Spire Methley Park Hospital

Quality Report

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

Ratings

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

Overall summary

Spire Methley Park Hospital is operated by Spire Healthcare Limited. The hospital has 24 inpatient beds including three operating theatres, outpatient department, diagnostic and imaging facilities. At the time of inspection, the hospital was undergoing building work and the number of beds had temporarily been reduced to 16.

The hospital provides surgery and outpatients and diagnostic imaging. We inspected surgery, outpatient department, diagnostic and imaging facilities. The hospital had stopped providing services for children and young people (below the age of 18) prior to our inspection to enable a full review of services in line with latest national guidelines.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 1 and 2 November 2016, along with an unannounced visit to the hospital on 17 November 2016.

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

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

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

We rated this hospital as good overall.

We found good practice in relation to surgery, diagnostics and outpatient care:

- There were sufficient qualified, skilled and experienced staff to meet people's needs. The service managed staffing effectively. Staff teams and services worked together effectively to deliver good care.
- The hospital had good systems and processes in place to protect people from abuse and avoidable harm. There were systems in place for incident reporting, staff knew how to use them and learning was shared to prevent recurrence.
- We found patient care, treatment and support achieved good outcomes and helped patients to maintain their quality of life, based on the best available evidence. There were clear pathways of care and staff were able to recognise and respond to warning signs of deteriorating health.
- All staff showed a caring approach to their patients. We saw patients treated with dignity and respect and feedback from patients was positive.
- The provider met national indicators for referral to treatment (RTT) waiting times. The service took account of the different individual needs of people using the service, including those living with dementia and learning disabilities.
- Staff had worked closely with the local Healthwatch; they had done environment checks and assessed the hospital for dementia and learning disability friendliness. They had worked closely together to design a dementia friendly room as part of the new building work.
- Leaders were visible, promoted an open and fair culture. Staff felt listened to and said the hospital was a good place to work. There was a clear vision and strategy and effective governance systems in place to ensure that quality, performance and risks were managed.

There were no breaches of regulations. However, there were areas where the provider should make some improvements, even though a regulation had not been breached, to help the service improve. These were:

- The provider should implement plans to ensure there is appropriate pharmacy provision at the hospital.
- The provider should continue to review and revise the risk register to reflect the specific risks for Spire Methley Park Hospital.
- The provider should consider installing clinical hand wash basins and hard flooring in patient bedrooms as part of the refurbishment programme.
- The provider should continue to raise staff awareness regarding safeguarding including domestic abuse.
- The provider should review the audit programme within the outpatient department.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
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 to people's needs and well-led.
Outpatients and diagnostic imaging	Good 	We rated this service as good because it was safe, caring, responsive to people's needs and well-led. We did not rate the effectiveness of the service.

Summary of findings

Contents

Good

Spire Methley Park Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Spire Methley Park Hospital

Spire Methley Park Hospital is operated by Spire Healthcare Limited. It is a private hospital in Methley village located between Leeds and Wakefield. The hospital primarily serves the communities of Leeds and Wakefield area. It also accepts patient referrals from outside this area.

Spire Methley Park is a purpose-built hospital built in 1984. The hospital has been under varied ownership during that time. Since 2008, the hospital has been in the ownership of Spire Healthcare. Spire Methley Park Hospital was re-registered in July 2016 with CQC when the company became Spire Healthcare Limited.

The hospital has not been inspected whilst services have been registered and provided by Spire Healthcare Limited.

The registered manager was the hospital director and, at the time of the inspection, had been in post since 13 February 2014.

The hospital offers general surgery, cosmetic surgery, diagnostic imaging, endoscopy, oncology, and outpatients clinic appointments. It is registered for the regulated activities of treatment of disease, disorder and injury, diagnostics and screening, family planning and surgical procedures.

We inspected two core services at the hospital, which covered all the activity undertaken. These were surgery and outpatient and diagnostic services. We inspected the hospital on 1, 2 and 17 November 2016. The hospital was undergoing building development and refurbishment work at the time of the inspection. The theatres were not operational at the time of the announced visit due to unforeseen circumstances; we visited theatres as part of the unannounced inspection when they were fully operational.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, CQC inspection manager, and four specialist advisors with expertise in surgery and operating departments, radiology, outpatients and governance. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Information about Spire Methley Park Hospital

The hospital has one mixed-sex ward and provides outpatient services, including physiotherapy, and diagnostic imaging facilities on site. The outpatients and physiotherapy services moved into new accommodation in November 2016.

Outpatient services cover 17 different specialities. The specialties with the highest outpatient activity are orthopaedics, cosmetic surgery, general surgery, gynaecology, and ophthalmology. The hospital provides services for adult patients over the age of 18. Services for children and young people were withdrawn from outpatients and inpatient services on 1 October 2016 to enable a full review of services in line with latest national guidelines. Between July 2015 and June 2016, outpatients had seen 86 children aged 16 to 17, 72 children aged 3 to 15 years and two children aged 0 to 2 years.

The hospital provides a range of diagnostic imaging services including digital plain film x-ray, digital mammography and ultrasound. Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scanning are provided by a Spire Healthcare owned mobile service. Radiation protection advice is outsourced to an external radiation protection advisory body. Radiology carried out 5,860 investigations per annum.

Summary of this inspection

All pathology services are outsourced; Spire Pathology Services provides pathology and blood transfusion services and a local NHS trust provides histopathology services.

Spire Methley Park Hospital is registered to provide the following regulated activities:

Diagnostic and screening procedures

Family planning

Surgical procedures

Treatment of disease, disorder, or injury

During our inspection, we visited the ward, theatres, outpatient department, cosmetic surgery outpatients, physiotherapy department and diagnostic imaging department at Spire Methley Park Hospital. We spoke with over 38 members of staff, including heads of departments, nurses, operating department practitioners, medical staff, healthcare assistants, radiographers, physiotherapists, administrators and receptionists. We held two focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee. We also spoke with four patients about outpatient services and four patients on the ward. We looked at 21 sets of patient records and other documents relating to the management of the services. Before the inspection, we reviewed performance information from, and about, the hospital.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This is the first inspection since the service provider's registration changed with CQC in July 2016. We found that the hospital was meeting all standards of quality and safety it was inspected against.

Inpatient Activity (July 2015 to June 2016):

- There were 6,081 inpatient and day case episodes of care recorded at the hospital in the reporting period; of these 72% were NHS funded and 28% were other funded.
- 20% of all NHS funded patients and 33% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 21,950 outpatient total attendances in the reporting period (Jul 15 to Jun 16); of these 76% were NHS funded and 24% were other funded.

There were 150 medical staff employed under practising rules or privileges. This consisted of 95 medical/surgical consultants, 40 anaesthetists and 15 radiologists. Two regular resident medical officers (RMO) worked on a seven days and a 24 hours rota. The hospital also employed 29.6 whole time equivalent (WTE) registered nurses, 10.8 WTE care assistants and 71.5 WTE other staff which included receptionist and housekeeping staff. In addition, to their own staff taking up bank shifts, they occasionally used an agency for backfill shifts. The accountable officer for controlled drugs (CDs) was the registered manager.

The track record on safety between July 15 and June 16 showed :

- No never events
- Two serious injuries
- No cases of C.difficile, MRSA, MSSA or E. coli
- The rate of complaints per 100 day case and inpatient attendances was lower than the rate of other independent acute hospitals (29 complaints)
- The rate of clinical incidents in surgery, inpatients and other services (271 incidents) was higher than the rate of other independent acute hospitals
- The rate of non-clinical incidents in surgery, inpatients and other services (34 incidents) was similar to the rate of other independent acute hospitals
- 1% of clinical incidents were reported as severe or death
- The rate of clinical incidents in outpatient and diagnostic and imaging services (44 incidents) was similar to the rate of other independent acute hospitals
- The rate of non-clinical incidents in outpatient and diagnostic and imaging services (four incidents) was lower than the rate of other independent acute hospitals

Summary of this inspection

Services provided at the hospital under service level agreement included:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Sterile Services
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Radiation protection
- Laundry
- Maintenance of medical equipment
- Pathology, histology and blood transfusion
- RMO provision
- Agency staff
- CT/MRI scanning
- Occupational health

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:

- The hospital had good systems and processes in place to protect people from abuse and avoidable harm.
- There were systems in place for incident reporting, staff knew how to use them and learning was sharedto prevent recurrence.
- The hospital had invoked duty of candour on one occasion between July 2015 and June 2016. Practice had been changed following this incident even though no direct failing was identified.
- The hospital measured, monitored and analysed patient harm and harm free care. NHS safety thermometer data was collected and showed 100% harm free care between July 2015 and July 2016.
- All the actions from the most recent legionella risk assessment and water hygiene audit been completed. The site engineer had recently undertaken legionella refresher training.
- There were sufficient qualified, skilled and experienced staff to meet people's needs.
- There were clear pathways of care and staff were able to recognise and respond to warning signs of deteriorating health.

However, we also found the following issues that the service provider should improve:

- At the time of the inspection, the hospital did not have a dedicated pharmacist; pharmacy provision was supplied, through a service level agreement, by a local Spire hospital. A robust action plan was in place and the pharmacy superintendent for Spire hospitals was providing support. Recruitment to vacant posts was in progress.
- Some clinical areas had carpets on the floor, although risk assessments were in place for these. The patient rooms did not contain clinical hand basins for hand washing. These were due to be addressed during the refurbishments.

Are services effective?

Good

We rated effective as good because:

- Policies and guidelines were up to date, based on national guidance and staff were able to access them on the intranet.
- There was evidence of audit at local and national level, with action plans produced in response to the results.

Summary of this inspection

- Staff were competent and had the skills and knowledge to deliver effective care and treatment. Staff teams and services worked together effectively to deliver good care.
- We found patient care, treatment and support achieved good outcomes and helped patients to maintain their quality of life, based on the best available evidence.

Are services caring?

Good

We rated caring as good because:

- All staff showed a caring approach to their patients. We saw patients treated with dignity and respect.
- Feedback from patients was positive. Patient satisfaction survey results showed that 98% of patients would recommend the hospital.
- Patients and their families were informed and involved in their care and treatment choices available to them .
- Staff supported patients and their families to cope emotionally with their care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- Services were organised so that they met the needs of the people using them.
- People could access care and treatment in a timely way.
- Outpatient clinics, radiology and physiotherapy services were planned flexibly over six days, including early mornings, late evenings and Saturdays. This meant patients could attend their appointments without needing to take time off work.
- The provider met national targets for referral to treatment (RTT) waiting times
- The service took account of the different individual needs of people using the service, including those living with dementia and learning disabilities. Staff had worked closely with the local Healthwatch; they had done environment checks and assessed the hospital for dementia and learning disability friendliness. They had worked closely together to design a dementia friendly room as part of the new building work.
- The service acted on complaints and concerns in a timely way and used the information to improve the quality of care.

Are services well-led?

Good

We rated well-led as good because:

- There was a clear vision and strategy and staff were aware of them.

Summary of this inspection

- There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.
- Leaders were visible and staff spoke positively about them. Staff felt listened to and said the hospital was a good place to work.
- The leadership and management encouraged learning and innovation, and promoted an open and fair culture.

However, we also found the following issue that the service provider needs to improve:

- The risk register was a general risk register which was In the process of being reviewed and revised to reflect the specific risks for Spire Methley Park Hospital.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
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

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as good.

Incidents

- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. No never events were reported between July 2015 and June 2016.
- Two serious injuries were recorded between July 2015 and June 2016. Root cause analysis (RCA) investigation was undertaken for each incident.
- We reviewed the RCA for one of these incidents. It contained root causes, lessons learned and an action plan. Staff told us that these actions had been implemented.
- A total of 315 incidents were reported between July 2015 and June 2016. Of these, 82.3% were classified as low or no harm, 16.8% were moderate harm and 0.6% were severe harm.
- The hospital had introduced an electronic incident reporting system and all staff and consultants had access to this to report incidents directly. To support staff with the introduction of electronic reporting, the hospital was in the process of teaching staff how to input incidents directly on to the system. In the meantime, staff reported incidents on a paper adverse events form. This was then scanned and uploaded to the electronic system by a member of staff.
- Staff were encouraged to reflect on practice when incidents had taken place and relate back to their professional code of practice. Staff told us they were encouraged to produce written reflections to the matron.
- Staff received feedback about incidents at team meetings and they had 'first sight' files which contained all new pieces of information. Staff had to sign to say they had seen the evidence in this file every month. Learning was also shared from incidents at other Spire hospitals.
- Staff were able to tell us about a change of practice following an incident. A patient had been taken to theatre and it was discovered that they had not signed a consent form. Practice had changed so that a member of theatre staff and a member of ward staff checked the patient together, before they went to theatre, in the patient's room to avoid a similar situation happening again. We saw this happening during the inspection.
- Staff were aware of the duty of candour and the need to be open and honest with patients. The matron was the lead for duty of candour and encouraged an open and honest culture. Patients received a leaflet explaining the duty of candour.
- The hospital had invoked duty of candour on one occasion between July 2015 and June 2016. We reviewed this incident and found that identified practice had been changed even though no direct failing was

identified. This meant post-operative x-rays were now always performed before discharge. Previously no x-rays were performed at the weekend, and the patient would wait until the follow-up appointment.

- Any issues regarding morbidity and mortality would be discussed at the medical advisory committee (MAC) meetings. We saw evidence of this in meeting minutes.

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

- NHS safety thermometer data was collected. Results showed 100% harm free care between July 2015 and July 2016.
- 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. These results were collated centrally and reported via Spires clinical scorecard.
- VTE screening rates were 100% in quarter one and quarter two of 2016. There had been no incidences of VTE in the first two quarters of 2016.
- There were no pressure ulcer incidences in the first two quarters of 2016.
- There were 2.9 patient falls per 1000 bed days recorded in quarter one and 3.7 per 1000 bed days in quarter two. These were above the Spire target of less than two. We discussed this with staff on the ward and they had looked at their incidences of falls. They had not found any particular pattern to the falls or that they affected any particular group of patients more than they affected others.
- Measures had been put in place to try to reduce the number of falls such as giving those patients at risk of falls a green wristband so that staff were aware. Whiteboards were in patient's rooms and the physiotherapists wrote down any mobility issues and equipment used so that all staff, on entering the room, were aware of any requirements.
- We saw clinical quality information was displayed in the staff offices and on the walls for patients and visitors to see.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and good standards of hygiene were maintained.
- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile or E.coli between June 2015 and July 2016.
- Staff followed the Spire policy and local trust guidelines for screening of patients for MRSA. We saw the Spire policy, which followed the Department of Health (DH) guidance for MRSA screening (2014). The hospital had an infection control lead. Seven and a half hours a week were dedicated to this role. Infection control link nurses were present in each area.
- An annual infection prevention and control plan had been produced with key points and actions and responsibilities. An infection control committee meeting took place every three months. This was chaired by the infection prevention lead and membership included a consultant microbiologist who had practicing privileges at the hospital. We saw a rolling action plan, which was produced following these meetings.
- Quarterly audits took place for the environment, sharps, waste, linen and hand hygiene. Recent hand hygiene results showed a compliance rate of 90%. This was a benchmarking audit which would inform a national target across the Spire hospital network from the start of 2017. A sharps audit completed in March 2016 showed 98% compliance. It was found in this audit that temporary bin closures were not being used and an action plan was developed, which included producing laminated signs reminding staff to use the temporary closures. The infection control link nurses discussed the issue at team meetings and information was kept in a first sight file in all departments. A re-audit in May 2016 achieved 100%. During our inspection, we saw sharps bins appropriately closed.
- We saw that the hospital's clinical waste compound was secure and large enough for the number of containers stored in line with the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste (2013). Clinical waste was collected three times a week and there were plans to install an improved green metal compound at the end of the car park as part of the building works. Domestic waste was collected twice a week.

Good

Surgery

- Between July 2015 and June 2016, there were nine surgical site infections. The rate of infections for primary hip arthroplasty, breast, gynaecological and other orthopaedic and trauma procedures was similar to or better than other independent acute hospitals. The rate of infections for primary knee arthroplasty was higher than the rate of other independent acute hospitals.
- We spoke with the infection control lead who told us it had been identified that there had been an increase in superficial skin infections. With the assistance of a microbiologist, they had reviewed records and tracked the patient's journey to investigate the cause. This had led to a change in practice in which patients had a shower with hibiscrub, on the ward on the morning of their surgery. The infection rates continued to be monitored.
- The ward had single, en-suite rooms, which allowed for isolation of patients. Eleven rooms had carpets on the floor; all other rooms had had this replaced as part of the ongoing refurbishment programme. There were risk assessments in place for these. The carpets were vacuumed on a daily basis using a hepa filtered hoover and cleaned every three months or on an ad hoc basis if there was a spillage or contamination. Spillage kits were available, if required. Those patients admitted for hip or knee replacements were never put in a room with carpet. The carpets were planned to be removed during the refurbishments.
- The patient rooms did not contain clinical hand basins for hand washing. Department of Health Guidelines (2013) HBN009 state that: 'En-suite single bedrooms should have a general wash hand basin for personal hygiene in the en-suite facility in addition to the clinical wash hand basin in the patient's room'. The senior management team were aware of these guidelines which had been introduced since the rooms were last refurbished and these were included in the hospital ongoing refurbishment plans. There was a risk assessment in place and the en-suite basins had been adapted with elbow operated taps to be effective for both patient and clinical use until the rooms were fully refurbished.
- Hand gel dispensers were available in the patient's rooms and patients we spoke with said they always saw staff using it when they entered and left the room. In addition, the hospital had installed child friendly hand gel dispensers which were bright and colourful and at appropriate heights to encourage children to use them when visiting the ward areas.
- The dirty utility room on the ward was cluttered and there were linen skips in front of the hand wash basin meaning it was difficult to access. We brought this to the attention of the hospital director and matron at the time of the inspection, who confirmed immediate action would be taken.
- Waste was seen to be appropriately segregated and cleaning schedules were seen and signed as completed.
- Theatre equipment that needed decontamination was done externally. The hospital used a local NHS trust's Hospital Sterile Services Unit (HSSU) for sterilisation of their reusable theatre equipment.
- Whilst the building work was being completed, endoscopes were sent to another local Spire hospital for decontamination. In the anaesthetic room, we observed all equipment kept off the floor so that the floor could be cleaned underneath.
- Theatre staff were observed to change their shoes every time they went in or out of the department and were observed using the hand gel.
- Whilst the building work was ongoing, the matron and infection control lead did regular walks round the hospital checking for any possible infection control issues. The consultant microbiologist had been involved throughout the various phases of the development in terms of identifying infection control risks. Building contractors had restricted access to certain areas of the hospital in line with Spire's management of contractors policy.
- Theatres normally had two deep cleans a year; this year they had already had three and another was planned for December due to the building works. The hospital had delayed opening their refurbished theatres in order to avoid excess dust from the building works.
- We reviewed the infection control policy. This contained care bundles for high impact interventions, which complied with NICE guidance.

- We observed staff adhering to the arms bare below the elbows policy and using appropriate personal protective equipment as required.
- We saw equipment with 'I am clean' stickers on so that staff knew that equipment had been cleaned after use. Curtains were changed regularly; we observed they were in date.
- Staff undertook infection control mandatory training. Compliance figures for 2016 showed that up to July 2016, 85.3% of staff had completed the training. The target for end of year compliance was 95%. Training was therefore on target for compliance.
- The hospital had developed a patient information board specifically for infection prevention and control.This included good practice for hand washing and precautions within the hospital and post-discharge as well as information on antibiotic use, seasonal flu, common infections, hospital infection rates and audit results.

Environment and equipment

- The ward environment was en-suite single patient rooms. At the time of our inspection, there were only 16 rooms in use due to the building work. The layout of the ward meant that some rooms were around the corner away from the nurses' station, however, each room contained a patient call and an emergency assistance buzzer.
- The recovery area in theatres was small with three bays. Staff tried to ensure that they used bays one and three and keep bay two free to allow privacy and dignity to be maintained. Staff said they could recover patients in theatre if recovery was full, but it was rare that this would happen.
- Theatres had an equipment store. There was a daily top up service for equipment, which was procedure specific, not consultant specific. This meant that staff were familiar with the equipment and this minimised the risk of staff working with unfamiliar equipment.
- We saw completed checklists for checking of anaesthetic equipment in theatres. All appropriate equipment was available.
- Breast implants were recorded on a local register. The hospital were a pilot site for the national breast implant registry earlier this year and were due to start a live register the week after our visit.
- One room on the ward could be used as an extended recovery room for those patients requiring more close observation after surgery. Staff were suitably qualified to care for these patients.
- Staff we spoke with said they had access to all the equipment they needed. All equipment we saw had been electrical safety tested.
- Resuscitation equipment was available in the ward area and theatres. Daily checks took place and we saw records to indicate this checking had taken place. Resuscitation trolleys were secured with tags meaning that there could be no unauthorised access to the contents of the trolley.
- Theatre staff had training for medical devices. We saw individual training records that indicated medical device competencies.

Medicines

- The hospital used the Spire medicines management policy. This included information on obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- Audits had been completed every three months of medication charts, fridge temperature recordings and controlled drugs in line with the Spire Healthcare Medicines management policy. We saw action plans that had been produced in response to findings. These were monitored and updated. Feedback was given to individuals and teams.
- If medicines are not stored properly, they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine. Fridge temperatures were checked daily on the ward and in theatres, including minimum and maximum readings. We saw completed checklists to indicate checks had been done. The checklists contained the required fridge temperature range and the process to follow if the temperature fell outside of this range.

- The drug storage area temperature on the ward was monitored daily and we saw completed records to indicate these checks took place. The recording sheet contained the required temperature range and the process to follow if it fell outside of this range.
- Staff handled, stored and recorded medicines, including controlled drugs, in line with national guidance from the Royal Pharmaceutical Society of Great Britain. We observed medicines being stored safely and controlled drugs kept in separate locked cupboards on the ward and in theatres, with appropriate checks recorded.
- The drug room on the ward had a sign on the outside of the door so that nurses were not disturbed when handling controlled drugs. This was devised in response to a number of errors noted during audit, such as dates recorded wrongly. A further audit showed improvement.
- Ward drug expiry dates were checked monthly, the second line drug bag was checked daily and the anaphylaxis kit was checked daily. We saw records to indicate these checks had taken place. Any shortfalls were rectified appropriately.
- The hospital introduced a pharmacy on site in 2016. At the time of the inspection, the hospital did not have a dedicated pharmacist. Pharmacy provision was supplied, under a service level agreement, by another local Spire hospital three days a week due to staff vacancies in the pharmacy team.
- Pharmacy provision had been identified as a risk on the risk register. There was suitable mitigation in place and regular reviews. There were plans to resume the pharmacy service when the appropriate personnel were appointed. Recruitment was underway.
- Nursing staff on the ward were undertaking medicines reconciliation, supported by regular review by the visiting pharmacist. When the hospital pharmacy was closed out of hours, drugs could be obtained from a local chemist. Medicines could therefore be obtained in a timely way.
- Staff told us they discussed pain relief for discharge as early as possible with patients to allow for ordering of supplies and avoid delays in discharge.

Records

- Records were paper based with medical and nursing records kept separate during the inpatient episode. Medical records were kept in a locked cabinet in the nurses' office. Nursing care pathways were kept in the patient's room. Physiotherapists wrote in the nursing records.
- We reviewed 11 sets of records which were accurate, up to date and legible. All entries were signed and dated.
- Records included pre-operative and risk assessments. These included falls, pressure ulcers and nutrition screening. The care pathway and patient assessment determined which risk assessments were completed. We saw additional individualised plans of care were in place, when appropriate.
- The patients record policy stated 'It is a condition of being granted and maintaining practising privileges that consultants and other doctors ensure that a copy of the operation notes and relevant medical records are accessible within the hospital, for use by other healthcare professionals. Without this access, a single chronological health record cannot be maintained.' Patients records were kept within the hospital and staff we spoke with said that the consultants did not carry their own separate records.
- Records were kept on site for three months following the patient's last attendance. Following this, they were sent for secure storage at Spire's National Distribution Centre. Records could be retrieved from here if required.

Safeguarding

- The hospital did not treat children under the age of 18 years.
- The hospital director was the safeguarding manager and the matron was the safeguarding lead. They were available in the hospital for staff to access for guidance if they had safeguarding concerns. Both had Level 3 safeguarding training.
- Staff we spoke with told us that if they had any safeguarding concerns they would inform the matron. Most staff were aware they could report safeguarding concerns directly to the local authority, if necessary.

- A Spire safeguarding vulnerable adults policy was available which set out responsibilities of staff with regards to safeguarding. A flowchart was available on the office wall on the ward for staff to follow which included contact details for the local authority.
- Information was displayed in the ward office about reporting female genital mutilation (FGM).
- The hospital records showed that there had not been any safeguarding concerns reported to the local authority safeguarding department or Care Quality Commission (CQC) in the reporting period (July 15 to June 16).
- Staff completed safeguarding adults training Level 1 and 2.Data provided by the hospital showed that up to July 2016, 82.4% of staff had completed the training. The target was for end of year compliance to be 95%. Training was therefore on target.

Mandatory training

- Mandatory training was available which covered fire safety, health and safety, manual handling and equality and diversity, information governance, compassion in practice, infection prevention, safeguarding adults and children level one and level two and display screen equipment.
- The training year ran from January to December. Data provided showed that up to July 2016, 78% of staff were compliant with their training. This exceeded their compliance at the same time in 2015, when their annual compliance rate was over 95% by the year end.

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

- A Spire Healthcare admission and discharge policy was available. There was also a Spire Methley Park hospital admission policy. We reviewed this and saw that it set out the criteria for those patients who could be admitted for surgery to minimise risks to health and wellbeing.
- Patients admitted for major surgery were seen in a pre-assessment clinic prior to admission. Preoperative assessment is a clinical risk assessment where the health of a patient is considered to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. It also gives an opportunity to ensure that patients are fully informed about the surgical procedure and the post-operative recovery period and can arrange for post-operative care at home.
- The hospital's critical care service provision had recently been reviewed, following the issue of new national guidelines, and level 2 support was no longer being provided until the hospital could be certain it could competently meet all required standards. Patients assessed as being likely to require level two or three support post-surgery were not admitted. A critical care lead had been appointed and staff were undergoing training, in order to meet the standards required to provide level two care. An extended recovery bed, for patients requiring level one care, was available if needed and staff were suitably qualified to provide care to those patients needing more close observation.
- If a patient deteriorated and needed level two or three support they were transferred to a local NHS hospital. Staff followed an agreed local transfer policy.
- The hospital had four units of blood available on site in case of emergencies. Arrangements were in place to obtain further blood, if required.
- The hospital used the national early warning score (NEWS) to recognise and respond to deterioration in a patient's condition. The NEWS chart contained guidance on the appropriate action to take in response to a patient's changing needs, in order to provide timely medical intervention. Of the 11 records we reviewed, 10 had fully completed and appropriately actioned NEWS charts. Any deteriorations were swiftly escalated. The one patient whose NEWS chart was not appropriately actioned had been reviewed and their condition had stabilised.
- The NEWS charts were audited as part of the records audit: however this audit did not include checking if patients had been appropriately escalated if their NEWS score indicated this.
- The World Health Organisation (WHO) five steps to safer surgery including the surgical safety checklist is a tool to ensure that teams consistently follow a few critical safety steps and thereby minimise the most common and avoidable risks endangering the lives and well-being of surgical patients.. Of the 11 records we reviewed, seven were completed fully. One had all

sections complete apart from swab/needle check on sign out, one had not had the first stage signed and two had not had all questions answered on one page. We saw evidence of surgical safety checklist audits.

- An audit carried out in July 2016 on 20 sets of records showed that, in the pre anaesthetic phase, four had not got dates recorded, four had incomplete questions and two had signatures missing. In the intra operative phase, five sets were incomplete and two did not have signatures. In the pre recovery phase 10 sets had a procedure code missing. We could therefore see an improvement during our inspection since the results of this audit.
- We observed staff following the WHO checklist in theatres. All appropriate staff were involved and the checklist was completed fully.
- Staff completed the Acute Illness Management (AIM) course. Records showed that up to November 2016, 86% of staff had been trained. This meant that staff could respond appropriately to a deteriorating patient.
- At November 2016, 89% of staff had undertaken immediate life support (ILS) training. In addition, thirteen staff and the RMO had undertaken advanced life support (ALS) training. The hospital followed the Spire policy of having one ALS trained staff in theatre for certain procedures and a minimum of two ILS trained staff at all times. Resuscitation and major haemorrhage scenarios were carried out at the hospital. Six cardiac arrest scenarios were undertaken each year. These had been held in March, April, June, July, October and November. The major haemorrhage scenario was run annually and had been done on 5 September 2015 and 11 October 2016.
- Risk assessments were undertaken including falls, pressure ulcers and nutrition screening. The care pathway and patient assessment determined which risk assessments were undertaken. We saw these were completed in the records we reviewed.
- All patients were risk assessed for venous thromboembolism (VTE) at pre-assessment clinic and on admission to the ward were re-assessed within 24 hours of admission. Patients were discharged with information on DVT signs and symptoms and given appropriate prophylaxis.
- We saw that staff had access to a sepsis bag, which contained blood culture bottles and a sepsis flow chart. We observed sepsis screening tools contained in the nursing records.
- Following discharge, patients were able to contact the outpatients department or the ward 24 hours a day if they encountered any problems. If patients returned with a problem then the consultant would be called to see the patient.
- We observed a nursing handover. The handover was a recorded handover. Inpatients were discussed including any allergies, medication or comorbidities. The reason for admission was given and any other relevant medical or social concerns they had. Medical history, family support and discharge plans were discussed. The handover was clear, concise and informative ensuring that all staff were aware of the patients on the ward.
- Staff held a safety huddle every morning, which included staff from the ward and theatre, a physiotherapist, the resident medical officer (RMO) and the matron. During the huddle discussions took place about the number of inpatients, expected admissions and discharges, any concerns about patients, a physiotherapist update, an RMO update and whether they had been disturbed overnight, any staffing or equipment problems on the ward and in theatres and whether there were any planned list changes.
- The hospital also held a weekly capacity meeting. This included a review of the previous week including highlights and areas for improvement, to share learning, and discuss the week ahead, including expected patients and events.

Nursing and support staffing

- There were 13.8 whole time equivalent (WTE) nursing staff and 1.6 WTE healthcare assistants in the inpatient ward. Theatres had 8.8 WTE nursing staff and 5.3 WTE operating department practitioners (ODP) and healthcare assistants.
- Bank and agency usage on the ward was between 3% and 8% from July 2015 and June 2016. This was lower than the average rate of other independent acute hospitals.
- There was a variable use of bank and agency staff in theatres. In January 2016, the rate of usage of qualified

bank and agency staff was 45%, in June 2016 this had reduced to 30%. Arrangements were in place to promote continuity of care and ensure appropriately skilled agency staff were used. In January 2016, the rate of usage of unqualified bank and agency staff was 38%, in June 2016 this had reduced to 6%, as a result of recruitment and less staff absences.

- There were 1.76 WTE vacancies for qualified staff on the ward and no vacancies for qualified staff in theatres. There were no vacancies for unqualified staff on the ward and 4.4 WTE vacancies in theatres.
- The ward manager told us that they used a dependency tool to calculate staffing requirements. The staff rota was not prepared a long way in advance to enable the rota to be planned flexibly around the number and dependency of the patients to be admitted and to minimise late changes to the rota. We looked at the wards daily dependency records from September to November 2016 and found that the actual number of staff had met the required number on every day.
- We looked at rotas in theatres and found that staffing met the Association for Perioperative Practice (AfPP) guidelines.
- The theatre manager told us that they found it hard to recruit at times. They planned in advance to replace staff, wherever possible, and were developing staff in house to cover for vacancies. All operating department practitioners were multi skilled so could rotate to fill gaps.
- The ward manager told us that staff were flexible to meet the needs of the service and some staff who worked part time would work paid overtime, if needed.

Medical staffing

- Patients were admitted under the care of a named consultant. The Spire consultant handbook required the consultant to attend to every inpatient under their care at least once a day and they or a nominated consultant must be available at all times in case of an emergency for all patients for whom they are responsible.
- Nursing staff confirmed that they had easy access to consultant support. Whilst on the ward we observed a staff member contacting a consultant to ask advice about a patient.
- Nine medical practitioners who held practising privileges at the hospital were on the GMC specialist register for cosmetic surgery.
- Resident Medical Officers (RMO) were provided via a service level agreement at corporate level with an agency. An RMO was available on site 24 hours a day, seven days a week to provide immediate response to any patient needs.
- We spoke with the RMO during our inspection. They said that they felt well supported by the consultants and they had no problems contacting them out of hours.
- All consultants and anaesthetists were required to be available at any point during their patients admission. They had to nominate a covering consultant if they could not be contacted in an emergency or were not available to attend within 30 minutes.

Emergency awareness and training

- Regular scenarios were held for emergency situations such as resuscitation and major haemorrhage. These were undertaken six times a year and annually respectively.
- Fire evacuation tests were undertaken regularly.
- A business continuity plan was available and we saw this on the wall in the ward office.
- Results of a health and safety policy and procedure review and verification audit from August 2015, showed that the hospital had comprehensive emergency procedures in place for foreseeable emergencies such as bomb threats, fire, chemical spill, gas leak and electrical failure.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Staff had access to policies, procedures and guidelines. These were updated centrally and cascaded to all hospitals within the Spire group.

Good

Surgery

- Policies and procedures were evidence based and based on national guidance including National Institute for Health and Care Excellence (NICE) guidance. We saw updated policies in the 'first sight' folder for intensive care transfer of adults.
- Updated NICE guidance was placed in the 'first sight' file to ensure all staff were aware of new guidance.
- Patient safety alerts from the National Patient Safety Alert (NPSA) were circulated to staff in the 'first sight' file.
- The hospital had a Commissioning for Quality and Innovation (CQUIN) target for 2016/2017 for reducing the number of patients who smoked before surgery. This indicator reflected NICE guidance.
- We saw that the hospital had systems in place to provide care and treatment in line with best practice guidelines such as National Institute for Health and Care Excellence (NICE) guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital and guidance on routine tests in pre-operative surgery. For example, an early warning score system was used to alert staff should a patient's condition start to deteriorate.
- Care pathways were used for all surgical patients, to support individualised care planning. This meant there was a standard system in place for each patient admitted.
- Staff were able to tell us about changes in practice related to NICE guidance. For example, they had stopped routinely urine testing every patient pre operatively. Pre-assessment was done in accordance with NICE guidance (Pre operative tests for elective surgery).
- We saw evidence in minutes of the clinical audit and effectiveness committee meetings that national guidance was discussed.
- The hospital collected data for the Spire clinical scorecard, which measured compliance with standards. Targets were linked to external benchmarks such as Public Health England.

Pain relief

- The ward used a pain scoring system. We saw evidence of this along with an analgesic ladder in the records we reviewed.
- The Spire clinical scorecard for quarter two showed that 100% of pain scores had been completed with every set of observations.
- Patients were normally prescribed oral medication. There was infrequent use of patient controlled analgesia (PCA). Patients we spoke with told us their pain had been well managed and staff had provided analgesia when it was required.
- Follow up pain issues were documented by physiotherapists, with the action taken and the outcome recorded on a spreadsheet on discharge from the physiotherapist.
- Patient satisfaction survey results from July 2016 showed that 90% of patients felt staff controlled their pain to a great extent.

Nutrition and hydration

- Patients were routinely prescribed medication post operatively to help with nausea.
- All patients we spoke with said the food was excellent and a nutritious, balanced diet was offered.
- We saw completed nutrition assessments and fluid balance charts, where appropriate, although some did not have totals added up.
- Staff told us that different diets could be catered for, such as gluten free and halal. Food request forms could be filled in at pre assessment clinic.
- Records showed that patients were advised what times they should fast from before surgery in accordance with national guidance. Compliance with the guidance was monitored on a quarterly basis and reported via Spire's clinical scorecard. Data from the quarter two period (July to September 2016) showed Spire Methley Park achieved 30% compliance. Action was taken to address this and compliance had improved to 60% at the time of inspection.

Patient outcomes

- Between July 2015 and June 2016, there were seven cases of unplanned transfers to other hospitals and 25 cases of unplanned readmissions within 28 days. Neither rate was high when compared with rates reported by similar independent acute hospitals.

- In the same period, there were 10 cases of unplanned return to the operating theatres.
- .The hospital participated in patient reported outcome measures (PROMs) before and after surgery for cataracts, hips, knees and groin hernias.
- The hospital outcomes for the Patient Reported Outcome Measures (PROM) from April 2014 to March 2015 for primary knee replacement and primary hip replacement showed that they were within the estimated range.
- The physiotherapy department used the 'patient specific functional scale' to measure functional outcome for patients with orthopaedic conditions. This was used at the initial assessment, follow-up assessments and on discharge to monitor outcomes. Results showed outcomes were good. For example, we reviewed feedback from shoulder patients, which showed good outcomes, and some patients avoided the need for surgical intervention.
- The hospital submitted data to the Private Healthcare Information Network (PHIN) system; data was submitted in accordance with legal requirements regulated by the Competition and Markets Authority (CMA).

Competent staff

- The appraisal year ran from January to December. Data provided showed that 99% of nursing staff on the ward, 100% of health care assistants and 99% of other staff had received an appraisal so far this year. In theatres, 100% of all staff had received appraisals.
- There was a clear process for the granting of practising privileges for new consultants. This included requesting qualifications, information on their current post held and a NHS appointment letter, GMC registration, specialist training and current appraisal and revalidation information. The request went to the Medical Advisory Committee (MAC) for ratification.
- Practising privileges were reviewed biennially. Each consultant's documentation, incidents, complaints and any other relevant information were reviewed and signed off by the hospital director and matron with support from the MAC chairperson. Consultant details were held on a practising privileges database to track renewal dates. We reviewed five files and found these to contain all relevant information.
- Practicing privileges were removed if consultants did not supply the required documentation to maintain their practising privileges or they had not used the hospital for over 12 months.
- RMO's were expected to have achieved certain competencies, qualifications and training prior to starting at the hospital. The agency that supplied them was responsible for their ongoing training. Any new RMO was provided with shadowing for at least one week to ensure they were familiar with all aspects of the role. Clinical supervision was provided by the chair of the Medical Advisory Committee (MAC).
- We looked at nine staff recruitment files. All relevant paperwork was in place and appropriate documents and revalidation had been checked.
- We saw a new starter induction checklist and agency worker induction checklist. We also saw the operating theatre training manual which ensured new starters were competent in relevant areas.
- Theatres had four qualified first assistants and one in training. One first assistant had been trained when the hospital was owned by a previous provider and three were trained externally.
- The hospital director identified that there had been some issues with first assistant doctor cover for cosmetic surgery. Some of the surgery was not carried out in NHS hospitals and therefore the theatre staff were not routinely exposed to the procedures. The hospital was working with local universities to enable staff to get the training and experience they needed. Some consultants brought their own first assistant to assist them during surgery. Appropriate checks were in place.
- Staff we spoke with told us they had training on sepsis and there was a sepsis policy for staff to access.

Multidisciplinary working

- Physiotherapists worked closely with the ward staff and pre assessment clinic. During the inspection, we saw the physiotherapist working with patients.
- The physiotherapist we spoke with told us that the multidisciplinary team worked well together. Nursing staff ensured patients were ready to see the physiotherapist when the physiotherapist attended the ward.

Good

Surgery

- We observed good multidisciplinary working with staff from all disciplines involved in the daily huddle.
- There was a positive working relationship between the ward and the theatre staff. A member of the theatre staff attended the daily huddle on the ward and communication between departments appeared to be effective.
- Staff we spoke with said the team worked well together. Nursing staff felt confident to contact consultants directly, if needed.

Seven-day services

- Physiotherapists worked six days a week; staff could access an on call physiotherapist out of hours.
- The RMO was available 24 hours a day, seven days a week. Consultants could be contacted 24 hours a day for their patients.
- There was an on call theatre team available as well as an on call radiology service.
- The hospital did not have a static MRI or CT scanner, so patients needing an emergency scan were transferred to a suitable hospital.

Access to information

- Patient records were kept in the hospital at all times which meant staff had access to them when needed.
- Discharge letters were sent to GP's in a timely manner. The hospital was in the process of implementing electronic discharge letters.
- Staff could access guidance, policies and procedures on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A Spire consent policy was available for staff to refer to.
- Staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Data showed that 100% of staff had received training.
- We saw a staff MCA folder, which contained staff signatures to say they had read the information. There was also a folder called 'Spire Hospital Briefs' which contained information on the MCA and DoLS. A DoLS policy was available.
- Staff we spoke to told us they would voice their concerns with the consultant and senior nursing staff if they had concerns that the patient was not competent to consent.
- Staff were able to give us an example of a patient who they felt lacked capacity to consent. Appropriate processes had been followed and a best interest meeting had been held.
- We saw completed consent forms in the notes. These had been completed in accordance with guidelines and detailed the risks and benefits discussed with the patient. Some patients had given consent in pre assessment clinic and this had been reconfirmed on the day of surgery.
- Patients having cosmetic surgery were given a two week cooling off period between agreeing to the cosmetic surgery and the surgery been performed, in line with the Royal College of Surgeons professional standards (2016).

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- We observed patients been treated with dignity and respect.
- Patient satisfaction survey results from July 2016 showed that 98% of patients were extremely likely or likely to recommend the hospital. 90% reported care and attention received from the nursing staff was excellent.
- Patients we spoke to said that all staff were kind and caring and responded to their needs.
- Patient-led assessments of the care environment (PLACE) audit results for 2016 showed that for privacy, dignity and wellbeing the hospital scored 75.9%. The organisation's average was 82.8% and the national average was 84.2%. From 2013 to 2015 the hospital had been above the organisation and national average. We spoke with the matron about these results. Included

within this domain were issues such as outdoor spaces. As the hospital was undergoing building work this had affected outdoor space and it was felt this was the reason for the lower score this year.

- Patients we spoke to during our inspection said that they did not feel affected by the building work in any way.
- Friends and Family Test (FFT) data from January to June 2016 showed that 99% to 100% of patients recommend the hospital. The hospitals scores were similar to the England average for Independent sector NHS patients.

Understanding and involvement of patients and those close to them

- Patients and their families told us they felt involved in their care and felt well informed.
- Each patient had a named nurse who this was identified on the bedroom doors.
- All patients completed a pre admission questionnaire, which included social factors as well as medical. This was reviewed and discussed before admission and allowed staff to work with patients and their families to tailor a care plan to meet their needs.

Emotional support

- Patients we spoke with spoke positively about the emotional support they had received from staff whilst on the ward.
- Staff told us that those patients having cosmetic surgery requiring psychological support would access this through their GP.
- Patient information in the rooms informed patients that staff could access chaplains from different faiths if required.
- Patients had access to phones and wifi in order to maintain their social contact.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital was in the middle of building work to increase their facilities and refurbish the ward.
- Staff had worked closely with the local Healthwatch; they had done environment checks and assessed the hospital for dementia and learning disability friendliness. They had worked closely together to design a dementia friendly room as part of the new building work.
- The hospital provided both NHS and private care; it did not provide emergency care. Admissions for surgery were planned in advance.
- The hospital was due to start offering a spinal service shortly after our inspection.

Access and flow

- Patient admissions for theatre were staggered throughout the day; this meant that patients did not experience extended waiting times.
- The national indicator is that at least 92% of people should spend less than 18 weeks waiting for treatment. Data showed that this standard was met between July and November 2015. From December 2015 to June 2016, it was not met. In December 2015 and January 2016, 90% of patients were seen within 18 weeks, February 81%, March 83%, April 91%, May 79% and June 75%. These figures coincided with the building work and a planned reduction in the number of beds.
- Theatres controlled the bookings in liaison with the ward. This had increased the throughput in theatres.
- Theatre staff had an on call arrangement for any unexpected returns to theatre.
- The hospital reported 28 cancelled procedures for non-clinical reasons in the last 12 months. All 28 patients had been offered another appointment within 28 days of the cancelled appointment.

Meeting people's individual needs

- The hospital was actively working to meet specific needs of individual patients.
- Staff were able to tell us about a patient they had cared for with learning disabilities. They had made

adjustments, for example, they changed the appointment to later in the day and a carer had accompanied the patient. The patient was able to visit the hospital before admission and meet the staff that would be caring for them.

- Fifty-four staff in the hospital had attended 'Dementia Friends' training to give them further insight in to caring for people living with dementia.
- The hospital had worked closely with the local Healthwatch group in the redesign and refurbishment of the hospital and was to have a room specifically tailored to patients living with dementia.
- Staff accessed interpreter services for those patients who spoke a different language or those who were deaf.
- Pre assessment allowed care to be tailored to each patient as an individual. It focused on the safe discharge of patients and ensured risks and individual needs were identified as early as possible.
- Theatres allowed a relative or carer to accompany a patient with learning disabilities to the anaesthetic room.

Learning from complaints and concerns

- The hospital had a robust complaints process and was proactive in dealing with any complaints received. This included inviting patients and their families into the hospital to meet with the senior team to discuss their complaint and how services could be improved for future patients.
- The complaints manager initially managed complaints; 29 complaints had been received between July 2015 and June 2016. The main themes of these complaints were financial processes, consultants and clinical issues.
- We reviewed five complaints and saw local procedures had been followed correctly. The response letters were appropriate, included an apology and were open and transparent. There was good evidence that complainants were kept updated.
- People appeared to be aware of the different methods for making a complaint. For example, formally in writing, by email or by telephone.
- We found thorough and comprehensive investigations were performed, senior managers were involved and action taken to prevent recurrence.
- Learning from complaints was shared with staff at team meetings.
- The clinical effectiveness and audit group reviewed complaints and any themes emerging to identify changes needed in practice.
- We were told of a change in practice following a complaint. Patients with hip replacements now had a pre discharge x-ray, including at the weekend.
- Staff we spoke with said they tried to resolve issues at ward level first and would contact the matron if needed.
- If issues could not be resolved and a formal complaint was made, the hospital had a complaint coordinator who would receive and track the complaint.
- Any negative feedback received on the patient questionnaire was followed up either with a phone call or face to face if the patient was still in the hospital.
- We saw information available to patients on how to make a complaint.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The hospital was led by the hospital director and matron, who were supported by the heads of department.
- During our inspection, there was a change of hospital director. This had been a gradual process with good overlap working between the hospital director leaving and the new one starting. The new hospital director had worked at the hospital before in the roles of ward manager and matron. .
- There was strong leadership displayed by the hospital director and matron. They had an open door policy.

- Staff said all managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level.
- Many of the staff had worked at the hospital for a long time. They felt it was a good place to work and that everyone worked as one big team. Many commented that it felt like a family. Staff said they felt they could go to anyone with concerns.
- Quality and patient experience was seen as a priority for staff. Staff told us that safety was not be compromised in favour of finances.
- An open and honest culture was encouraged. Staff were encouraged to complete personal reflections when involved in incidents and complaints.

Vision and strategy for this this core service

- The hospital had a clear vision and strategy. The vision was 'to be recognised as a world class healthcare provider'. The strategy was 'to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'.
- The hospital vision and strategy was well embedded with staff, who were able to articulate to us the hospital's values and objectives across the surgical wards and they were clearly displayed in ward areas.
- The values formed part of staff members' appraisals. We reviewed staff appraisal documents and saw that they identified objectives, which helped to promote the services values, and helped them comply with CQC's five key questions.
- The management team were planning ahead and recruiting extra staff that would be needed once the new build was finished.

Governance, risk management and quality measurement

- The hospital had a governance process in place as laid out in the clinical governance and quality assurance policy dated October 2014, which incorporated the governance structure and reporting channels.
- Governance was well established corporately and the hospital had recently appointed a governance and quality lead with responsibility for audits, incidents and root cause analysis (RCA).
- Hospital meetings included heads of departments, senior management team, infection control committee and the clinical audit and effectiveness group. These all reported into the governance meetings, which in turn reported into the medical advisory committee (MAC) and the Spire national clinical governance and quality committee.
- A health and safety committee, chaired by the hospital director, met regularly to oversee output from other groups.
- We reviewed minutes from ward and department meetings, senior management team meetings and the clinical audit and effectiveness committee. We saw that issues related to incidents, risks, complaints and audits were regularly discussed. Action plans were produced and regularly updated.
- A risk register had been in place since April 2016. At the time of our inspection it was a general risk register which was in the process of being reviewed and revised to reflect the specific risks for Spire Methley Park Hospital. However, it did adequately reflect the risks to the service and managers recognised the risks.
- There were 120 items on the risk register and 37 had been graded as high risk. The grading of risks did not always reflect the actual level of harm, as some of those graded as high risk did not appear to be high risk issues. We raised this with the management team at our inspection. They assured us that the newly appointed governance and quality lead was aware of the issues and had plans in place to address this.
- The theatre managerconfirmed that they had received a new National Safety Standards for Invasive Procedures (NatSSIPs) policy and were working through it. The guidance was to be incorporated in to an audit tool. NatSSIPs are a set of high-level national standards of operating department practice that support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures.

- External first assistants had to submit documents including an up to date DBS check, GMC registration, indemnity insurance, vaccination status and appraisal reference from the NHS hospital or university.

Public and staff engagement

- Staff took part in an annual engagement survey. As a result of the 2015 survey, staff forums were set up for staff to access support from peers without managers present.
- Staff forums were held every four to six weeks. Staff told us that they felt more informed about things since attending the forums.
- Heads of departments reviewed results from the staff engagement survey and produced action plans in response.
- The hospital management awarded 'inspiring people' rewards. Staff could nominate other staff members for good ideas or going that extra mile above and beyond their duty.
- Cards were available for patients to fill in if they felt a member of staff deserved a thank you, well done or had gone that extra mile.
- Patient satisfaction surveys were given to patients during their admission.
- The hospital was also getting feedback from patients about the complaints process and duty of candour. A leaflet was sent by post to all patients who raised a formal complaint. This allowed patients to provide feedback on how they felt their complaint had been managed and resolved allowing the hospital to reflect, learn and improve processes further.
- The hospital had introduced a regular magazine for patients and the public.
- Development meetings took place with Healthwatch.

Innovation, improvement and sustainability

- Building work was ongoing to improve the facilities. This would see the number of beds increased to 30 and a designated endoscopy suite that would aim to be Joint Advisory Group (JAG) accredited.

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

- The hospital had a good culture of incident reporting and we found good evidence of learning from incidents. Staff understood their responsibilities to raise concerns.
- For example, in radiology a radiographer told us about a needle stick injury they had reported. Because of this incident, the department now used safety needles and had a pack made up with the needle stick injury pathway and the blood forms required.
- In the 12 months from July 2015 to June 2016, there had been no never events or self-reported inpatient deaths at the hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- The hospital had an electronic incident reporting system and staff were encouraged to report incidents. In the 12 months from July 2015 to June 2016, there had been 44 clinical incidents reported in outpatients and diagnostic imaging services. This represented 14% of the total incidents reported in this period at the hospital. The assessed rate of clinical incidents was similar to the rate of other independent acute providers.
- In the same reporting period (July 2015 to June 2016) there had been four non-clinical incidents reported in outpatients and diagnostic imaging. This is lower than the rate of the other independent acute providers.
- In radiology, there had been two incidents involving ionising radiation between July 2015 and June 2016; under the Ionising Radiation (Medical Exposure) Regulations, these did not need to be reported to the Health and Safety Executive or Care Quality Commission. We reviewed these incidents and saw they had been documented as required.
- Staff we spoke with were aware the requirements of the duty of candour; they knew about being open and honest with patients and families when things went wrong.
- The hospital had invoked duty of candour on one occasion between July 2015 and June 2016. We reviewed this incident and found that identified practice have been changed even though no direct failing was identified. This meant post-operative x-rays were now always performed before discharge. Previously no x-rays were performed at the weekend, and the patient would wait until the follow-up appointment.
- The new process had been audited, and showed that three times more x-rays were now being performed prior to patient discharge.

Cleanliness, infection control and hygiene

- There were effective systems in place to reduce the risk and spread of infection; people were cared for in a clean hygienic environment.
- In the outpatients and radiology waiting area, the seating was appropriate with washable fabric. The

noticeboards were glass covered. Curtains were disposable and had been changed at the end of June 2016; staff told us the curtains were changed every six months.

- Patient feedback from the patient satisfaction survey in September 2016 showed that 97% of respondents felt cleanliness at the hospital was excellent or very good.
- In the 12 months from July 2015 to June 2016, there had been no incidents of MRSA (methicillin-resistant Staphylococcus aureus), and MSSA (methicillin-sensitive Staphylococcus aureus), Clostridium difficile or E. coli at the hospital.
- Appropriate containers for the disposal of clinical waste, including sharps bins, were available and in use in all the departments visited.
- All the instruments used in the ENT room were disposable. At the time of the inspection, scopes for ENT were being cleaned with disinfectant wipes. Staff told us this was a temporary measure and scopes would be taken into theatre for cleaning when the building works were completed. We saw there was a policy for three-stage scope cleaning process; this was in date with a review date. The policy had been signed off as an appropriate solution by the consultant microbiology lead who confirmed this met all decontamination requirements for this equipment.
- The phlebotomy room used individual disposable tourniquets.
- We observed green cleaning assurance stickers attached to equipment, indicating that equipment had been cleaned.
- We reviewed radiology cleaning rotas, which were completed by domestic staff and radiographers; we found good compliance.
- We observed staff using personal protective equipment (PPE), such as gloves and aprons, appropriately and complying with the arms bare below the elbows requirement. Hand gel was available in all areas with signage encouraging people to use it.
- Staff were trained in infection control. Mandatory training figures showed 85.3% of staff at the hospital had completed infection control training by July 2016. The training year ran from January to December and the target for compliance by the year-end was 95%. This meant the hospital was on track to meet this compliance target by the year-end.
- We found all the actions from the most recent legionella risk assessment and water hygiene audit been completed. The site manager had undertaken legionella refresher training in the approved code of practice the week before the inspection.

Environment and equipment

- The outpatients, radiology and physiotherapy departments were located on the ground floor of the hospital. Outpatients and radiology were co-located and shared a waiting room. Signage throughout the internal and external areas was clear.
- The hospital's patient-led assessments of the care environment (PLACE) scores for 2016 were the same or higher than the England average for cleanliness, food, condition, appearance and maintenance. Staff told us there were plans for the gardens to be landscaped once the building work was completed.
- During the same reporting period, the hospital's PLACE scores for dementia, disability, privacy, dignity and well-being were lower than the England average. The hospital had plans to improve the facilities for patients with additional care needs, such as dementia and disabilities.
- The outpatients' treatment rooms had positive air pressure; positive air pressure is required in all treatment rooms were minor procedures take place. The matron told us the new treatments room would have an improved air exchange rate.
- All the equipment in the outpatients department had been electrically checked in December 2015.
- Radiology senior staff told us they were getting quotes for a new ultrasound machine, which they were hoping to get in 2017 and senior managers confirmed that this had been added to the capital expenditure budget for 2017.The current ultrasound machine had been installed in November 2009 and had been regularly serviced and maintained in line with requirements.The ultrasound machine was also used for echocardiograms and urodynamics.

Good

Outpatients and diagnostic imaging

- All of the general radiology equipment was CR (computerised radiology). Computerised radiology is old technology and DR (digital radiology) is replacing it. DR is faster, gives better resolution and image quality and less radiation exposure for patients. Mammography equipment had full field digital radiology.
- We saw radiology had an equipment inventory on display and in a folder. Staff told us equipment was regularly serviced, records reviewed confirmed this.
- We reviewed the annual Radiation Protection Advisor (RPA) radiation safety survey for equipment performance, dated 1 September 2016. Results showed that equipment safety features and warning devices operated correctly, patients were protected from exposure to ionising radiation and the equipment was safe to use.
- We noted there was no wash hand basin in the mammography room or the ultrasound room, hand gel was available in both rooms and the ultrasound room had a wash hand basin in the adjacent ensuite room, which staff and patients could use.
- In the radiology department, personal protective equipment (PPE), including lead gowns, were checked and found to be in good condition. Senior staff told us these were checked quarterly for tears and checked before every use for cleanliness.
- Staff in radiology told us the hospital had one hoist, which was kept in physiotherapy and had disposable slings.

Medicines

- Appropriate arrangements were in place for obtaining, recording and handling medicines.
- Senior staff told us the hospital and services were expanding and acknowledged the pharmacy service needed to cover increased hours and further resource was required.
- The hospital was recruiting into several new pharmacy posts to provide the assurance systems and staff cover required. In the interim, a robust action plan was in place, with support from the pharmacy superintendent for Spire Healthcare. This was a standing item on the senior team action plan and agenda.
- We asked the staff in radiology whether the where any problems with the pharmacy service. They told us there had been a problem that morning where they had received six tablets instead of 10. Staff had completed an incident form, sent the box back and re-ordered.
- We checked medicines storage in the departments visited. We found medicines stored securely appropriately in locked cupboards and fridges. No controlled drugs were stored.
- Fridge and room temperatures where medicines were stored were recorded daily; we checked the records and found there were all completed as required.
- Prescription pads were stored in a locked cupboard and there was a patient tracking system in place.
- Medications that were required in ophthalmology were stored in the fridge and taken to the ophthalmology consulting room at the start of the clinic.
- Radiology had a locked medicines cupboard in the main x-ray room. Stock held included antibiotics and contrast media, there were no controlled drugs.
- We reviewed daily temperature check records and the monthly check for expiry dates; these were both completed as required. We saw that short-dated medicines were labelled.
- Patient group directives (PGDs) in radiology were all signed and up-to-date. PGDs provide a legal framework, which allow some registered health professionals to supply and/or administer medicines without them having to see a doctor or dentist.

Records

- Fully integrated single patient records were maintained on site and a dedicated medical records team managed the processes.
- We reviewed 10 sets of patient records in outpatients; we found these were well maintained and completed correctly.
- The provider reported that over the previous three months' the hospital had seen less than 1% of patients in outpatients without all their relevant medical records

being available. Internal checking processes were in place to ensure any missing information could be located prior to a patient's outpatient clinic appointment.

- If the record could not be located, then the team would make up a temporary set of notes using the most recent consultant letters and investigation results from the electronic archive systems.
- Original copies of medical records were not permitted to be taken off site by consultants unless there was a clinical emergency. The hospital told us that having on-site medical secretaries meant there was rarely a need for consultants to request notes to take away.
- Medical records were paper-based; three months of records were kept on site after which time there were archived off-site. Staff in the medical records department told us they were not aware of any plans to change to electronic records.
- There was also a team of medical secretaries on site who supported the consultants; they dealt with more than 98% of clinical activity.
- In radiology, we found staff scanned referral forms onto the radiology information system (RIS). This was an example of good practice; we saw the forms included consent, justification and previous imaging.
- Radiology was due to get a new picture archiving and communication system (PACS) in January 2017.

Safeguarding

- The hospital had withdrawn services for children and young people under the age of 18 years on 1 October 2016 to enable a full review of services in line with latest national guidelines.
- Safeguarding policies were in place and provided staff with information about identifying, responding to and reporting any safeguarding concerns.
- The majority of staff working at the hospital were trained to adult safeguarding level 1 and 2 and three staff were trained to safeguarding level 3. Safeguarding training figures were high; 82.4% of staff had completed safeguarding level 2 training by July 2016. This meant the hospital was on track to meet the target for compliance, which was 95% by the year-end. Training data was not disaggregated; this was because it was a small service and some staff worked between departments.
- The hospital director was the safeguarding manager and the hospital matron was the safeguarding lead. There were plans to roll out level three safeguarding to other key members of staff.
- Staff we asked about making a safeguarding referral all told us they would report their concerns through a manager, if available, or the hospital matron. None of the staff we spoke with had ever identified or reported any safeguarding concerns. The matron confirmed that the hospital had never made a safeguarding referral.
- The hospital's safeguarding children e-learning module, and safeguarding policies, included information about recognising and reporting female genital mutilation (FGM).This was added in January 2016 following the introduction of a new statutory duty for health professionals to identify and report cases of FGM in October 2015.In addition, Spire had issued a clinical briefing to all staff to give a quick guide tool.
- However, despite 94% of staff having completed this training, when we asked staff about FGM and domestic abuse, they told us they could not recall the training. We were not assured that staff would know what to do if they identified a woman that had experienced FGM.
- We raised the issues we found about staff safeguarding knowledge with the management team at the announced inspection. When we returned on the unannounced inspection, we found remedial actions had already been taken. This included information on display about reporting FGM and flowcharts for making a direct safeguarding referral.

Mandatory training

- Mandatory training compliance rates were high. For example, in 2015 the hospital achieved more than the 95% completion target.
- The training year ran from January to December, and in July 2016, 159 out of 204 (78%) staff were fully compliant with the mandatory training. At the time of the inspection, 93% of staff working at the hospital had completed all of their mandatory training.

Good

Outpatients and diagnostic imaging

- In physiotherapy and radiology, all staff were fully compliant with their mandatory training. Data was not provided for outpatients' staff separately. Managers all told us they expected to reach the annual training targets by the end of the year.
- Mandatory training included fire safety, health and safety, infection control, manual handling and equality and diversity. Staff told us all the mandatory training was done using e-learning, apart from basic life support and advanced life support. Staff could access their e-learning training at home; time was given back for any time spent completing training at home.

Assessing and responding to patient risk

- There were systems and processes in place for assessing and responding to patient risk. For example, radiation monitoring was in place as required by the Ionising Radiations Regulations 1999 (IRR99).
- The hospital had two resident medical officers (RMOs) who provided cover 24 hours a day seven days a week. They were on duty one week at a time.
- Radiology staff wore dosimeter badges; these were changed and sent for analysis every two months. A dosimeter is a device that measures exposure to ionising radiation, and is used to protect staff from the risks of working with radiation.
- The radiology department used an external radiation protection advisory body for radiation protection advice, who provided a radiation protection advisor (RPA). The clinical lead in radiology was the radiation protection supervisor (RPS) for the hospital.
- The most recent annual RPA report for January 2015 to December 2015 had been completed in March 2016 and issued in April 2016. This was due for review in March 2019. We saw from the 2016 annual report that adequate standards of compliance were achieved which met the performance expected. There was a standard template containing a summary report of staff radiation doses and full records of personal staff radiation dose levels.
- We saw that simplified versions of the radiology local rules, which had been issued in March 2015, were on display and attached to each piece of equipment.
- However, we found the IR(ME)R procedures, local rules and radiation risk assessments were not signed by the RPA and RPS as required. When we told the radiology manager about this, they said were they would rectify this immediately.
- Staff in radiology told us the local rules and risk assessment were updated every three years. Records reviewed confirmed this.
- We observed notices on display asking patients whether they could be pregnant; the radiology department had a good flowchart and guidance for pregnant patients. This meant pregnant patients were protected from the harm of exposure to radiation.
- We found the radiology department was using the Society of Radiographers' 'pause and check', which was on display in all areas, including mammography.
- We saw exposure guides were on display in radiology rooms.
- There were systems in place to ensure staff would respond if the health of people visiting the service deteriorated while they were in the department. There were an emergency call buttons in all the outpatient consultation rooms and the hospital's crash team would respond in the event of a medical emergency. Staff were familiar with the processes.
- There was a Resident Medical Officer (RMO) on-site at all times to provide immediate response to any patient need.
- Radiology and outpatients shared a resuscitation trolley, which was in a central position in the outpatient's department. There was a paediatric emergency grab bag on the top. We checked the contents of the resuscitation trolleys and records of daily and monthly checks; contents were all in date and records all completed as required.
- We saw radiology had an anaphylaxis bag, which was sealed and checked daily, there was a summary of contents on the bag. Outpatients had an adult anaphylactic bag and paediatric anaphylactic bag.

Staffing

- There were sufficient qualified, skilled and experienced staff to meet people's needs.

Good

Outpatients and diagnostic imaging

- On 1 July 2016, the hospital employed seven full time equivalent (FTE) outpatient nurses and 3.8 FTE health care assistants in the outpatients' department. The ratio of nurses to healthcare assistants in outpatients was 1.8 to 1.
- There was just over one FTE outpatient nurse posts vacant, giving a vacancy rate of 13%. There were no vacancies for outpatient healthcare assistants.
- Data provided by the hospital showed there had been no unfilled shifts in outpatients between April and June 2016.
- Bank and agency nurse usage in outpatients between July 2015 and June 2016 was between 1% and 7%, which is lower than the average for independent acute hospitals.
- Bank and agency healthcare assistant usage in outpatients between July 2015 and June 2016 was between 2% and 24%, which is higher than average when compared to other independent acute hospitals in the reporting period. In July, August and September 2015, the rates were lower than average (0%, 2% and 7% respectively)
- All bank and agency staff were subject to a robust induction process and competency checks. This provided assurance that these staff had the skills and knowledge to provide good patient care.
- There were no agency nurses or healthcare assistants working in outpatients in the last three months of the reporting period (April to June 2016).
- The rate of outpatient nurse turnover between July 2015 and June 2016 was 10%, which is similar to the average for other independent acute providers. There was no staff turnover for outpatient healthcare assistants in this period.
- Between July 2015 and June 2016, the rates of sickness for outpatient nurses were lower than the average for other independent hospitals we hold this type of data for. Apart from in August 2015, October 2015 and March 2016 when the rates were higher.
- The rate of sickness for outpatient healthcare assistants in the same period was below the average for other independent acute providers, except for in July 2015 when the rate was higher than the average.
- The nursing and physiotherapy teams accepted students on placement from two local universities.
- The radiology clinical lead told us there were five permanent radiographers and one bank radiographer. The five radiographers all worked part-time. There were no nurses working in radiology
- When we asked the radiology manager about staffing in the office, they told us they were planning to get a full-time apprentice to work in the radiology office.
- Physiotherapy employed three physiotherapists and physiotherapist assistant /administrator, all of whom worked part-time. There were six staff on the physiotherapy bank. The physiotherapy manager told us they had always been fully staffed in the 12 years they had been working at the hospital.

Medical staffing

- See surgery section for main findings.
- Patients attending outpatient clinics for appointments related to procedures carried out at the hospital saw their own consultant.
- At the time of the inspection, radiologists did not provide an on-call service; this had been risk assessed. Any patient requiring an emergency CT or MRI scan was transferred for this procedure and results would be reported at the point of investigation

Major incident awareness and training

- Staff told us they had regular fire evacuation tests and the hospital had comprehensive emergency procedures in place.
- We saw the hospital had a business continuity plan and held planned scenario training that included contingency arrangements for the outpatients and radiology departments. Radiology had effective systems in place in the case of a radiation incident; these were documented in the radiation safety policy.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected effective but we do not rate.

Good

Outpatients and diagnostic imaging

Evidence-based care and treatment

- The hospital followed Spire corporate policies and procedures which were accessible to staff on the hospitals intranet. We saw these referenced the National Institute for Health and Care excellence (NICE) and national guidance.
- The hospital also had local policies for the specific work they did around gender reassignment. The matron and senior management team (SMT) reviewed these.to ensure compliance with current best practice.
- In outpatients, we saw corporate policies were available to staff and were all in date. Staff showed us local policies on the intranet, for example transport of specimens.
- Local policies and procedures in radiology were reviewed every two years; staff were required to read and sign whenever a policy or procedure was updated.
- The radiology department did not participate in the Imaging Services Accreditation Scheme (ISAS).
- Radiology had a good radiation safety policy, which had last been updated in March 2015 and was due for review in March 2018. We saw that each page had been signed by the hospital director. We also reviewed the 'appointment of RPS' letter.
- We reviewed the information policies and guidelines for diagnostic imaging and found these were comprehensive and of a good standard. These included state registration, mammography certificate of competency, clinical authorisation of reports and symptomatic and asymptomatic breast imaging procedures.
- Radiology was using the quality assurance guidelines for mammography in accordance with the NHS breast screening programme publication No 63 (April 2006). Mammography policies reviewed stated that Spire adopted NHS breast screening programme standards in April 2010.
- The department was not inspected by the NHS breast screening programme but did use the national NHS breast screening guidelines and competencies.
- Staff told us there was a quality assurance program for image quality, which included regular peer-reviews.
- Mammography undertook quality assurance every three months and the hospital worked with a link hospital in Surrey. We reviewed the results and found these were very good.
- All mammography images were double read as recommended by the NHS breast screening programme in 2013.
- The peer review of images met the current Standards for the Reporting and Interpretation of Imaging Investigations (2015).
- We also reviewed radiology's IR (ME)R and IRR99 procedures and found these were all compliant with current national guidelines.
- Radiology staff had signed to say they had read the policies and procedures.
- We saw radiology had carried out a patient dose audit in August 2015; the department had adopted national diagnostic reference levels. It is good practice to use diagnostic reference levels to manage radiation doses to patients. This ensures patients are not exposed to doses of radiation unnecessarily.
- Radiology had also carried out an audit on the completion of referral forms in 2015, which showed very good compliance.
- The hospital matron told us outpatients complied with NICE guidance NG45 for Routine preoperative tests for elective surgery (April 2016). This includes guidance for investigations and testing.

Pain relief

- When patients reported experiencing pain, staff said they would assess the level of pain and contact the consultant or registered medical officer for advice and support as required.
- Staff in physiotherapy showed us the forms they used for recording pain scores; these had a scale of 0 to 10. They aimed to reduce the pain score at each visit. These 'pain management tracking' forms were used for every patient.

Patient outcomes

- Radiology held an annual meeting of the radiation protection committee. We saw that the radiation protection advisors most recent annual report was

dated 2 April 2015 showed patient radiation dose audits had good compliance national diagnostic reference levels (DRLs). Radiology had adopted national DRLs because the departmental activity was too low to establish local DRLs.

- There was limited audit of patient outcomes in outpatients.

Competent staff

- Information provided by the hospital showed 100% of outpatient nurses and healthcare assistants had completed their appraisals in the current year and in 2015, 100% of staff had received an appraisal. In radiology and physiotherapy, the appraisal compliance rate for the current year was also 100%.
- The appraisal year ran from January to December. The appraisal process within Spire healthcare was called 'Enabling Excellence.'
- The healthcare assistants working in outpatients all had NVQ level two or three and they were all trained in phlebotomy (taking blood). Outpatient staff had an annual review of competencies. We reviewed the competency file for all staff members in outpatients and saw these had been recently updated in October 2016.
- One of the nursing staff had been on an external breast care course.
- Radiology staff had attended national conferences, for example, staff had attended United Kingdom Radiological Conference for radiographers and radiologists.
- The clinical lead radiographer told us all the radiographers were qualified to work in general radiology and three were qualified to work in mammography. Two of the radiographers had the postgraduate certificate of education (PGCE) in film reading.
- We asked the clinical lead radiographer about non-medical referrers, they told us there was only one external physiotherapist who could make referrals. They explained that the department would not accept non-medical referrers unless they had completed IR(ME)R (ionising radiation medical exposure regulation) training.
- When we asked the matron and outpatients manager about clinical supervision, they told us they used staff meetings for group supervision where incidents were discussed. Nursing staff in outpatients did not receive planned individual clinical supervision. Managers could recommend individual clinical supervision and staff could also request this.

Multidisciplinary working (related to this core service)

- All staff we spoke with told us the internal multidisciplinary team (MDT) working at the hospital was good. One radiographer told us they regularly liaised with all the other departments in the hospital, especially theatres and outpatients.
- There was a one-stop breast care clinic in mammography on Wednesday afternoon. Staff told us this was a triple assessment clinic for symptomatic patients led by two breast radiologists from the local NHS trust. Investigations included a consultant examination, mammogram (if over 50) and ultrasound.
- Staff in radiology told us they had good working relationships with the radiologists.
- In physiotherapy, staff told us they completed clinic reports to keep the consultants informed about the patient's progress. They said they had regular discussions with the consultants, who often asked their opinions.
- Staff in medical records told us the whole hospital worked well as a team; they said they liaised daily with secretaries, ward staff and outpatients' staff.
- The hospital had a GP liaison and hospital relationships manager who managed external relationships.

Seven-day services

- Opening times for clinics and services met the needs of people that worked during the day.
- In outpatients, the reception desk was open from 7am to 9pm Monday to Friday, 8am to 8pm on Saturdays and 8am to 5pm on Sundays.
- Radiology and physiotherapy services were available from 8am to 8pm every weekday. Radiology evening

Good

Outpatients and diagnostic imaging

clinics from Monday to Friday, usually finished at 8:30pm apart from on Tuesdays (7pm) and Fridays. On Friday evenings, there was a breast clinic, which finished between 7pm and 9pm.

- Radiology had an on-call service for radiographers; there was no on-call radiologist service. There was no out of hours imaging.
- Radiographers were regularly on-site Saturday mornings to follow up on images on post-operative joint surgery after the patients had seen the physiotherapist. Staff told us they would occasionally come in and do this on a Sunday too.
- Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scanning was provided by a Spire Healthcare owned mobile service. We did not inspect this service as part of this inspection. The mobile MRI scanner visited four of five times a month (once a week) and the CT scanner visited once a month.
- The RMO on duty was on site 24 hours a day; each RMO worked one week on and one week off.
- Outpatients did not provide a seven-day service; however, clinic hours had been extended to include Saturday morning and evening clinics. For example, there was a dressing clinic on a Saturday morning.
- Cosmetic surgery outpatients was open from 8am to 9pm Monday to Friday, with no weekend clinics available.
- Physiotherapy provided a seven-day service to the inpatient ward.

Access to information

- We reviewed imaging results on the radiology picture archiving and communication system (PACS). Radiology staff told us all patients' imaging results were stored and available on the PACS.
- Paper copies of imaging results were sent to the requesting consultant.
- Staff told us pathology results were available online, and paper copies of the results were filed in the patient records. Our review of patient records in outpatients confirmed this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Before people received any care or treatment, they were asked their consent.
- Staff explained the risks and benefits of treatment options to patients as part of the consent process. This meant patients could make informed decisions about their care.
- For example, in radiology we saw there were very good pathways for intravascular contrast and MRI contrast which required patients to sign to consent to the procedure.
- Consent was completed for all procedures carried out in the outpatient treatment room. The consent form was completed and filed in the patient's notes..
- Clinical staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed 100% compliance.
- Staff said they would refer to a manager or the safeguarding lead if they were concerned about a patient's capacity to consent to their procedure. This meant decisions could be made in the patient's best interests.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- We saw patient feedback from the patient satisfaction survey in September 2016 on display in the outpatient and radiology waiting area. These showed 99% of respondents would recommend the hospital, 99% felt their care had been excellent or very good, and 100% felt the consultant care had been excellent or very good.
- One of the physiotherapists showed us email feedback from a patient who had undergone a total knee replacement in August 2016. Their feedback was very positive and said they would recommend patient care and services at the hospital.

Good

Outpatients and diagnostic imaging

- Staff we spoke with in outpatients spoke with compassion and told us they always treated patients and relatives with respect and dignity.
- All the patients we spoke with were very happy with the service and said they would recommend the hospital. They said staff were caring, friendly and approachable. One patient said the staff were always, 'smiling and happy'.
- Staff we spoke with told us working in a smaller organisation meant they had more time for the patients, and could put them at their ease.
- Radiology staff told us radiology participated in the friends and family test (FFT). The last set of results had scored 100% for patient satisfaction.
- Staff we spoke with told us they felt patients using the hospital received good care. They said many patients came to the hospital through personal recommendations.
- During the focus group meetings, staff told us they would recommend the hospital to their family and friends; several said they had experienced being a patient.
- However, in radiology, we observed that patient changing cubicles were not immediately adjacent to the radiology rooms and the ultrasound room was on a different corridor. This meant patients had to walk along the hospital corridors in gowns and dressing gowns, which did not promote / protect their privacy and dignity. When we asked staff about this, they said no patients had complained about having to walk from the changing rooms to the ultrasound room.
- At the time of the inspection, physiotherapy services were based in the gym, which had three beds. Patients were screened from one another using curtains; this meant conversations between patients and physiotherapists could be easily overheard.
- Staff explained that the service would be moving into a large treatment room in the new build the following week. This would have three private physiotherapy treatment rooms, which would improve the privacy and dignity arrangements.
- In the outpatient's main reception, we saw photographs of staff uniforms to help patients and relatives identify staff roles.

Understanding and involvement of patients and those close to them

- Radiology staff told us they explained any procedures patients were undergoing face-to-face. This meant patients had the opportunity to ask questions or raise concerns.
- Physiotherapy staff said they had extensive discussions with their patients about their surgery and recovery, and they tried to educate them about their procedures.
- All the patients we spoke with in the outpatients waiting area were very happy with their involvement in their treatment and staff explanations about their procedures.

Emotional support

- Staff supported people to cope emotionally with their care, treatment or condition. Throughout our visit, we observed staff treating patients with kindness and compassion.
- Staff were skilled in supporting people who were receiving difficult messages about their health.
- There was access to advice and counselling by specialist nurses through referrals by individual consultants. For example, a specialist breast care nurse supported patients at the one-stop breast clinic. They told us they always carried out the counselling element of the pre-assessment visit.
- One physiotherapist told us they had been into theatre with the consultant surgeon; they said this helped them to have better empathy with their patients.
- The physiotherapy manager told us the physiotherapists ensured patients were appropriately supported and prepared for their operations when they saw them at pre-assessment.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of local people using the hospital.
- We saw the shared outpatients in radiology waiting area had a television, hot and cold beverages, newspapers, magazines and information leaflets.
- All pathology services were outsourced; Spire Pathology Services provided pathology and blood transfusion services and the local NHS trust provided histopathology services. Couriers transferred samples to the testing laboratories twice a day, emergency couriers could be booked if required.
- Radiology carried out dental OPG (panoramic orthopantomography) in the general x-ray room.
- Radiology office staff told us patients could have an appointment for an MRI or CT scan at other local Spire hospitals, if the dates at the hospital were not convenient. Nuclear medicine referrals were sent to a large local trust.
- The tests available in the radiology department included CT colonoscopies and echocardiograms. Mammography ultrasound-guided biopsies were performed., However, if the consultant requested a stereoscopic procedure, patients would be referred to the local NHS trust. The hospital did not have the equipment for the removal of breast lumps.
- There were no sonographers in radiology; the ultrasound service was consultant led.
- Staff told us breast screening was carried out on patients aged 40 and above; policies we reviewed confirmed this.
- Radiology also carried out chest x-rays for people applying for jobs abroad.
- At the time of the inspection Spire healthcare offered 'Lifescan' procedures, such as diagnostic imaging scans and blood tests. These were compliant with current Department of Health guidance. However, Spire Healthcare withdrew this service on 2 December 2016.

Access and flow

- People using the service could access care and treatment in a timely way.
- Outpatient clinics, radiology and physiotherapy services were planned flexibly over six days, including early mornings, late evenings and Saturdays. This meant patients could attend their appointments without needing to take time off work.
- The provider met the 92% national indicator for referral to treatment (RTT) on incomplete pathways waiting 18 weeks or less from the time of referral in the reporting period (July 2015 to June 2016).
- Above 95% of patients started non-admitted treatment within 18 weeks of referral in the reporting period July 2015 to June 2016. Apart from in April 2016 and June 2016 when 93% of patients started treatment within 18 weeks of referral.
- The hospital reported that no patient had waited six weeks or longer from referral to MRI, CT or non-obstetric ultrasound in the reporting period July 2015 to June 2016.
- The Clinical lead radiographer confirmed the turnaround time for MRI results was four to five days.
- Staff in the radiology office told us the department used 'live dictation;' this ensured patient results were reported as soon as the medical secretary and the radiologist's dictation to the report.
- Physiotherapy staff were the first staff to see surgical patients post discharge for hip or knee surgery
- New patients could usually get a physiotherapy appointment within a week.
- Do not attend rates were monitored by the administration team. There was a process in place to record this on the patient administration system and follow-up, as appropriate.

Meeting people's individual needs

Good

Outpatients and diagnostic imaging

- Services had made reasonable adjustments to meet the needs of people with additional needs, such as age, disability or people living with dementia.
- Outpatients and radiology were located on the ground floor. We saw the shared waiting area had several high seat chairs with arms to assist people with mobility problems and a hearing loop was provided. However, we saw the reception desk in this area did not have a low area for patients in wheelchairs. The reception desk in cosmetic surgery outpatients did have a lower area.
- We saw the toilets in this area were well labelled, with dementia friendly signage (picture of a toilet) on the doors. There was also a disabled toilet and baby changing area.
- A total of 54 people working at the hospital had been trained as dementia friends.
- Staff told us they could arrange for interpreters if these were needed for people whose first language was not English or people who could communicate by British Sign Language
- When we asked about bariatric patients, staff in physiotherapy told us there would be a bigger couch in their new area. The outpatients' manager told us there was a bariatric wheelchair. Staff in outpatients showed us there were extra-large cuffs available for the blood pressure machine. The hospital did not carry out surgery on bariatric patients.

Learning from complaints and concerns

- See surgery section for main findings.
- Senior staff told us learning from complaints was shared with staff at departmental meetings. Staff we spoke with confirmed this, for example in radiology staff told us they received feedback about complaints received at staff meetings and heads of departments meetings.
- Physiotherapy staff told us there been no complaints about their department.
- We saw information was available for patients on how to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership / culture of service

- The hospital was led by the matron and the hospital director, who were supported by the heads of department.
- At the time of our inspection, the hospital director was due to move to a neighbouring Spire location. Some staff told us this move had caused unrest, however, they also told the new hospital director had worked at Spire Methley Park in the past.
- The hospital management team were proactive, visible and supportive of each other and their teams. Managers told us they had an open-door policy. Staff we spoke with told us the management were flexible, approachable and visible.
- Several staff related instances of management being supportive and understanding when they had personal problems, such as family illness or bereavement.
- The physiotherapy manager, who was a physiotherapist, also managed radiology. Radiology had a clinical lead radiographer, who was also the radiation protection supervisor (RPS).
- The outpatient manager position had been vacant for some months; however, a newly appointed outpatient manager had been in post since August 2016. Staff we spoke with in main outpatients and cosmetic surgery outpatients confirmed they had been without a manager for a few months between the previous manager and the new manager. The management team acknowledged that leadership and management of the outpatients departments was one of the hospital's current challenges.
- The hospital had a stable workforce and staff turnover was low.
- Staff told us communication was good and they were well informed. Methods of communication included forums, newsletters (Methley Matters) and team meetings.

Good

Outpatients and diagnostic imaging

- Staff we spoke with told us it was nice working in a smaller hospital as they got to know everyone and had more opportunities to learn about work in other departments. Staff told us everyone working at the hospital was supportive.
- Staff told us they all worked flexibly, in radiology all the part time staff overlapped; this ensured there could be a handover.
- Radiology staff told us people came in for the staff meetings on their day off.

Vision and strategy for this this core service

- See surgery section for main findings.
- We found staff were aware and engaged with the values of the hospital. They were also aware of the Care Quality Commission's five key questions and were using them in their enabling excellence (appraisal) work.
- The senior management team (SMT) were being proactive in recruiting staff in advance of April 2017, when the building work would be completed and the hospital would be fully open.
- We saw noticeboards in the outpatients and radiology waiting area displayed information about the hospitals vision, mission and values.

Governance, risk management and quality measurement for this core service

- See the Surgery section for main findings.
- A risk register had been in place since April 2016. At the time of our inspection it was a general risk register which was in the process of being reviewed and revised to reflect the specific risks for Methley Park Hospital. The grading of risks did not always reflect the actual level of harm. We raised this with the management team at our inspection. They assured us that the newly appointed governance and quality lead was addressing this.
- Outpatients had six risks on the hospital risk register. These included poor compliance with safeguarding, failure to obtain written consent for minor procedures and poor processes for collection, testing and reporting specimen results. We found these risks were adequately controlled during our inspection.
- Radiology did not hold separate governance meetings; the clinical lead radiographer attended the clinical effectiveness and infection control meetings within the hospital. We saw that the radiology staff meetings included discussions about governance.
- The radiology manager knew what radiology risks were on the hospital wide risk register.
- We saw evidence of radiation protection committee meetings and minutes in radiology.
- Radiology had a comprehensive audit programme. Staff carried out regular audits of WHO checklists, consent forms, request forms, and warning lights. Audit analysis showed that the reject rate was below 3%, which is good and the automatic exposure chambers (AEC) device sensitivity tests showed no issues.
- There was a lack of national audits relevant to outpatient services, however the hospital had a number of local audits in place to measure services and participated in audits linked to Spire's clinical scorecard. Such examples included monitoring waiting times, cancellations, DNA rates, infection control, pre-admission risk assessments for VTE and pregnancy status, patient satisfaction, and equipment checks.
- Staff in outpatients told us they audited delays in clinics; each nurse was given 15 patients per month to check whether there had been any delays. They said this helped to identify trends, such as regular delays with the same consultant.

Public and staff engagement

- Friends and family test results for the hospital showed patients in radiology and physiotherapy were 100% satisfied.
- Staff told us they were getting a system to allow patient feedback on the hospitals 'You said - we did' via the hospital's Wi-Fi system.
- The hospital was also getting feedback from patients about the complaints process and duty of candour. A leaflet was sent by post to all patients who raised a formal complaint. This allowed patients to provide feedback on how they felt their complaint had been managed and resolved allowing the hospital to reflect, learn and improve processes further.

Good

Outpatients and diagnostic imaging

- The local Healthwatch and been involved in PLACE audits, outpatient audits, plans for the new build, and the external planning. This included establishing a community allotment.
- Staff we spoke with knew the values of Spire Methley Park and how they applied in their job roles. They also told us about the changes following the last staff survey, in October 2015. They said the managers took the results seriously and staff meetings were now held every four to six weeks to gain a better understanding of the teams and to provide peer support.
- Staff told us about the 'Ask xxxxx (hospital director's name)' box which was in the staff room. They said staff used this box to make suggestions and give feedback.
- Staff told us Spire was a good company to work for, they said benefits included cinema tickets, help with childcare and cycle to work schemes. The hospital had 'inspiring people' awards to reward innovative ideas and staff that had gone the extra mile for patients or colleagues. Awards were displayed in the staff restaurant and in staff newsletters.
- Staff in radiology told us they had monthly staff meetings, we saw current minutes on display on the noticeboard and previous minutes were available in a folder.
- Staff told us they got copies of the heads of department meetings, and they were required to read and sign.
- Staff in physiotherapy told us they had had a lot of input into the new build, even down to choosing the floor colour.
- Feedback from patients in physiotherapy showed the department scored 3.7 out of four for confidence in care.
- The hospital had introduced three type of comment cards, which patients, visitors and staff could use to show their appreciation. The cards were 'a big thank you,' 'well done' and 'you went the extra mile.' Staff members were also encouraged to use these to recognise the same in their colleagues. This way to gather feedback from people who used services had been recognised by Spire Healthcare and shared across the group.

Innovation, improvement and sustainability

- Building works were in progress at the time of the inspection. When these were completed the two outpatients' departments would be combined with a total of 10 consulting rooms. The physiotherapy department would also have improved facilities and three private treatment rooms.
- There were plans in radiology to introduce voice recognition software; staff told us this would relieve pressure within the department, especially on the administrative staff.

Outstanding practice and areas for improvement

Outstanding practice

Staff had worked closely with the local Healthwatch; they had done environment checks and assessed the hospital for dementia and learning disability friendliness. They had worked closely together to design a dementia friendly room as part of the new building work.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should implement plans to ensure there is appropriate pharmacy provision at the hospital.
- The provider should continue to review and revise the risk register to reflect the specific risks for Spire Methley Park Hospital.
- The provider should consider installing clinical hand wash basins and hard flooring in patient bedrooms as part of the refurbishment programme.
- The provider should continue to raise staff awareness regarding safeguarding including domestic abuse.
- The provider should review the audit programme within the outpatient department.