff said that other people parked there as it was close to the town and to the general hospital where patients had to pay for parking, there were plans to increase parking and the hospital was on a number of bus routes.

Access and flow

- There were 33,174 attendances in the OPD in the period July 2015- June 2016. Of these attendances 40 were for children aged 0-2 years of age, 1% was for children aged 3-15 years of age, 1% was for children between 16 and 17 years of age, 84% was for adults aged between 18 and 74 years of age and 15% was for adults aged over 75. Outpatient activity accounted for 89% of the activity at the hospital and 47% of OPD activity was NHS and 53% was fee-paying. This was in the period July 2015-June 2016.
- Approximately 36% of outpatient appointments were for orthopaedic, 15% for cardiology, 10% for general surgery, 10% for ophthalmology, 8% for ear, nose and throat, 7% for gynaecology, 5% for urology, 4% for dermatology, 4% for spinal, 3% for breast, 2% for gastroenterology and 1% for neurology, vascular, rheumatology and oral.
- The referral to treatment times for the incomplete pathway was higher (better) than the England average and the standard. These are the waiting times for patients waiting to start treatment at the end of the month. The department was better than the England average (92%) from the period July 2015 - June 2016 and consistently scored 100%. This meant that patients were treated in a timely manner.
- The hospital took patients from other hospitals to help them meet referral to treatment times.
- NHS patients were sent letters for their appointments through the “choose and book” system. These letters were sent three weeks in advance of appointments. There were separate booking staff for NHS and private patients. The hospital had recently recruited an additional call handler to the service to meet the needs of the service as it was becoming busier.
- There was a booking in process for patients attending for their first appointment, where next of kin details, the patients GP and other information was collected and the patients were asked to sign this.
- If patients did not attend (DNA) for appointments, the reception staff would ring patients to see if they were caught in traffic or if they had forgotten their appointment and tried to fit them in on the same day or they were given another appointment. If they could not contact them by phone, letters were sent out to patients, if the patient did not attend three times and if there was no response the patients were referred back to their GP. The hospital did not measure their DNA rates.
- Staff told us that clinics rarely ran late. There were signs were on the tables in the OPD department asking patients to alert nurses if they had been waiting for more than 15 minutes and if a clinic was running late, staff would keep patients informed about delays During the inspection we saw that all clinics ran to time and waiting times for patients after arrival were minimal.
- The hospital were auditing wait times for patients attending the OPD, they had done this over a three day period and patients had not been kept waiting more than 15 minutes.
- Staff described an incident where a consultant was stuck in traffic and the staff spoke to patients individually to apologise for the delay. Staff told us that they spoke with patients if their waiting times were more than 15 minutes. All the clinics that we observed during the inspection ran to time.
- Staff told us that they always tried to give patients a physiotherapy follow up appointment following surgery before they left the hospital; if this could not be done patients were telephoned the following day.
- Staff told us that the waiting lists for diagnostic imaging services were very low as most patients were seen in the same week; patients waited about a week for ultrasound procedures. We observed that patients attending for OPD appointments were x- rayed following their appointment which meant that they did not have to return to the hospital for x- rays. We also observed that patients who telephoned for appointments were given an appointment at their convenience within a few days of telephoning.
- Staff told us that all diagnostic imaging reporting was done on site and usually within the week, urgent requests were reported on the same day and ultrasound procedures were also reported on the same day.

Meeting people’s individual needs

Good

Outpatients and diagnostic imaging

- During the booking in process the reception staff asked patients about any disability or mobility issues that they had and these were noted in the patient record. There was a hearing loop at reception for those with hearing difficulties.
- Following the last patient-led assessments of the care environment (PLACE) audit in the period Feb 2016-June 2016, it was highlighted that there was a need to gain more insight into the needs of patients living with dementia. A teaching programme was delivered using resources within the community. There were link nurses who had taken a lead to provide specific support to patients and there was a check list for dementia care.
- The outpatients department had a range of patient information leaflets to give to patients. These clearly explained the patient's condition and treatment. These were provided during consultations and meant that patients were able to consider their options at home before making any decisions to proceed.
- There was a box of toys available in the OPD reception for children, there was a cleaning schedule for these. One of the consultants said that they would have liked a designated waiting area for children but as the numbers of children attending the OPD were so small this was unlikely.
- Interpreters were booked in advance if staff were aware that they were needed, telephone translators could be used if necessary. Staff were aware of the processes for booking interpreters but administration staff said that they weren't always made aware of the need for an interpreter for first appointments by the patients GP. Patients were given the choice of rebooking their appointment or telephone translators could be used in those cases. The use of an interpreter was very rare.
- The OPD had few patients attend who were living with a learning disability though staff said that the pre-operative assessment process was robust enough for a patient with a learning disability. This included giving patients the first appointment of the day so that they did not have to wait.
- We saw that stickers were put onto patient records to alert staff about patient issues such as dementia, communication difficulties, co-morbidities, learning disabilities and any issues for anaesthetists, including allergies to specific medicines and the patient's smoking status.
- There was a nearby centre for patients living with a learning disability and the diagnostic imaging staff were used to them coming to the department and made appropriate changes to accommodate them as necessary, such as giving patients the first appointment so that they didn't have to wait. They also tried to give patients continuity as they were used to seeing the same radiographer.
- Staff told us that patients living with a learning disability brought their health passports with them, which contained information to enable health staff to understand their everyday needs, including communication, medicines and eating and drinking. They used the information when the patient was in the department for their treatment.
- Anatomical models were used to describe the different treatment and their side –effects for patients who were considering bariatric surgery. They were given literature about the various treatment options and life style changes.
- The outpatients and diagnostic imaging departments were located on the ground floor of the hospital and were accessible for patients with mobility difficulties. A lift was available to access the upper floors if needed.
- Staff told us that chaperones were always available in the OPD and in diagnostic imaging. There were signs up around the department informing patients about chaperones.
- We spoke with a carer who was waiting for their friend who had come for a radiological intervention. There had been a delay in the patient's treatment and staff offered the carer a light lunch while they were waiting.
- We saw in the minutes of a departmental meeting the complementary feedback from the mother of a patient with autism who had poor communication skills. She said "I have never witnessed such care and understanding in all the time I have been to hospitals."

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.
- There were few complaints to the OPD and staff tried to address complaints locally with patients before they were made formally.
- We were told that when a complaint was received, the relevant head of department was informed of the issues raised in the complaint and was asked to investigate. Patients were invited to attend a meeting with the

hospital director and/or matron who would gather more information and provide an explanation into the concerns that they had raised. This was followed up with a letter.

- We were told that complaints were entered onto the electronic incident reporting system and the lessons learned were documented as well as the outcome of the investigation. All the correspondence was also attached into the electronic system. The complaint was reviewed and signed off by the hospital director. Lessons learned were shared with staff through staff meetings. We saw this in departmental minutes of meetings.
- We saw in the departmental minutes of meetings that patient complaints were used to provide feedback and trends were analysed and reported at relevant meetings. Patients were also provided with the opportunity to feedback to the hospital via the customer service email and hospital website. Negative feedback was processed in line with the hospital complaints process.
- We were told that complaints were discussed weekly by the hospital director, matron and the personal assistant to the hospital director who oversaw the handling of complaints. We saw from minutes of meetings that complaints and the learning from them were then discussed at monthly senior management team meetings, every three months at clinical governance committee and monthly at departmental meetings across the hospital.

Are outpatients and diagnostic imaging services well-led?

Good

Vision and strategy for this core service

- See information under this sub-heading in the surgery section.
- Staff in the outpatient department (OPD) had a clear vision, mission and values which prioritised the delivery of high quality patient care. These were incorporated into staff appraisals.
- Staff were encouraged to develop their services and in the OPD there were plans to increase the types of minor surgical procedures available. This included the removal of small lymph nodes.
- The physiotherapy manager said that future developments included a sports massage service, a service level agreement with an orthoptist to develop lower limb services and new treatments.

Governance, risk management and quality measurement

- See information under this sub-heading in the surgery section.
- There were monthly staff meetings in the OPD; agenda items included governance, adverse events/incidents, the learning from these events and development training. There was two way communications between the department and the senior management team. This was confirmed by the minutes of the OPD staff meetings and the senior management team minutes.
- Audits were taking place in the OPD, diagnostic imaging and physiotherapy departments and staff were keen to further develop the audit programme. The audits were mainly about routine practice but the manager of the outpatient department said that she would like to continue with audits about patient outcomes similar to the hysteroscopy fainting audit.
- There were departmental risk registers and the top three risks for each department were highlighted on staff notice boards. However, not all risks had a review date on them and we were not assured about the governance of the risk register. At the unannounced inspection there had been a review of the risk registers and review dates for the risks were being identified

Leadership and culture of service

- See information under this sub-heading in the surgery section.
- The manager for outpatients and radiology was the clinic support manager who reported to the matron.
- There was a good open culture in the OPD department, leadership was strong and there was a theme of continuous learning and improvement.
- Staff we spoke with said that they liked working there and felt that there was good career development. Morale was good and some staff said that they had waited for a vacancy to come up at the hospital.
- Service managers described the matron as having an open door policy and said that she taught them good management skills.
- Staff turnover at the hospital was low and many staff had been there for many years.

Good

Outpatients and diagnostic imaging

- Staff we spoke with described the matron as being very caring and she had taught them about how to deal with stress and acted as a mentor to them. A member of staff said that they had been well supported by matron following an incident.
- Staff reported that the organisation was very supportive and examples were given where both emotional and practical support had been provided to staff.

Public and staff engagement

- See information under this sub-heading in the surgery section.
- The results of all patient surveys were analysed and discussed in depth at quarterly clinical governance meetings, as well as any other relevant committee and this information was then fed into monthly departmental meetings. There were specific surveys for outpatients, physiotherapy, paediatrics which included how involved patients felt in their care and treatment and how able they felt to discuss any worries that they may have had. When negative feedback was received in a survey, this was forwarded immediately onto the relevant heads of department, and we were told, where possible, the patient was contacted with a phone call or letter.
- There was a book in the OPD where the senior staff collected examples of patient feedback which they could share with relevant teams and individual members of staff.
- There were electronic devices to enable patients to feedback information about outcome measures who may not have a computer at home.
- There was an annual staff survey, one of the issues from the 2015 survey was that staff felt that different teams did not work well together and work had been done to try to improve this.
- The hospital had an inspiring people nomination and awards programme to reward staff members who had worked above and beyond their role. In the 2016 awards members of staff from the outpatients team had been nominated from the hospital

Innovation, improvement and sustainability

- Surgeons and physiotherapists had been working together to develop a service for patients following shoulder surgery. The physiotherapist went into theatre with the patient and from their observation of the surgery they were able to tailor the rehabilitation for the patient.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should consider locked entrances to theatre to prevent access by unauthorised personnel.
- The hospital should consider medical supply stocks being in locked cabinets in the extended recovery area to minimise the potential risk of theft.
- The extended recovery area should not be used as an eating area for staff
- The hospital should consider updating the safeguarding policy to include the latest guidance on female genital mutilation.
- The hospital should consider changing carpets in the ward corridors to meet national guidance.
- The hospital should consider the addition of clinical hand basins in patient rooms, to minimise the risk of cross infection and meet national guidance.
- The hospital should consider using Q-PROMS which is a recommended tool to collect and report data in relation to cosmetic surgery.
- The hospital should consider the requirement of staff who are working as surgical first assistants to complete an accredited qualification.
- The hospital should consider the need for a formal policy for consultants to follow in relation to the '2 week cooling off' period in cosmetic surgery.
- The hospital should take action to improve attendance at the medical advisory meeting in order for robust information sharing, discussion and dissemination
- The hospital should take action to identify and mitigate all risks specific to the hospital and risks should be included as a standard agenda item in committee meetings with robust systems for agreeing timescales and actions and monitoring of risk.
- The hospital should revise its systems and processes to ensure that patient harms are correctly scored and ensure duty of candour applied in all instances.
- The hospital should review their policy regarding the destruction of controlled drugs in line with Safer Management of Controlled Drugs and Royal Pharmaceutical Society Guidance.
- The hospital should make arrangements that monitor and determine the outcomes for patients receiving medical care separate to surgery and outpatients.
- The hospital should consider using a world health organisation (WHO) checklist for minor surgery procedures in the outpatient department.