

Spire Healthcare Limited

Spire Parkway Hospital



Quality Report

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This report describes our judgement of the quality of care at this hospital. 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 hospital	Requires improvement	
Surgery	Requires improvement	
Outpatients and diagnostic imaging	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Parkway Hospital, part of Spire Healthcare, offers private hospital treatments, procedures, tests and scans to patients from Solihull and surrounding areas. The hospital offers a range of surgical procedures, cancer care, rapid access to assessment and investigation and a physiotherapy service. Paediatric services are offered to children aged three and over.

Patients are admitted for elective surgery, day case or outpatient care. There are no urgent admissions.

Facilities included 42 beds each with ensuite facilities, including two double rooms, 8 beds in day care, and four in the high dependency unit. There are four theatres, outpatient facilities, and plans are underway for a refurbishment of the cancer care suite. Cancer care was being delivered in temporary accommodation. The hospital also offered services to NHS patients on behalf of the NHS through local contractual agreements and 24% of its activity was NHS funded care.

Prior to the CQC on-site inspection, the CQC considered a range of quality indicators captured through our monitoring processes. In addition, we sought the views of a range of partners and stakeholders. A key element of this is the focus groups with healthcare professionals and feedback from the public.

The inspection team make an evidence based judgment on five domains to ascertain if services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

Our key findings were as follows:

Spire Parkway Hospital was selected for a comprehensive inspection as part of a first wave of independent healthcare inspections. The inspection was conducted using the Care Quality Commission's new inspection methodology.

The inspection team included CQC inspectors, doctors, nurses, expert by experience and senior managers with experience of working in the Independent Healthcare sector. The inspection took place on 21 July 2015, with an unannounced visit on 1 August 2015. The inspection team looked at the following core services: surgery, high dependency unit (HDU) services for children and young people, outpatient and diagnostic imaging services.

We saw an area of outstanding practice:

- Installation of a new MRI scanner which has a wider bore, more comfortable for patients, with the added capability of treating uterine fibroids with MR guided Focused Ultrasound Surgery (MRgFUS), only two of its kind nationally.

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

Importantly, the provider must:

- Ensure the hospital maintains complete sets of patient records on site and ensures patient confidentiality is maintained at all times.
- Ensure robust governance arrangements are in place to ensure consultants adhere to the hospital's directives when risks had been identified and action required to monitor and mitigate risks.
- In addition the provider should:

Summary of findings

- Ensure all medications are managed as per Spire Medications Policy.
- Improve incident reporting across all areas of the hospital including pharmacy.
- Improve mandatory training attendance for all staff including MCA and DoLS.
- Ensure clinical audits include findings, actions and demonstrate patient outcomes so care improvements can be measured clearly.
- Ensure the Lone Working Policy applies to all staff working at the hospital and includes staff working out of hours.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff reported incidents using an electronic reporting system. Outcomes and learning from incidents were cascaded to staff. However, incidents were often recorded by a senior member of staff and not by the staff member directly involved. Low harm and near miss reporting of incidents such as faulty equipment needed to be improved and were not routinely reported using the electronic system.
- Staff were aware of the duty of candour and a robust Duty of Candour Policy was in place for staff to access electronically and in paper form. Senior hospital staff recalled more than 600 patients at Spire Parkway Hospital relating to historic operations performed by a former breast care surgeon. The recall of patients was to provide a full explanation and apology for care and treatment which had gone wrong. The recall register was in place and the recall process was completed in June 2015.
- Staff were aware of their responsibility to safeguard adults and children and the action to take if there was a concern and both training courses in 2014 were well attended. There was an open culture and a named safeguarding lead, known to all staff.
- There was a resident medical officer (RMO) at the hospital with skills appropriate to the hospital case mix available 24 hours a day seven days per week. Consultants were responsible for their patients throughout their inpatient and day case stay or a 'buddy arrangement' using a deputy consultant in their absence. However this arrangement was not robust because cover arrangements was not a formal process. We were not assured the hospital demonstrated clearly that the named buddy has been checked and was available before each period of absence or had communicated who had medical responsibility of their patient's care to the ward staff. At the time of the inspection 60% of consultants had a buddy system in place. Post inspection we were informed this figure has increased to 82%.
- There were sufficient staff to meet people's needs across outpatients and diagnostic services and surgery. A recruitment campaign was underway to meet vacancies across all areas

Requires improvement



Summary of findings

and many staff worked overtime and as part of a bank to ensure safe staffing levels. We saw an increase in agency usage across the OPD services to backfill vacancies which were not filled by hospital bank staff.

- The children's service was small and was staffed in line with national guidance for surgical and theatre staff. Children's' outpatient appointments were carried out throughout the week and children's surgery was carried out on the first Saturday of each month. Paediatric nurses were provided by an external organisation under a service level agreement. All staff who provided paediatric care had paediatric experience and had emergency paediatric life support training.
- Consultants were required to be available on site within 45 minutes. There was a resident medical officer (RMO) in the hospital at all times. In case of an unexpected emergency, the hospital had a resuscitation team consisting of the RMO, a HDU nurse, a senior nurse and an operating department practitioner. Staff in the operating theatre and a general anaesthetist were also available.

Are services effective?

- Local policies and care pathways to treat patients followed national guidance. Governance and research and the introduction of new technologies had been followed.
- There was some participation with national audits, benchmarking clinical practice was measured and compared across the 39 Spire Healthcare Hospitals. A clinical scorecard was updated monthly and performance and quality was monitored and measured using a RAG rated system which fed up to the central governance team. Any area rated red was escalated automatically and remedial action plans were in place to address concerns.
- Initial data submitted by the hospital relating to unplanned readmissions was contradictory. Further data was submitted which showed between March 2014 and April 2015 there had been 12 unplanned readmissions to hospital, this was 'similar to expected' compared to the other independent acute hospitals.
- Staff understood their responsibilities in relation to gaining consent. However, staff were unclear about their responsibilities under the Mental Capacity Act 2005 and when an assessment should be carried out. Staff had not fully

Requires improvement



Summary of findings

understood when they should initiate a Deprivation of Liberty Safeguard (DoLS) although it is noted that there had not been any instances where this had been a requirement at Spire Parkway Hospital.

Are services caring?

Good



- We observed that patients were treated with dignity and respect across all areas of the hospital and achieved 100% for their equivalent of the NHS FFT (friends and family test). Patients' emotional needs were supported by ward staff and a specialist nurse provided one to one advice on admission, during the stay and on discharge.
- The needs of patients living with dementia or who had a learning disability were identified at pre-assessment and were supported by staff across the hospital.

Are services responsive?

Good



- Patients were positive about the information they received to help them in making decisions. Written information was available to support verbal information, however this was only available in standard English text. We were told by the hospital information could be translated in advance into other languages on request by the contracted translation service.
- Patient operations and procedures were rarely cancelled. The hospital undertook 24% NHS funded care. There was no differentiation in care provision between NHS or private patients, although theatre staff told us that if cancellations were required this would more likely be for NHS patients.
- Historical complaints relating to a former breast care surgeon had generated a significant volume of issues during the past few years. The hospital had reviewed its complaints' procedure and the complaints' policy and process was robust. Staff at all levels were aware of their responsibilities as to the management of service specific and hospital level complaints.

Are services well-led?

Requires improvement



- During the inspection we reviewed the 15 recommendations made by an independent review body as a result of a review commissioned by Spire Healthcare and completed in March 2014. The review had been commissioned in April 2013 to report on the governance arrangements at Spire Parkway and Spire Little Aston hospitals in the light of concerns raised about the surgical practice of a consultant surgeon who operated at those two locations. The consultant's practice led to the

Summary of findings

consultant's ultimate dismissal and the recall of more than 600 patients at Spire Parkway Hospital. We found evidence at this inspection to demonstrate that the majority of the recommendations made by the independent review had been implemented at the hospital. In addition to the 15 recommendations made by Verita, Corporate Spire had adopted a further eight actions across the Spire hospital network to improve governance and monitoring arrangements. We were assured all eight had been completed at Spire Parkway

- Not all staff were aware of the Hospital's vision to be the first independent hospital of choice in the city or the Spire's corporate vision and strategy, but identified with values of the hospital and the need to provide excellent care.
- Consultant competencies were assured through annual appraisal, biennial reviews and the General medical council (GMC) revalidation process. We saw appraisals were up to date and signed off by the appraiser from the local NHS trust.
- Consultant competencies were also assured through the clinical review process. This formed part of the biennial review and included reviewing the clinicians' whole practice appraisal, untoward incidents, increased new patient to follow up ratio, overbooking of OPD appointments, general activity, behaviour and complaints data.
- Communication between the senior management team and consultants required improvement. There had been a directive from the senior management team to cease all children's tonsillectomy procedures from January 2015 until results of an investigation concerning the practices of one consultant had been reviewed. We saw during our inspection, one consultant had booked a child's procedure in for surgery against the hospital directive and the theatre manager had not been informed of this. The procedure had then been cancelled. We were not assured consultants had adhered to the initial directive.
- Prior to the inspection we learned of concerns raised with a second consultant at the start of 2015, the senior staff member highlighted anomalies in practice which led to the suspension of their practising privileges and subsequent investigation.
- Policies and procedures across all areas were agreed through the Medical Advisory Committee (MAC) signed off and in line with current guidance.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Requires improvement

Rating



Why have we given this rating?

Surgical services at Parkway Hospital required improvement. Services followed procedures to provide care that protected patients from avoidable harm but there needed to be improvements in incident reporting and investigations, infection prevention and control and records' management. The recall of several hundred patients relating to a previously dismissed breast surgeon had been fully completed, Duty of Candour was well embedded and the complaints process was robust. Where audits had been carried out there were minimal actions to support findings of the audit and poor evidence to measure patient outcomes. A staff induction programme was in place for new clinicians and consultants, however there was a lack of structure with timescales and signing off nurses' competencies. There were appropriate systems in place to respond to deteriorating patients and medicines were managed safely. The hospital provided a small paediatric service. Staff followed safety procedures, from admission to discharge. Lists were well organised and paediatric staff were sourced from an external organisation. The environment and facilities did not fully meet the needs of children and children's environments were created by added toys and facilities to adult areas. Staff treated children and parents in the hospital with kindness and compassion and care was delivered in a dignified and respectful manner. Staff supported people with complex needs such as those with learning disabilities or people living with dementia appropriately. Patients' pain, nutrition and hydration needs were met and staff were kind and caring. Improvements had been made with governance arrangements, however more work was required around quality monitoring processes and monitoring of actions taken on identified risks. Regular review of consultants' practising privileges was in place. However, we were not assured there were robust on call arrangements for consultants. Staff described local and senior managers as "approachable, supportive and visible"

Summary of findings

Outpatients and diagnostic imaging

Requires improvement



The outpatient and diagnostic service department (OPD) required improvement. Incident reporting was not well embedded. Complete records were not kept in the OPD as stipulated in the consultants handbook but retained by consultants and patient confidentiality needed to be tightened up. The storage of medicines needed improvement. Patients in the outpatients and diagnostic unit were protected from abuse and avoidable harm as risks were identified and responded to quickly by staff. Staffing levels were appropriate across OPD and diagnostic services with increased usage of agency staff within OPD to backfill vacancies. National guidelines were used to treat patients and these were monitored although more information on measuring and improving patient outcomes was required. Imaging regulations were followed appropriately and standard operating procedures had been developed by staff. There was a collaborative approach to care and treatment. Staff were well supported with appraisals and were competent within their roles. Appointments ran on time and results of tests were provided within agreed timescales. Equipment was well maintained and in good supply. The hospital was undergoing a refurbishment to improve and expand the areas to meet increasing demands for clinical services this included a new Oncology suite. Patients receiving chemotherapy received treatment from temporary accommodation which did not promote privacy and dignity. The new oncology suite was due for completion at the end October 2015. Staff were caring and compassionate and treated patients with dignity and respect. Patients with complex needs such as learning disabilities or patients living with dementia were well supported. Access to services was good and the majority of MRI and CT scans were being reported within 48 hours. Governance arrangements were effective to review risks, although clinical risks needed more formal documentation. Not all staff were aware of the hospital's vision and strategy, however the culture was open and transparent and staff said their departments were well led. Staff reported that the managers ensured they felt respected, valued, and

Summary of findings

engaged with good communication processes in place. Patients were encouraged to feedback on services and their comments were used to improve the service.

Requires improvement 

Spire Parkway Hospital

Detailed findings

Services we looked at

Surgery; High Dependency Unit; Children and young people's care; Outpatients and Diagnostics

Detailed findings

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Background to Spire Parkway Hospital

Spire Parkway Hospital, part of Spire Healthcare, offers private hospital treatments, procedures, tests and scans to patients from Solihull and the surrounding areas. Facilities included 42 beds with en-suite facilities, including two double rooms, 8 beds in day care, and four in the high dependency unit. There are four theatres, two of which have laminar flow ventilation systems which ensures cleaner air for more complex surgery. Outpatient facilities include 13 consulting rooms. There were 237 consultants with practising privileges to work at the hospital. Services offered covered cancer care, thoracic surgery and cardiology investigations, cosmetic and plastic surgery, dermatology, ear nose and throat conditions, gastroenterology, general surgery (eg hernia repair, haemorrhoids and varicose veins), gynaecology, neurology, neurosurgery, ophthalmology, oral and maxillofacial, orthopaedics (e.g hip and knee replacements), spinal surgery, urology, and weight loss (bariatric) surgery. The diagnostic imaging department offered rapid access to MRI scans, CT scans, X-rays, ultrasounds and mammograms. In 2013 the hospital installed a new MRI scanner which has a wider bore, more comfortable for patients, with the added capability of treating uterine fibroids with MR guided Focused Ultrasound Surgery (MRgFUS), only two of its kind nationally. The physiotherapy team provided a service for

neck pain, back pain, upper and lower limb problems and post-operative orthopaedics as well as a Women's Health Service. Services were available to people who held private insurance or to those paying for one-off private treatment. Fixed prices, agreed in advance, were available. The hospital also offered services to NHS patients on behalf of the NHS through local contractual agreements. Spire Parkway Hospital was selected for a comprehensive inspection as part of the first wave of independent healthcare inspections. The inspection was conducted using the Care Quality Commission's new methodology. The inspection team inspected the following core services:

- Surgery
- High Dependency Unit
- Children and young people's care
- Outpatients and Diagnostics

The Hospital Director for Spire Parkway Hospital was newly appointed in March 2015. The Hospital Director at the time of the inspection applied for but was not approved as Registered Manager due to a short tenure at Spire Parkway Hospital.

Detailed findings

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper Care Quality Commission (CQC)

The team included inspection managers; inspectors; a policy lead, consultant surgeon, professor in

gynaecological research, senior nurse manager, theatre nurse specialist, managers in radiology and outpatients and an expert by experience. Many of our experts had current experience of working in the independent sector.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commission group and Healthwatch. Patients were invited to contact CQC with their feedback and we

received information from more than 50 patients. We carried out an announced inspection visit on 21 July 2015 and an unannounced inspection on 1 August 2015. We held a focus group with a range of staff in the hospital, including theatre nurses, ward staff, therapists, pharmacists and other healthcare professionals and administrative and clerical staff. We also spoke with staff individually as requested. We talked with patients and staff from all the wards areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Spire Parkway Hospital.

Facts and data about Spire Parkway Hospital

The Hospital contains the following

42 beds
7 day-case beds
13 consulting rooms
4 theatres (2 laminar flow),
1 endoscopy suite
Physiotherapy department
Imaging with CT/MRI/plain radiography/Mammography
2 treatment rooms
4 HDU beds

Top five most common medical procedures.

184 Diagnostic colonoscopy
149 Facet joint injection under X-ray control
121 Diagnostic oesophago-gastro- duodenoscopy
113 Epidural injection caudal / lumbar
105 Injection +/- aspiration of joint.

Top five most common surgical procedures:

398 Phacoemulsification of lens with implant
265 Laparoscopic gastric band
157 Endoscopic resection of semilunar cartilage
148 Multiple arthroscopic operation on knee
133 Bilateral dissection tonsillectomy

Detailed findings

Staff (Doctors & dentists headcount, all other staff groups WTE):

Doctors & dentists working under rules or privileges

237 (at the time of the inspection)

Nurses:

43.9

Inpatient departments

18.6

Theatre departments

18.0

Outpatient departments

7.3

Operating department practitioners (theatre)

8.0

Care assistants:

14.7

Inpatient departments

4.9

Theatre departments

7.0

Outpatient departments

2.8

Other hospital wide staff:

Allied health professional

22.6

Administrative and clerical staff

31.9

Other support staff

11.7

Core private services provided by Spire Parkway

HDU

Diagnostic imaging

End of life care

Endoscopy

Gynaecology

Maternity

Medical care

Oncology

Outpatients

Surgery

Refractive Eye Surgery

Services accredited by a national body

Pathology laboratory has Clinical Pathology Accreditation (CPA)

BUPA accredited MRI, CT, Mammography, Colorectal Cancer Service, Breast Cancer Service, Paediatric Service

SGS -, Yardsley assessed and accredited Sterile Supplies Department.







Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Surgery

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

Information about the service

Spire Parkway Hospital provided day surgery and inpatient treatment for patients across a range of specialties.

Surgical specialities were: orthopaedics, general surgery, breast surgery, ear, nose and throat surgery, gynaecology, urology, cosmetic surgery, ophthalmology, vascular surgery, and gastroenterology.

Between March 2014 and April 2015 2,383 overnight patients and 5,245 day case patients were admitted to the hospital. There were 6,716 visits to theatre recorded in that time. This included 118 theatre visits by children aged between three and 17 years. Patients attended for planned surgery and only if there were any post-operative complications would patients receive emergency surgery.

Surgery services at Spire Parkway comprised of four operating theatres, two with laminar flow (a specialist system of circulated filtered air filtered to reduce the risk of airborne infection) and two without which were used flexibly Monday to Saturday for surgery specialities.

A new endoscopy unit with six patient bays and one theatre was due to open in August 2015.

The hospital had 36 single rooms over two floors and two double rooms. There were seven day case beds. There was a four bedded High Dependency Unit (HDU), although this was not in use at the time of our inspection.

We visited theatres, endoscopy, and the recovery (post anaesthetic) area. There were no patients accommodated on the ground floor at the time of our inspection and beds were empty but we spent time on the ward area on the first

floor. We spoke with the managers for both theatres and the ward areas. We spoke with 12 staff and six patients. We observed care being provided and looked at eight patients' records.

Surgery

Summary of findings

Surgery services required improvement overall.

The arrangements for governance and performance did not operate effectively. Information used to monitor performance or to make decisions about the service was incomplete or unreliable.

Leaders and managers did not appropriately cascade responsibilities to other staff. We were not assured that the hospital had appropriate systems in place to respond to risks and issues in a timely way. An incident reporting system was in place but was not well embedded.

There had been six serious incidents and 18 post-operative infections. We were not confident that incidents and the causes of infections were adequately investigated nor that timely actions were undertaken to address any identified risks and concerns. Staffing levels and multidisciplinary working were safe and met patients' needs.

Surgery services were found to be caring and responsive. Patients were treated kindly and with compassion. Patients felt involved in decisions made about their care and treatment. Services were responsive to meet patients' needs. The admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs.

There were appropriate systems in place to respond to a deteriorating patient. Medicines were managed safely and record keeping in all surgical areas was completed and audited, with any shortfalls addressed.

Some national audits were completed to establish outcomes for patients although the hospital was not monitoring patient outcomes sufficiently to provide assurance of the effectiveness of the service.

Patients were well cared for on the ward and in theatres. Pain was well managed and patients' nutrition and hydration needs were met well.

Are surgery services safe?

Requires improvement 

We found that the safety of surgery required improvement; improvement was needed to provide assurance that patients were adequately protected from avoidable harm. For example, an incident reporting system was in place but was not well embedded. We found that staff were generally unsure or reluctant to report incidents and incident reporting was left to managers to undertake.

The lack of an effective reporting system gave rise to a risk that all incidents including near misses may not have been reported and actions not taken to minimise the risk of reoccurrence. The hospital had a number of post-operative infections. We were not confident that the cause of infections was adequately investigated and timely actions were undertaken to address any identified risks and concerns.

The organisation monitored the hospital's performance to analyse patient harm or potential harm and 'harm free' care. Surgical safety checklists were in place and were checked and monitored to ensure ongoing compliance. There were appropriate systems in place to respond to a deteriorating patient.

Levels of staff including medical, nursing, and therapy and support staff were appropriate and met patients' needs. Agency staff were used when necessary to maintain safe staffing numbers and mandatory training was ongoing.

Medicines were managed safely and record keeping in all surgical areas was completed and audited, with any shortfalls addressed.

Incidents

- Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. No never events were reported on Strategic Executive Information System (StEIS) from 1 April 2014 to 31 March 2015. However the requirement to report never events to StEIS relates only to NHS patients.
- The hospital had an electronic system for reporting incidents and near misses. Between 1 April 2014 to 31 March 2015 there had been six serious incidents

Surgery

reported that required investigation. This included two cases identified as surgical errors and a third as a broken needle tip that could not be removed at the time of the operation (retained foreign body). We looked at a selection of serious incident records and found that investigations had been undertaken.

- Four staff told us that incidents were reported on a paper system and that managers would then 'put them on the computer'. We asked staff about incidents and what they would report. Staff other than managers we spoke with said that they had never reported an incident, but thought that cancelled operations, and falls were reported. Staff said that medication errors were not reported
- electronically but a paper based 'variance' sheet was completed which showed that the patient's expected pathways of care was not followed. There was a risk that appropriate actions may not be taken to learn from and address these errors. Two staff told us that named senior staff were very thorough and they would review the records (to identify cancelled operations, patients who had been readmitted or had returned to theatre) and when needed report this information electronically. However these staff told us that this was not always the case. Managers told us that other staff did not like to use the computer and were reluctant to report incidents and there was a reliance on managers to do so. We were not assured by the effectiveness of the arrangements which may mean that incidents and near misses were not always reported and when needed timely actions may not be taken to minimise the risk of reoccurrence.

Duty of Candour

- Staff we spoke with were aware of the 'Duty of Candour'; they told it was about being honest and open if things went wrong.
- The theatre manager told us that there had been an incident in theatre due to a faulty operating table. They told us that both the surgeon and anaesthetist had visited the patient after their operation, explained what had happened, apologised and wrote to the patient. They told us how feedback from the patient had changed their practice to ensure they would also visit any patient if concerns were identified about their care or treatment.
- We saw minutes that showed that reported incidents were reviewed and discussed during clinical governance

meetings, heads of departments meetings and Medical Advisory Committee (MAC) meetings depending upon the nature of the incident. Staff told us that learning from reported incidents was shared with them either in person or in ward or department meetings. However the reluctance of some staff to report incidents did not give assurance that appropriate and timely action would be consistently undertaken in response to incidents that occurred.

- There was a quarterly report of the number of deaths during each three month period and the year to date. There had been no deaths in the last 12 months. Staff told us that any deaths would be discussed in the clinical governance and MAC meetings and when appropriate any learning would be shared with other staff.

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

- The hospital used a monthly clinical dashboard and a quarterly reported 'scorecard' as management tools to assess its performance against agreed targets. The ward and theatre dashboard included information on spot-checks such as records of early warning scores, patients' observations, completion of risk assessments and compliance with the 5 Steps to Safer Surgery check lists. Before our inspection the hospital sent us the scorecards for September and December 2014. However despite our request for more up to date scorecards and dashboards and any action plans, if applicable, no information was supplied and we could not be assured that required actions had been taken.
- Post inspection visit quarter one and two 2015 clinical scorecards were provided. The audit showed there had been nil surgical site infections for total hip and knee procedures. There had been no reported pressure ulcers for the last 1000 bed days and 1.9 slip trip and falls by an inpatient, per 1000 bed days against a target of 2.0.
- We saw information that the hospital performed 'similar to expected' compared against a hospital target of 95% of adult inpatients having their risk of venous thromboembolism assessed. There had been two cases of a 'hospital acquired' venous thromboembolism or pulmonary embolism between 1 April 2014 and 31 March 2015. An investigation had been undertaken into the cause of the embolism.

Cleanliness, infection control and hygiene

Surgery

- The hospital had policies and procedures in place to manage infection control. This included in relation to infection prevention, decontamination and waste disposal. A policies and procedures file was accessible on the ward and in theatres. Staff we spoke with knew how to access the policies and procedures if needed.
- We saw that adequate hand-washing facilities and hand sanitising gel were available. We observed staff washing their hands before and after seeing each patient and using sanitising gel. The ‘bare below the elbows’ policy was observed by staff during clinical interventions. We saw hand hygiene audits which were based on quantities of hand gel used within a given time frame and how many times this equated to the gel being used. However there was no system to assess the number of times staff had attended to the patient or if hand gels were used by the patient and their visitors. This meant that there was no assurance of the frequency of staff hand washing to reduce the risk of cross infection. This hand hygiene audit did not give assurance that there were effective systems in place to monitor hand washing/ hand hygiene.
- We saw that there was a quarterly infection control report. Between 1 April 2014 and 31 March 2015 the report identified that there had been no reported infections which included MRSA and C. Difficile. We found that there was confusing and inconsistent information about post-operative infections and requested further information about these. For example, the hospital identified that there had been eighteen patients who had post-operative wound infections between 1 June 2014 and 31 July 2015 and this included six patients who were readmitted with signs of infection. We were not confident that the investigations into wound infections were sufficient and actions to reduce the risk of further infections were adequate. For example we saw two of the three root cause analysis investigations identified that no lessons could have been learnt. Also there was no review identified of hospital procedures such as theatres’ cleaning records or assessment of the skin cleansing prior to incision.
- We observed that staff complied with the hospital’s policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- Information received from the hospital identified that since the appointment of an infection control nurse in January 2015 it was identified that no formal housekeeping audits were being undertaken and the work structure for cleaning was not robust. Information from the hospital identified that as a result of this, schedules, equipment, and training had been improved and there was now a process in place to monitor and measure the effectiveness of the housekeeping performance.
- We observed that the ward areas including patients’ rooms were visibly clean. The hospital provided us with an infection control audit dated June 2015 which included information about cleanliness. When the required standard was not met such as: “All chairs and stools in clinical areas are covered in an impermeable material e.g. vinyl”, actions undertaken were detailed. In this example there was a comment stating “Still some chairs in patients’ rooms covered with velour type fabric. Gradually being replaced. Steam cleaned as required.” However this response did not include a timescale for replacement or specific information about the schedule for steam cleaning other than “when required” and there was no plan to indicate which items could be used in the meantime.
- The 2014 Patient Led Assessment of the Care Environment (PLACE) scored the hospital 94.5% for cleanliness.
- During the surgical pre-assessment appointment all patients due to be admitted for surgery were swabbed for potential infections such as MRSA and results were recorded in patients’ records. Patients were only admitted for surgery if no infection was identified.
- Domestic staff told us that additional staff had been made available to ensure that the hospital was kept clean during the renovations which were ongoing at the time of our inspection.
- We saw that infection audits of theatres had been undertaken in March 2015. The audits did not clearly identify actions required within an identified timescale. Examples we saw included, “Is there a comprehensive written policy for the cleaning of operating theatres on a session, daily, weekly, monthly and annual basis” The audit identified “No” and then said “Inadequate”, currently being reviewed and updated”, however no action or timeframe for action was identified. Another example
- was, “Are there comprehensive written cleaning standards and procedures?” The comment was, “Inadequate”, currently being reviewed and updated” although no timeframe for this was identified. We saw

Surgery

that a further but less comprehensive infection control audit was undertaken in June 2015. However there was no review of standards not previously met or an update of actions undertaken.

- The theatre manager told us that additional staff had recently been employed to assist with deep cleaning of theatres. One healthcare assistant had received special deep clean training to ensure appropriate deep cleaning was undertaken, we saw evidence to support this.
- The hospital had a sterile services department on site which followed national guidance. We saw that there was an appropriate flow of dirty equipment to the dirty sluice area where the used equipment was packed and taken outside for collection. This reduced the risk of contamination.

Environment and equipment

- Resuscitation equipment was available on the ward so that patients of all ages could be immediately resuscitated. Equipment was visibly clean, regularly checked and ready for use.
- Staff confirmed and we saw there was suitable and sufficient equipment available to support the type of surgical procedures undertaken.
- We saw that in one patient's room on the first floor the window restrictor was broken which allowed the window to be fully opened. The height and opening of this window put people at risk of falling if they opened it. We informed the estates manager of this and they said they would ensure it was addressed immediately.

Medicines

- All arrangements for medicines were checked by our specialist pharmacist inspector.
- We found that medicines were managed safely. The hospital had an on-site pharmacy and pharmacists visited the ward five days a week to check and re-stock the medicine supply. The pharmacy team were actively involved in all aspects of a person's individual medicine requirements from the point of admission through to discharge. Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times.
- We found that there was an open and transparent culture of reporting medicine incidents which was recognised as safe practice. We were told that any

medicine incidents were documented on an electronic incident reporting site. Although there was a record of any dispensary errors kept within the pharmacy department they were not recorded onto the hospital wide electronic system. This meant that there was no consistency in recording medicines' incidents.

- Learning from incidents was communicated to all staff. The pharmacy team also undertook monitoring of any changes to ensure safe practice continued. The learning from these incidents helped to improve medicines' safety and therefore patient safety.
- Information from the hospital demonstrated that audits of medicines management took place and any shortfalls were identified and investigated. A recent audit found no areas of concern for the management of controlled drugs.
- Stocks of controlled drugs were audited by the pharmacist. Controlled drugs are medicines that need extra checks and special storage arrangements because of their potential for misuse. Stock levels were limited and monitored.
- Patients' medicines were stored in locked cupboards. Should a patient have their own controlled drugs, they were stored in the controlled drug cupboard and returned to the patient on discharge.
- Medicines were administered safely. Medicines administration records were well maintained and clear about the medicines prescribed and administered. Patient medicine rounds were observed
- and patients were advised to not take the medicines without the knowledge of the nursing staff to ensure safe practice.
- At the morning briefing of theatre staff it was confirmed that theatre anaesthetic equipment had been checked. The anaesthetic machines were checked daily by an operating department practitioner (ODP) and the bottled oxygen supply was checked daily by the head porter.
- Emergency medicines were available for use and there was evidence that these were checked regularly.

Records

- The hospital used a paper-based records system for recording patients' care pathways. These were documents that covered the patient's journey from admission through surgery to discharge which included

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a local record of the patient's stay There were different care pathways available for the different types of surgery undertaken at the hospital, for example gynaecology, and hip and knee replacement.

- NHS records were available for patients whose treatment was funded or part funded by the NHS.
- We looked at the pre-assessment information and saw that any tests and investigations undertaken were clearly documented and the patients' medical and social history was recorded prior to them being admitted for surgery. However, during the unannounced visit on 1 August 2015 we looked at 11 sets of patients' records including two children's records and saw six were incomplete and did not contain the initial referral letter. Staff told us all consultants work differently and not all will ensure patients' records are complete.
- Risk assessments were available and completed during pre-assessment and then followed up on the ward.
- The records gave an easily accessible record of the patients' journey through the hospital including the procedures undertaken and clearly showed the input of the various specialisms including the anaesthetists and physiotherapists.

Safeguarding

- The hospital had an identified staff member who was the lead for safeguarding adults and children and the point of access for staff should they have questions about safeguarding issues.
- The hospital safeguarding policies and procedures were readily available for staff in paper files which staff were able to show us.
- Staff were aware of their responsibilities to protect vulnerable adults and children. Four staff we spoke with were uncertain about safeguarding procedures or how to report concerns but said they would report any concerns to their ward / department manager.
- Information provided by the hospital showed that compliance with safeguarding adults and children training had more that met the provider's target of 95% and was recorded as between 92% and 96% each month for the last 12 months.

Mandatory training

- The hospital used electronic learning to provide much of their mandatory training. We saw that training records demonstrated compliance with mandatory training throughout the year. Average staff training compliance was:

Health and safety 97.5%

Blood - safe transfusion 82.5%

Infection control 96.5%

Information governance 76.7%

Moving and handling 81.5%

- All anaesthetics and recovery staff (registered nurses and operating department practitioners (ODP) completed Resuscitation training annually. Figures for the last 12 months was 87.7%.
- Staff told us they were reminded to undertake mandatory training when required by their managers and that completion of mandatory training was assessed as part of their appraisal and if not completed may adversely affect their eligibility for any bonus pay.

Assessing and responding to patient risk

- Risks to patients were considered at their pre-admission assessment and should there be any concerns the surgery would not take place. Staff gave us an example of a child who was booked for two different surgical procedures on the same day. This was identified as part of the pre assessment and it was agreed that the surgery should be undertaken on two separate occasions and ensure the child was fully recovered before the second operation.
- The national early warning score tool (NEWS) for adults and paediatric early warning score tool (PEWS) for children were in use to assist staff to identify any deterioration in patients. We checked five patients' NEWS scores and all were correct.
- Children under the age of three years were not operated on and only operations which could be undertaken as a day cases were undertaken on children aged between three and 17.
- There was a formal agreement in place for patients to be transferred to the local NHS hospital if they required high dependency or critical care (level one-three).

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- Within theatres each morning a 'morning brief' took place. Each planned procedure was discussed and notes made. These notes were stored for future reference, should any issues be raised about planning and procedure.
- The WHO Surgical Safety checklist was embedded in daily practice and adhered to. This is a process recommended by the National Patient Safety Agency to be used for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors. We saw hospital audits of the checklist which identified compliance levels of 90% in April 2015, 87% in May 2015 and 95% in June 2015. Information we received from the hospital identified that a drop in completion of the WHO checklist in May 2015 was found to be due to the use of agency staff and had been addressed by the theatre manager.
- Formal arrangements were in place for the transfer of children to the local NHS hospital in the event that they required overnight care.
- The resident medical officer (RMO) provided the first response in an emergency situation.
- Nurse agency usage within in-patients areas had increased from occasional to moderate use in response to increased NHS surgical activity and averaged 2% a month in the 12 months up to
- November 2014. Staff told us that whenever possible they used the same agency nurses.
- The hospital operated on children on one Saturday each month and children were admitted on a day case basis. A named paediatric nurse co-ordinated all paediatric admissions. Staff we spoke with said that there was a staffing ratio of two paediatric nurses to four children. When we visited the hospital unannounced we found that there was one paediatric nurse assisted by a new ward nurse providing care for five children. The ward nurse had started working at the hospital four days previously and had no paediatric training. The paediatric nurse told us the list was put together with agreement from the consultant and paediatric nurse who carried out an individual risk assessment for each child. For example, the age of the child and type of procedure planned. This determined the number of paediatric nurses who were required to be available. Staff told us that paediatric nurses were on duty at all times when children were being cared for.

Nursing staffing

- The hospital used the Shelford Safe Staffing Tool since January 2015 which is an evidence-based, staffing level tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity / dependency. It was completed daily by the nurse manager and recorded patient numbers including admissions and discharges with each patient's dependency scored against set criteria. The number of both trained and untrained staff required was identified. We saw that that the required numbers of qualified nurses were available to care for patients. Planned and actual staffing levels were not displayed at the time of our inspection.
- The hospital only undertook elective surgery which means the number of nursing and care staff hours needed on any particular day could be calculated and booked in advance. Employed staff worked their contracted hours flexibly to cover the rota and any gaps were filled by bank or agency nursing staff or by overtime.

- We observed one nurse handover during our visit. We found that the handover was unstructured there was no information relating to the surgical procedure and number of days since operation. This meant that that nurses did not have sufficient information and there was increased risk that patients would not receive the care they needed.

Surgical staffing

- During the inspection we reviewed 15 recommendations made by Verita, who is an independent consultancy who carry out reviews and investigations to regulated organisations. The Verita review was commissioned by Spire Healthcare and was completed in March 2014. The aim of the review was to understand the circumstances that enabled a former breast care surgeon to practice as they did at Spire Parkway which led to the consultant's, suspension of practicing privileges and ultimate dismissal from practice in 2013. The consultant had practicing privileges at both hospital sites but Spire Little Aston Hospital to a much lesser extent. The report looked specifically at governance arrangements within both hospitals.

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- Surgical consultants' and anaesthetists' workloads varied and so a wide range of surgical staff were available. There was a resident medical officer (RMO) on the hospital site 24 hours a day, seven days a week, who liaised with the consultant and nursing teams. The RMOs worked for seven days and then had seven days off and were supplied by an agency. Staff told us that the RMOs were responsive and would come to assess patients when requested. The RMO told us this arrangement was manageable and worked well.
- We saw there was no formal arrangements for anaesthetist cover, although anaesthetists remain responsible for patients for 24 hours post operatively as stipulated in the Spire Consultants' Handbook. The anaesthetist must be available to attend the hospital should the need arise within 24 hours of surgery or at the request of the admitting consultant. We saw anaesthetist contact details were stored in the consultants' database on the ward. Post inspection, we were told consultants use their own identified anaesthetist, however the hospital also has an arrangement with the Excel Group of Anaesthetists which is a group of Anaesthetists who have formed a partnership to provide anaesthetic cover within the private sector. We were told Spire Parkway Hospital have had no reported incidents or issues with contacting an anaesthetist when required to suggest the current system required a review.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. Patients were booked for operations around consultants' availability. Consultants had agreed 'buddy' arrangements for alternative cover from another consultant with practising privileges (i.e. who had been assessed and screened) at the hospital, in the event that they were not available.
- However this arrangement was not robust because cover arrangements was not a formal process. We were not assured the hospital demonstrated clearly that the named buddy has been checked and was available before each period of absence or had communicated who had medical responsibility of their patients care to the ward staff. At the time of the inspection we saw 60% of consultants had a buddy system in place. The senior management team told us they were actively working to

improve this figure by sending out emails, a standing agenda item at the MAC meeting and face to face requests with consultants. Following the inspection we were told and we saw this figure had increased to 82%.

- Spire Parkway had a Medical Advisory Committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if they were deemed competent and safe to do so. We were told by the senior management team this was achieved by reviewing the skills and competence of new and substantive consultants and continually monitoring the behaviours and practice of consultants who work at Spire Parkway.

Major incident awareness and training

- The hospital had a service continuity plan that informed staff of the actions they should take in the event of emergencies such as fire or power failure. Staff told us that in the event of a power failure any operations in progress would continue with the hospital emergency generator but no other operations would be undertaken until power had been restored.

Are surgery services effective?

Requires improvement 

The effectiveness of the service required improvement. Patient outcomes were not sufficiently monitored to provide assurance of the effectiveness of the treatment and service provided. Some national and local audits were completed to establish outcomes for patients but there was insufficient data available to identify patients' outcomes in all areas. The hospital was asked before and during the inspection visit for all audits they undertook to determine that care and treatment was evidence based and that appropriate pathways were followed.

The hospital failed to provide us with sufficient information to provide assurance that evidence based care and care pathways were followed. Following the inspection we were sent Clinical scorecard information and updated action plans from April to September 2015.

Patients were well cared for on the ward and in theatres. Pain control was well managed. The hospital had identified that there were shortfalls in patients receiving adequate fluids prior to theatre.

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Benchmarking was undertaken which compared the hospital's performance to other Spire hospitals but further data collection was needed to ensure that patients received appropriate care. There was evidence of good multidisciplinary working and out-of-hours services were provided when needed. Staff had variable understanding of the mental capacity assessment process to protect patients' rights under the Mental Capacity Act 2005.

Evidence-based care and treatment

- We asked the hospital for all audits they undertook including those to determine that care and treatment was evidence based and that appropriate pathways were followed. We saw that the MAC reviewed new care and treatment pathways and considered the effectiveness of the treatment. For example a new treatment was not supported as insufficient evidence of the effectiveness of the treatment was available.
- We saw information that some practice was reviewed during the MAC meetings such as 'starvation times' prior to theatre and cost effectiveness of joint prosthesis in line with good practice. However we found insufficient evidence of how the MAC reviewed and benchmarked the hospital against good practice guidelines or care pathways.
- Clinical scorecard Information sent to us post inspection showed from July 2015 to September 2015, 36 clinical areas were monitored, measured and rated as part of the 39 Spire Hospitals. The central governance team produced the clinical scorecard and are aware of results. Any red areas are reported in an escalation report and followed up with the hospital. We saw out of the 36 clinical areas, 26 were RAG rated green, two were rated amber, two were not rated as were not clinical issues and six were rated red. Two red areas related to complaints, one area related to mandatory training, another to agency spend across theatres and wards. One red area related to the percentage of patients fasted, the target was 45%, Spire parkway achieved 35% and the percentage of inpatients discharged by 11am, the target was 55%, Spire parkway achieved 45%.
- We saw there were action plans to support all red areas, with timescales for review and identified person responsible for each action.

- Policies we looked at were accessible, current and referenced good practice guidelines and where relevant, made reference to professional body guidance and published research papers; for example, the safer staffing policy.
- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.
- The endoscopy unit could be benchmarked through the Joint Advisory Group (JAG) accreditation system. The hospital management team told us that that they were collating data to enable them to apply for JAG accreditation.
- We saw information in the April 2015 clinical governance meeting minutes that identified "Antibiotic prescribing needs to be audited as there were concerns that they were being prescribed inappropriately". We asked for further information relating to these concerns and any actions taken to address them, however this information was not supplied. The effective use of antibiotics is essential to ensure future public health and management of infections.

Pain relief

- We spoke with six patients. Patients told us they were happy with the management of their pain "I have no pain." "When I buzz for a nurse they come immediately".
- Staff told us and records we looked at confirmed that pain management was discussed with the patient at their pre-assessment appointment and again on admission to the ward. While in theatre recovery staff were supported by anaesthetists to make decisions about pain relief needed by patients.
- We saw records which showed that patients were prescribed regular pain relief and also additional 'as required' pain relief. All pain relieving medicines administered were recorded on the patient administration chart. In addition we saw that if patients had 'as required' medicines staff completed a 'variance form'. Staff explained that any 'variance' from the usual care pathway was recorded in this way and all variance forms were collected and reviewed by the governance lead.

Nutrition and hydration

- Records relating to nutrition and hydration were well completed and provided an audit trail of decisions

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about hydration and nutrition and the actions completed. Fluid balance charts were consistently completed and we saw that patients had access to drinks and snacks at all times.

- All patients told us that they had been given instructions not to have anything to eat from midnight and no fluids from two hours prior to their admission time. Theatre staff told us that they discussed the list and informed the ward of the time the until which patient could continue to drink. We found that these instructions were inconsistently passed to ward staff and as a result there was a risk that patients may not receive fluids for several hours. The hospital had been monitoring time that patients had been without fluids and it was a recognised area for improvement on the hospital's clinical scorecard.
- The 2014 PLACE audit scored the hospital 85.6% for food overall.

Patient outcomes

- Some national audits were completed to establish outcomes for patients. However insufficient data was available to identify patients' outcomes in all areas.
- Patient Reported Outcome Measures (PROMs) are standardised validated question sets to measure patients' perception of health and functional status and their health-related quality of life. The hospital invited all patients (private and NHS) who had undergone hip or knee replacement surgery to complete a PROMs questionnaire. PROMs data for knee and hip replacements for the year 2013-2014 showed that the hospital performed satisfactorily when compared with other hospitals.
- Information provided by the hospital showed that there had been 11 cases of unplanned returns to theatre between 1 April 2014 and 31 March 2015. CQC have assessed this to be 'similar to expected' compared to other independent acute hospitals. In addition there had been 21 unexpected readmissions to the hospital within 31 days of discharge. Reasons for readmission included ongoing vomiting and signs of infection.
- For the time period October 2013 to September 2014, CQC has assessed the standardised 30 day emergency readmission rates for surgical procedures compared to other independent acute hospitals. Readmission rates for hernia procedures, hip replacements and knee replacements were all found to be similar to expected.
- Information on comparative outcomes by clinicians for orthopaedic specialities was reviewed on the National Joint Registry (NJR) website (available through the NHS Choices website). We saw named consultants with practising privileges at Spire Parkway with indications of their outcomes as being within the expected range.

Competent staff

- The hospital provided opportunities for induction, staff development and appraisal. However, staff were unsure how long new staff were supernumerary. We spoke to two new staff who told us that they felt that their induction was poor.
- Records we looked at during our inspection showed that the induction arrangements for new staff were that they spent time within different departments but had no identified learning plan. We asked the hospital to provide further information about staff induction. We were provided with details of one staff member's induction training. This information confirmed that the member of staff had spent time in each department. In addition the staff member had undertaken a 'Spire Induction' which identified areas to be covered such as fire procedures and timeframe for it to be completed. However we also saw that required actions were not undertaken in a timely fashion and despite a timescale to be completed on 'day one' and within the first month actions were not signed as completed for six months. There was a need to ensure that new staff received training and supervision to assess their competencies and skills to meet the needs of their role.
- Student nurses from the local university were also working on the ward and were mentored and supported during their period at the hospital.
- Appraisal rates for all staff were 100%. Staff told us they received the training necessary for them to do their specific jobs in addition to the mandatory training provided for all staff.
- The head of clinical services told us that nursing staff were required to complete competencies in various aspects of their roles, for example, medicine administration. Staff told us that their competencies were assessed.
- There was a human resource (HR) process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.

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- The role of the MAC included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken.
- Consultant competencies were assured through annual appraisal, biennial reviews and the General medical council (GMC) revalidation process. All consultants must have an appraisal by an approved appraiser to maintain practising privileges at Spire Parkway Hospital. We looked at a selection of consultants' appraisals for; plastic surgery, trauma and orthopaedic and paediatrics and saw they included maintaining and developing professional performance, training and development to improve skills and working collaboratively with others to maintain and improve patient care. We saw appraisals were up to date and signed off by the appraiser from the local NHS trust.
- Consultant competencies were also assured through the clinical review process. This formed part of the biennial review and included reviewing the clinicians' whole practice appraisal, untoward incidents, increased new patient to follow up ratio, overbooking of OPD appointments, behaviour general activity, behaviour and complaints data. We heard examples where clinicians' practicing privileges had been revoked and saw incidents where practicing privileges were deferred pending further information. We saw one example when concerns of poor practice had been reported to the General Medical Council (GMC) and the NHS trust where the consultant was employed.

Multidisciplinary working (in relation to this core service only)

- Multidisciplinary teamwork (MDT) was evident throughout the surgical service. This ensured that patients' needs could be met across a range of treatments and therapies. We observed medical staff, nursing staff, therapists and a pharmacist working as a team on the ward. Records of care and outcomes were maintained by the whole multidisciplinary team. Ward rounds took place daily, although this mainly included doctors and nurses.
- Staff told us that there were MDT arrangements in place with a local trust for patients' cancer care and treatment. However senior management team meetings and MAC meetings identified that availability of MDT

information was inconsistent and sufficient information was not available. This would give rise to a risk that patients may not receive effective multi-disciplinary team care.

- Discharge letters were sent to patients' GPs with details of procedures completed, follow up arrangements and any medicines prescribed.
- Should a patient need to return to theatre unexpectedly out of hours, there was a theatre team on call, supported by senior nursing staff, x-ray and physiotherapists.
- Physiotherapy was available on the ward and following discharge when needed.
- There was a service level agreement in place with a local Trust should a patient's condition deteriorate and they require additional care or if a child required readmission to hospital following a surgical procedure.
- There was a dietician and speech and language therapist with practice privileges who could be called upon if required.

Seven-day services

- The theatres were available 8am to 8pm Monday to Friday and from 8am to 7pm on a Saturday (the hospital operated on most Saturdays during the year and offered a regular six day service).
- The theatres were also available for any patient needing to return to theatre 24 hours a day, seven days a week when the need arose. There was a staff on call rota which included scrub staff. Staff worked variable hours to accommodate surgeons' requests.
- There was an out-of-hours pharmacy with access available through the nurse in charge of the hospital.

Access to information

- Observation records were kept in each patient's room and were accessible to patients and staff.
- On discharge further information was provided. Parents of paediatric patients received a telephone call from the paediatric nurse prior to the child's admission to hospital, to allow them to ask questions should they wish to. Also, the paediatric nurse telephoned parents two days post discharge to ascertain the child's health status and answer any post discharge questions. Staff said that patients could telephone the ward with any concerns post discharge.

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- Staff told us they had access to policies and procedures and felt they were kept informed by the management team. Staff told us that they all received a newsletter which updated them about
- events and incidents at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were clear about their responsibilities in relation to gaining consent. However staff were unclear about their responsibilities under the Mental Capacity Act 2005, they told us that best interests decisions were undertaken by consultants. We noted that the hospital did have a patient at the time of our inspection who had limited capacity to make informed safe decisions and we saw their consent forms complied with current Department of Health guidance.
- Consent forms identified the procedure to be undertaken, its associated risks and included records of the health care professional responsible for consulting with the patient. They also recorded signatures from patients indicating that they were providing consent to undergo the proposed procedure.
- We looked at the recording of consent for those patients undergoing surgery at the time of our inspection and found the forms were fully completed.

Are surgery services caring?

Good 

Surgery services were caring. Patients were treated kindly and with compassion.

Consideration was given at all times to their privacy and dignity.

Support was available for those patients who were vulnerable or had complex care needs. Patients felt involved in decisions about their care and treatment.

Compassionate care

- Patients spoke in complimentary terms about the staff and the care they received. They told us that care had been “excellent”.
- The Friends and Family Test (FFT) was undertaken by the Spire Parkway to capture patient feedback. Results showed that between June 2014 and December 2014

100% of respondents said they would recommend the hospital. The patient satisfaction survey from July 2015 to September 2015 showed 90% of patients responding 'excellent' overall to the quality of care provided by their Consultant against a target of 89%. 85% of patients responding 'excellent' overall to the care and attention provided by nursing staff which met the target of 85%.

- We observed all staff knocking on patients' doors and waiting for a response before entering. We observed staff were patient, caring and saw them reassuring one person who was very confused.
- The 2014 PLACE audit scored the hospital 73.6% for privacy and dignity.
- We observed that staff provided compassionate care for a patient who was living with dementia. One member of staff, an occupational therapist remained with the patient for the majority of the day of our visit. They assisted the patient to dress, encouraged them to eat and drink and spent time talking to the patient. We noted that this staff member helped to reduce the patient's anxiety and met their needs.
- Patients told us that they had received sufficient information prior to their planned surgery. Patients were provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. They told us that they had any risks explained to them.

Understanding and involvement of patients and those close to them

- Information about care was provided in a way patients understood and appreciated. Five patients told us that they had their planned procedure explained thoroughly to them at pre-assessment and again on admission. Patients were clear about the risks involved with their procedures.
- Patients receiving day surgery underwent the same process. Sufficient information was provided on discharge about what to expect following treatment and what to do if they had any concerns. Staff at the hospital had identified from surveys that more specific information was needed and were developing additional documentation about medicines for patients to take home with them.

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- Parents whose children had surgery at the hospital said that staff not only provided “excellent” support and care to their child but also to them. One parent said: “I knew they would look after [my child] but I never expected the excellent support that I received”.

Emotional support

- Staff explained that visiting hours were flexible and that on occasions relatives may stay overnight.
- Counselling services were not provided at the hospital. There were no facilities for religious worship or on-site or regular visiting clergy. However, staff maintained a list of contacts for local clergy for different faiths who may be able to provide religious or spiritual support to people.

Are surgery services responsive?

Good 

Surgery services were responsive to the needs of the patients using the service. The admission, treatment and discharge pathways were well organised and flexible to meet patients’ changing needs.

Staff worked in a flexible manner to meet the theatre schedule and ensure patients’ needs were met.

Learning was taken from complaints and helped to inform service improvement.

Service planning and delivery to meet the needs of local people

- The hospital provided both privately funded care and had a contract to provide identified procedures under the NHS which amounted to 24% of the hospital’s activity.
- The hospital did not provide emergency care and all admissions were planned and arranged in advance of the person’s admission.
- As part of the Hospital’s refurbishment plan, there was an upgrade underway for one of the theatres to include laminar flow (a specialist system of circulated filtered air filtered to reduce the risk of airborne infection). This meant three out of four theatres would have this facility and due for completion end of November 2015.

Access and flow

- The admission process and care provided was the same for private patients and NHS patients. The assessment of the patient’s suitability for surgery at the hospital was graded at four levels. However some patients including those undergoing major surgery (surgical grade three or above as defined by NICE guidelines) and / or those with one or more other co-morbidities (other health conditions) proceed directly to level three assessment:

Level one– This includes receipt and assessment of the patient’s pre-admission medical questionnaire (PAMQ).

Level two - Nurse-led telephone clinical assessment.

Level three - Nurse-led pre-operative assessment within the pre-operation clinic (this may also include therapy input dependent on the patient and their planned operation).

Level four - Anaesthetic referral.

- Patient admissions for theatre were staggered throughout the day to ensure patients did not experience extended waiting times. The lists for theatre were compiled by each consultant surgeon’s secretary with sufficient time allowed to enable the theatre to be cleared and prepared for the next patient.
- There was a one week ‘window’ for booking operations and staff confirmed that lists were rarely ever changed past that window.
- Patients told us that they were required to confirm that they had somebody at home to support their care before they could be discharged.
- A theatre recovery area was available with dedicated staff. If needed, additional help was available to recovery staff from the theatre operating department staff.
- The NHS referral to treatment waiting time targets between 1 April 2014 and 31 March 2015 were met for all areas.
- Patients were seen by the resident medical officer and consultant before discharge and all treatment communicated to the patients’ GP.
- Between 1 April 2014 and 31 March 2015 the hospital cancelled 11 operations due to non-clinical reasons such as a theatre list over running so insufficient time for the proposed operation, or no anaesthetist available. There was no differentiation in care provision between NHS or private patients, although theatre staff told us that if cancellations were required this would more likely be for NHS patients.

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Meeting people's individual needs

- The hospital provided NHS dental care under general anaesthesia for people who had special needs such as a learning disability. Staff told us that these patients were brought into the hospital by an alternative entrance so they did not see staff in uniforms or equipment which may frighten them. Rooms were made as homely as possible. Doctors would wear normal clothes when they came to see patients with individual needs. Carers were able to accompany patients to theatre. Staff said that the patients saw it as a day out rather than a frightening experience.
- Staff told us that patients who were living with dementia were allocated staff on a one to one basis. We observed that throughout the day of our inspection a confused patient had an occupational therapist assessing their capabilities whilst providing them with meaningful activities. Staff told us that the occupational therapist provided excellent support and would come in at any time if needed.
- The hospital provided one paediatric surgical list each month. There was at least one paediatric nurse available whilst children were in the hospital as patients.
- There was an interpretation service available for patients and their families who did not have English as their first language. Staff told us that although they had used this service the hospital had a multi-cultural staff base and they were often able to get a member of staff to translate.
- We saw that on the day of our inspection, three patients had their operations cancelled due to clinical reasons. We spoke with two of these patients who told us that they had been informed of the reason for the cancellation of their operation. One patient told us that as soon the anaesthetist had told them their operation had been cancelled they had been asked if they would like a drink and some breakfast.
- Arrangements for discharge were considered at pre-admission and again on admission. Should there be a change of plan and the patient not have somebody at home, a longer hospital stay was arranged.

Learning from complaints and concerns

- Staff told us that the duty manager talked to all patients before their discharge to confirm they were happy with their stay. If patients expressed any concerns at this time managers said they could respond quickly to those concerns.
- The hospital had received 24 direct complaints between 1 June 2014 and 30 June 2015, eight of these complaints were related to surgery services (ward and theatre care). Senior management told us and we saw that staff followed the hospital complaints process and all complaints received by the hospital had been managed as per the Complaints policy. We were told by senior management if a patient was dissatisfied with the result of their complaint they would be provided with contact details of the Independent Sector Complaints Adjudication Service (ISCAS) who acts as the NHS equivalent to the complaints ombudsman.
- We saw information in the hospital about how to raise concerns via a form titled "Please talk to us". This form could be completed either whilst the patient was in the hospital or could be sent in after discharge. Staff were encouraged to respond to complaints or concerns at the time of complaint.
- Staff told us about learning shared following one complaint and learning from the complaint had been shared via the monthly hospital newsletter. There was confusion about numbers of visitors allowed and the cultural implications of this for the patient's family.
- A new 'patient experience committee' had been formed to review patients' complaints to identify trends in concerns. Complaints were discussed at various meetings where outcomes, lessons learnt and improvements on practice were discussed. Details were shared at the monthly heads of departments meetings, monthly clinical governance meetings, monthly senior leadership meetings and quarterly MAC meetings.
- The hospital had a "You said, we did" scheme. This highlighted feedback received from patients and actions taken to address these concerns such as improvements to the fabric of the building and the introduction of hourly 'comfort' checks by staff for people who were waiting for their operations, which also allowed an opportunity for staff to discuss any concerns including where the person was on the operating list.

Are surgery services well-led?

Surgery

Requires improvement 

The management arrangements for surgery required improvement.

There was a failure by management to ensure that staff appropriately reported incidents. Investigations into the cause of infections were not thorough and failed to suitably identify potential risks. Risks were not suitably identified and timely actions were not undertaken to minimise the identified risk.

Some Information relating to the way the hospital monitored performance or made decisions about the service was requested by us but not provided. The hospital's inability to respond in a timely fashion to requests for some information about the service meant that we could not be assured that governance arrangements were robust and effective in those respects.

Staff were clear about the vision for the hospital but were unsure how about the organisation's values would underpin this vision. Staff felt well supported by both their immediate managers and senior managers. Staff were positive about the standard of care they provided.

Vision, strategy, innovation and sustainability for this core service

- Staff were aware of the vision to be recognised as a world class healthcare business.
- Staff were positive about how the improvements and refurbishment would contribute to them being the first choice hospital for private treatment. They felt that the culture was inclusive and had a 'family feel'. They commented about the vision for the service as structured around the £8.3 million refurbishment. However staff were not clear about hospital values although all said they were proud to work at the hospital.
- The theatre manager told us their vision in addition to the improvements planned for theatres was JAG accreditation for the new endoscopy unit.
- Surgical activity within the hospital had continued to grow and this had included the increase in NHS contracted patient operations. However this increase in workload was dependent on ongoing staff recruitment.

Governance, risk management and quality measurement for this core service

- In 2013 Spire Healthcare commissioned an independent review by Verita to understand the circumstances that enabled a former breast care surgeon to practice as they did, which led to the consultant's ultimate dismissal and the recall of more than 600 patients at Spire Parkway Hospital. The report looked specifically at governance arrangements within Spire Parkway and made 15 recommendations for Spire Parkway to implement and to strengthen governance arrangements. Corporate Spire had adopted a further eight actions across the Spire hospital network to improve governance and monitoring arrangements. We were assured all eight had been complete at Spire Parkway.
- During the inspection we reviewed the 15 recommendations and looked at whether Spire Parkway had implemented them. We saw evidence to demonstrate that the majority of recommendations had been implemented at the hospital. However, in recommendation number four, paragraph two, the hospital was recommended to implement a corporate practicing privileges database to enable relevant up to date information to be stored for individual consultants and to be accessed remotely. The database to be linked directly to the electronic reporting system and produce incident data for each consultant.
- We were told this database had not yet been set up at Spire Parkway Hospital because they had not uploaded all their consultants' details onto the system in time for the first wave. Therefore this recommendation remained outstanding. We were told post inspection that plans were in place to implement this early in 2016 and that to mitigate the risk of the delay, the Spire Parkway senior management team had created a local excel database with consultants' details available and carried out clinical reviews to measure practice and performance. We saw this was in operation and used as part of the biennial reviews and at quarterly intervals in between.
- Recommendation number eight of the independent report advised Spire Parkway Hospital to consider how best to strengthen the systems in place for knowing about and monitoring a consultant's scope of practice, should concerns be raised. We saw there was no official process in place to formally access or discuss consultants' practice as between Spire Parkway Hospital and the acute NHS trust where they practised. However,

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we were told and we saw a Partnership Assurance Group had been set up and sat every six to eight weeks, chaired by Chief Executive Officer from the local NHS trust and attended by representatives from the NHS trust, Spire Parkway and other independent health providers.

- The aim of the meeting was to look at recalling patients collaboratively due to multiple cross overs with some patients attending appointments/surgery from the same sites. We were told that the intention was to include a process to enable easier access of consultant's details between independent and acute hospital sites. In the meantime, we were told relationships between Spire Parkway Hospital and the local NHS trust was open and transparent and should there be a request of information relating to a consultant's NHS practice, this request would be readily met, either by telephone or email. We saw emails to evidence this relating to one consultant. We saw evidence to support that communication systems between Spire Parkway and the trust was open and that access to NHS admission data was effective.
- Consultants' clinical practice was reviewed on a regular basis in a number of ways. Each quarter a number of Clinical Committees met and reviewed performance and the Clinical dashboard for that quarter. This process looked at clinical incidents/near misses reported on the hospital's electronic system, including returns to theatre, readmissions, infection rates, complaints, conversions to overnight stay and cancellations of day of service.
- We were told and we saw minutes of the monthly senior management team meeting and clinical governance committee meeting that incidents were discussed, trends were looked for and any concerns were raised including trends with particular consultants which may indicate a competence or training issue.
- The consultants' biennial review included a clinical review which looked at specific areas of the consultant activity for example: an increase in new patient ratio to follow up, increased rates of OPD appointments, behavioural concerns, for example, started work late or finished early would be reviewed and highlighted for further investigation.
- We saw an example of one consultant had a slight increase in 'new patient ratio to follow up'. This had been highlighted on the consultant's database and

discussed with the MAC chair, the hospital director and the governance lead. We were told and we saw the consultant's performance was monitored for a period of three months. We saw evidence to support the consultant had been interviewed and was informed that their practice and performance would be monitored for a further 12 months. We saw this was an effective system to monitor, measure and identify risks. Another example, involved a consultant who had a significant increase in 'new patient ratio to follow up'. Their performance was monitored at the beginning of 2015 which resulted in their suspension of practising privileges and a full investigation.

- We saw that communication between the senior management team and consultants required improvement. For example, due to a high return to theatre for children's tonsillectomies, six in total over several months, there had been a directive to cease all children's tonsillectomy procedures from January 2015 until the investigation had concluded. We saw during our inspection, one consultant had booked a child's procedure in for surgery against the hospital directive and the theatre manager had not been informed of this. This was highlighted by the inspection team and the procedure was then cancelled and rebooked following the results of the investigation. The investigation was carried out by an ENT NHS Consultant and concluded there was no untoward practice and children's tonsillectomy procedures at Spire Parkway could continue. However, we were not assured that there was effective governance arrangements in place to ensure consultants followed hospital directives.
- Staff told us that the hospital used ward and theatre dashboards and score cards to assess risks and the care provided. "The central governance team produced the clinical scorecard and are aware of results. Any red areas are reported in an escalation report and followed up with the hospital. This dashboard also provided the hospital with comparison against other Spire hospitals. Whilst we saw the electronic version of the scorecard during our inspection, we requested copies of the clinical scorecard post inspection and this information was not provided. Following further requests, the information was provided and showed the Clinical Scorecard was produced quarterly by the Central Clinical Team and formed part of the quarterly Clinical Governance Report. This was discussed throughout the

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Clinical Governance Structure of the hospital on a quarterly basis. We saw six actions to address red areas in quarter one and quarter two, with an identified responsible person and timescales for next review and or completion.

- There was a ‘buddy system’ in place for when consultants were on leave. Consultants had a named colleague who would take over the care of their patients. Details of the named individual was disseminated to staff. However we were not assured this was a robust process as there was no formal update to demonstrate that the named buddy has been checked and was available to provide cover before each period of absence.
- There was an assessment of the hospital’s performance against other Spire Hospitals which was discussed during senior management team (SMT) and heads of department (HOD) meetings.
- The hospital risk register recorded 199 identified risks. The majority of risks identified were very low, low or medium risk. We saw that there were five risks that may affect surgery which included: safe management of hand sanitiser and two ‘high risks’ which identified access to the toilet and shower in certain bedrooms (this was an actual risk but was not identified). These risks were identified on 15 July 2014 with a date for review of 7 January 2016 and comments which identified “awaiting refurbishment of rooms”. We did not consider that this was a reasonable response to identified high risks and more timely action should be undertaken. We were not assured about arrangements to review the risk register.
- Governance arrangements relating to infection control issues and lack of robust actions to support theatre audits were not in place. Senior management were aware of the issues concerned, but had not taken appropriate action to mitigate the risks.
- The role of the MAC included periodically reviewing existing practicing privileges and advising the hospital on their continuation. They gave examples where practicing privileges had been suspended or withdrawn as a result of concerns raised.
- There were risk management and clinical governance meetings which linked into the HOD, SMT and MAC

meetings. This gave both senior managers and clinicians an opportunity to review risk and take appropriate actions to address and reduce highlighted risks.

- Consultant surgeons and anaesthetists were represented on the MAC. We saw and consultants told us that incidents and complaints were presented and discussed at the MAC. The MAC also discussed any issues and reviews of surgical procedures as required.
- A clinical quality report was produced monthly and this report was used as a basis for further discussion with the hospital’s governance meeting and Medical Advisory Committee.
- Patient satisfaction scores, recorded in the clinical quality report were reviewed at the head of department meeting and senior manager team meetings. Areas which required improvement were highlighted for further focus, for example the refurbishment of bedrooms.
- We saw that the senior management team and head of department meetings reviewed monthly patient feedback, complaints and their friends and family score to assess patient satisfaction with the service provided. However we did not find that there was an appropriate and timely response to patients’ comments such as a need to refurbish patient bedrooms.
- The monthly mortality report identified the number of patient deaths within that quarter and the year to date and hospital death rate. There had been no deaths in the hospital in the last 12 months. However we saw that no other information was identified such as other patient deaths outside the hospital to identify if all appropriate actions had been undertaken by the hospital.

Leadership/culture of service related to this core service

- The hospital director led the organisation supported by the head of clinical services. Leadership within surgical services was provided by the theatre manager who managed theatre activity and clinical services managers who managed nursing staff on the ward, and a clinical governance manager who oversaw clinical governance both within surgery and throughout the hospital.
- The ward and theatre staff told us they felt that they found the ward and theatre manager approachable. Staff also told us that the both the hospital director and head of clinical services were visible and approachable.

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- Managers had not taken appropriate actions to ensure that staff reported incidents and relied on managers to record the incident. This may mean that management were not aware of all incidents and appropriate actions were not taken.
- We saw that a monthly sisters' meeting took place but ward and theatre meetings were less frequent.
- Staff told us that they were kept up to date either by managers in face to face meetings or by the monthly staff newsletters.
- We saw that positive comments about care received were fed back to staff. Staff appreciated this supportive feedback.
- Staff told us that the hospital was a friendly place and they would recommend it as a place to work.






Public and staff engagement

- Prior to the inspection we encouraged the public to use 'share your knowledge' online feedback forms about the

hospital. We received more than 50 complaints from March 2015 to July 2015 all related to a former breast care surgeon, who had been dismissed in 2013. We saw on the hospital website that patients were directed to the independent report for further information.

- The historic complaints ranged from distress caused to patients and their relatives by the former breast care surgeon to complaints about how Spire Parkway Hospital had previously responded.
- Newsletters were produced for all staff and distributed by email and printed copies. The November and December 2014 newsletters were combined into one issue and in 2015 they had been issued quarterly. Both newsletters contained items on developments at the hospital, staff achievements, charity events, learning from incidents and training opportunities and requirements. Staff newsletters also contained details and photographs of any consultants who were new to the hospital.

Outpatients and diagnostic imaging

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

Information about the service

Outpatients' services at Spire Parkway Hospital are provided from 13 private consulting rooms, used by consultant doctors with practising privileges to work from the hospital and from a chemotherapy suite.

Outpatients procedures offered at the hospital include mole removal, gynaecology diagnostics and investigations, minor plastic surgery procedures for ophthalmology, post-surgical cosmetic tattooing, minor podiatry surgery and treatments and vasectomies.

At the time of our inspection chemotherapy was being provided in a temporary treatment suite while a separate building on the hospital site was converted into a permanent chemotherapy unit. There was a strategy to expand the oncology suite which was due for completion in September 2015, later extended to October 2015.

Diagnostic imaging was provided on site. Services offered included computerised tomography (CT) and magnetic resonance imaging (MRI) scans, mammography, x-rays, fluoroscopy and ultrasounds.

Services were provided to patients who were self-funding, those covered by private medical insurance and to NHS patients who had been referred by their GP or who had booked via the NHS 'choose and book' service.

Summary of findings

Overall we rated outpatients and diagnostic imaging at Spire Parkway hospital as requires improvement.

Risk recording and assessment was inconsistent and we were not reassured that it was effective. The hospital's incident reporting system was not robust and many staff were not able to use the electronic reporting system.

The hospital did not hold satisfactory records of patients who were seen in the outpatients' department.

We found one piece of resuscitation equipment was out of date despite regular checks being undertaken and some prescription medicines unattended in an unlocked cabinet.

Patients were provided with evidence-based treatment in accordance with national guidelines and legislation.

Adequate numbers of qualified, well-trained staff were available to care for patients. Patients told us that the care they received was high quality and that staff had time to talk to them and explain their treatment clearly and thoroughly.

Services were planned and adapted to meet the needs of patients. Appointments ran on time and patients were not kept waiting for assessment or treatment. Managers were approachable and supportive and senior managers were visible daily in the hospital. Staff told us they would be happy to approach senior managers directly with any concerns they had.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement 

We found that the hospital did not keep its own records of patients who were assessed or treated by consultants with practising privileges. We found patient records unattended in a treatment suite with no staff present.

We found one piece of resuscitation equipment was out of date despite regular checks being undertaken and some prescription medicines unattended in an unlocked cabinet.

Not all staff used the electronic incident reporting system and we had inconsistent reports about how long the system had been in use. A mixture of paper forms, verbal reporting and the electronic system were used to report incidents.

Premises and equipment were found to be visibly clean however staff were not seen to be using hand cleansing gel regularly.

Nurse staffing numbers and skill mix was found to be sufficient to provide a safe service to patients. Staff had a good understanding of the implications and responsibility of Duty of Candour. Staff had received training in safeguarding adults and children. Completion of mandatory training stood at 73% for 2015, with a deadline of the end of December to complete outstanding modules

Equipment was well-maintained and serviced.

Incidents

- The hospital used an electronic incident reporting system, however not all staff were able to use it and some incidents were reported on paper forms then were inputted onto the electronic system by managers. One manager told us the electronic system had been in use for over five years but another manager told us it had been in use for about two years, and another said they had “only recently” started to use it. This demonstrated that the incident reporting process was not consistent or reliable in different departments in the hospital. This gave rise to a risk that incidents and near misses may not be reported properly and learning to prevent reoccurrence of incidents may not take place.

- Administration staff in radiology told us they were aware of the incident reporting system but had never used it. One member of radiology staff told us they did not know how to use the system so would report incidents to a senior team member for them to input details electronically. This meant that there was a risk of the electronic record not being an accurate reflection of the incident as it was second hand information.
- We were told about a change to the hospital’s sharps management policy that had resulted from incidents that had been reported about the way certain very fine needles were being disposed of. The hospital had introduced an adhesive foam pad to be used for safe disposal of these needles and the new policy had been distributed to all staff attached to their payslips. We were provided with a copy of the staff notice about this policy.
- Details of reported incidents and investigation findings were shared at the six-weekly radiography team meetings. Minutes of these meetings were made available to permanent and bank staff who were not able to attend in person. We saw copies of the minutes of the April 2015 meeting in which staff were given details of and learning outcomes from two incident reports and two complaints.

Duty of Candour

- The outpatients and radiology managers demonstrated a good understanding of the hospital’s duty
- of candour obligations should an incident result in harm to a patient. They described the process as being open and honest, apologising if the hospital was to blame and keeping an open dialogue with the patient or their representatives during an investigation.
- All the staff we spoke to in both departments had a broad awareness of the implications of duty of candour and how it affected their managers and the hospital. There was a Duty of Candour policy in place and we were told that information booklets about duty of candour had been distributed to all staff attached to their payslips.
- We were given copies of the minutes of the radiology team meeting from April 2015. The minutes showed that the radiology manager had given staff an overview of duty of candour during the meeting.

Cleanliness, infection control and hygiene

Outpatients and diagnostic imaging

- 2014/15 patient-led assessment of the care environment ('PLACE') audit scored outpatients 11 out of a possible 24 points for cleanliness, one out of two for condition and appearance, zero out of two for access. Diagnostic imaging was not audited. We were shown a copy of the hospital's action plan, dated April 2015, in response to the audit.
- A consultant microbiologist attended monthly infection prevention and control meetings with the outpatients manager, to advise on risks and practise.
- We inspected seven consulting rooms and found all of them to be visibly clean and to have cleaning wipes, alcohol gel or foam and hand washing facilities available. All of the rooms had a cleaning schedule displayed on the door.
- Alcohol gel was available in outpatients' reception but was not placed in prominent positions. We did not see staff using alcohol gel to clean their hands while we were in the department, however we did observe staff regularly washing their hands.
- We were shown cleaning records for radiology equipment. These records evidenced that cleaning had taken place regularly.
- A system of labelling equipment when it had been cleaned had recently been introduced into the outpatients department. Staff told us this was an improvement as it made it obvious when items were clean and which ones would need to be cleaned before being used. We saw this system in use.
- Curtains in consulting rooms were changed every three months. The last logged change before our inspection was on the 1 July 2015.

Environment and equipment

- The resuscitation equipment trolley in outpatients was clean and tidy and weekly checks were recorded, however the ventilation bag was past its expiry date of November 2014. This meant that we were not assured that checks had been properly undertaken. We raised this issue with the department manager and the bag was replaced immediately.
- The outpatients department provided a warm, comfortable environment for patients. Consultants used private rooms to assess and treat patients.
- All of the equipment used in the diagnostic imaging department was covered by a service contract provided by a large medical equipment manufacturer.

- Every item of equipment was logged on a register and marked with an asset tag, to allow the contractor to keep accurate servicing and maintenance records.
- All equipment in outpatients had a service record and all were in date.
- All equipment used in diagnostic imaging was approved by the National Institute for Health and Care Excellence ('NICE') and recognised by the medical insurance companies who provided cover for patients.
- We checked 10 items at random from equipment trolleys in each of seven consulting rooms and found them all to be in date and the sterile packaging to be intact.

Medicines

- We found 11 different medicines, some of which were prescription-only, in an open freestanding cabinet in the chemotherapy suite, which was unlocked and unstaffed at the time. This presented a risk to patients being treated in that area as medicines could have been tampered with. The medicines in this cabinet were ondansetron injection 2mg/ml, magnesium sulphate 50% w/v injection, dexamethasone 3.3mg/ml injection, heparin sodium flush solution, chlorpheniramine injection, atropine sulphate injection 600mcg/ml, granisetron 1mg/ml injection, zantac 50mg/2ml injection, various intravenous fluids, prochlorperazine 5mg tablets and ondansetron 8mg melt.
- We were told that the procedure for management of prescription forms had been changed twice. This was because the Outpatient department management found they had not been able to account for all of the forms once they had been given to visiting consultants. The forms were now held centrally and form numbers logged when they were issued.
- Following an incident reported on the hospital's electronic incident management system an investigation had established that a consultant had brought a medicine from another Spire hospital and it had not been stored at the correct temperature. We were told that an email had been sent to all visiting consultants about this incident. We requested a copy of this email, details of the investigation and copies of correspondence with the patient however it was not provided. This meant that we were not able to confirm

Outpatients and diagnostic imaging

that the hospital had investigated the matter properly, taken action to ensure that a similar incident did not reoccur or complied with its duty of candour towards the patient concerned.

- The hospital pharmacist trained radiographers to administer five medicines specific to their scope of practice. Once trained and competent they were authorised to give these medicines under the terms of patient group directives (PGDs). We saw copies of the five PGDs and found they were properly completed. This meant that the medicines could be administered to patients who required them during diagnostic imaging procedures without a doctor having to prescribe them individually.
- There was no PGD for saline flushes, a type of injectable medicine. As a result of our inspection the hospital had written a PGD for this medicine and we were shown a copy of the part completed document, described as a work in progress, before our inspection was completed.

Records

- Consultants using the hospital's facilities to see patients, held their own patient records. Patient notes (or were copies of key information) were not held by the hospital. This meant that the hospital was unable to maintain an accurate, complete and contemporaneous record in respect of patients, including the reason for the initial referral, a record of the care and treatment provided to patients and of decisions about care and treatment. This is a legal requirement under the Regulation Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, we saw this went against Corporate Spire's own consultant handbook which states "Consultants may retain a copy of their own notes on patients under their care, but are required also to ensure that hospital in-patient and out-patient records represent a complete account of the patients care".
- We found a card file containing confidential personal information about patients left unsecured on a desktop in the chemotherapy suite, which was unlocked and not staffed at the time. We were able to walk in to the suite unchallenged. Staff later told us that there was a policy that the suite should be locked when no staff were present. We were later shown a copy of this policy,

which was dated July 2015. Both the unsecured card file and the unlocked door were breaches of this policy. We informed the hospital's senior management team of this before we left the premises.

- Radiology used Spire Healthcare's consent form and the Radiological interventions safety checklist before carrying out any diagnostic imaging procedure. We were shown a copy of the online policy about this, which contained a hyperlink to the checklist page on the National Patient Safety
- Agency's website. This meant that the most up-to-date version of the checklist would always be used.
- The minutes of the radiology team meeting from April 2015 recorded that two consultants had incorrectly completed these forms and that as a result the Medical Advisory Committee ('MAC') chair had written to all radiologists who worked at the hospital to ensure that this did not recur.
- We saw imaging request forms which contained confidential personal information about patients being kept secure and out of sight at the radiology department reception.
- Information governance training was provided for all staff as part of the department's mandatory training programme.

Safeguarding

- Safeguarding formed part of the department's mandatory training programme. 64% of staff had completed their 2015 safeguarding refresher training. 80% of staff had completed child protection training. All hospital staff were expected to complete this training within the calendar year.

Mandatory training

- Mandatory training completion rates were monitored monthly by the outpatients' manager and stood at 73% for 2015. All staff were expected to complete the mandatory training relevant to their roles within the calendar year.
- Mandatory training for outpatients and diagnostic imaging staff included safeguarding, infection prevention and control, manual handling, health and safety, information governance, basic life support and on-line training provided by the hospital's medical gases supplier.
- Records of mandatory training for visiting consultants were held on site.

Outpatients and diagnostic imaging

Assessing and responding to patient risk

- Outpatients and diagnostic imaging had procedures in place to recognise and respond to patients who deteriorated while in either department.
- Sufficient numbers of staff were trained in appropriate levels of basic, immediate and advanced life support.
- Equipment and medicine to treat a number of acute, life-threatening conditions was available in outpatients and in the diagnostic imaging department.
- Staff told us that if patients, relatives or carers became unwell while in either department, they were attended to and treated with no regard for fees being charged, and that the welfare of the patient took priority over commercial or financial considerations.

Nursing staffing

- We asked for details of nursing staff numbers, vacancies and agency nurse usage in outpatients. At the time of our inspection outpatients had vacancies for one whole time equivalent (WTE) qualified nurse and 1.25 WTE healthcare assistants. The Outpatient department manager told us that offers had been made to fill those vacancies, and the vacancy information we were given after our inspection confirmed that the department had a full complement of nursing staff in August 2015.
- During our inspection we saw that there were sufficient nurses working in outpatients protect patients from abuse and avoidable harm.
- We were given data on agency nurse usage in outpatients, which ranged from zero in March 2015 to 222 hours in July 2015, we were told and we saw that the vast proportion of available shifts were filled by their own bank staff.
- We spoke with the newly-appointed outpatients manager who told us that the department had previously shared a manager with the inpatient wards, but that the decision had been made that outpatients needed its own manager to look after the staff's needs.
- The outpatients manager told us that there was a policy of locking the front doors to the clinic after a certain time in the evening and that no member of staff was ever left alone in the department. We were given a copy of the hospital's lone working policy, however it made no reference to this procedure.

Medical staffing

- A reception administrator in the outpatients department told us that a database of consultants with practising privileges was available to all staff and was checked whenever a consultant telephoned to book a room. Any queries about whether a consultant was allowed to practise at the hospital were referred to the compliance manager.
- We asked to speak to a radiologist but we were told they were not available to talk to us due to their heavy workload. Radiologists were not employed directly by the hospital. Consultants whose patients required diagnostic imaging employed a radiologist to complete the part of the consultation relating to imaging.
- Consultants operated a 'buddy' system to respond to their patients' needs if the named consultant was unavailable due to other commitments, leave or sickness. The MAC meeting minutes dated May 2015 showed that 60% of consultants had a buddy system in place and the matron had sent letters to all consultants to improve these figures.

Imaging staffing

- The radiology manager and other radiology staff told us that the computerised tomography (CT) scanner was operated five days a week and there were a minimum of two radiographers present whenever it was in operation. The radiology manager also told us that when the magnetic resonance imaging (MRI) scanner was in use there was a minimum of one radiographer and one radiography assistant present. These staffing levels meant that patients undergoing scans were kept safe.
- The radiography department had six full time and three part time permanent staff, making up eight whole time equivalent staff.
- We saw there was no radiologist on call at Spire Parkway Hospital, We were told this was not general practice across any Spire Hospitals or the independent sector. Post inspection, the senior management team told us most consultants preferred their regular NHS radiologist to report their imaging or a radiologist with experience with that specialism. Therefore a blanket on call register may not guarantee this. The senior management team stated and we saw there had been no reported incidents to date where there had been an issue contacting an appropriately skilled radiologist.

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- Radiography also used six bank staff as required. The manager told us that each of the bank staff were used for one shift a week on average so that they maintained their familiarity with the way the department ran.
- We were given details of bank radiographer usage from April to July 2015. We were told that only two bank radiographers were used during that period. For those four months bank radiographers were used for an average of five and a half hours per week. This meant that bank staff were familiar with the department
- Five of the permanent radiographers had worked at the hospital for over 10 years. This meant that they had a familiarity of the processes and equipment in use.

Are outpatients and diagnostic imaging services effective?

Assessments and treatments were carried out in line with evidence-based guidelines and legislation.

Patients were provided with adequate pain relief and were able to contact a telephone advice line 24 hours a day, seven days a week.

Staff were provided with induction training and were actively encouraged and supported to engage in further training to improve their knowledge and clinical skills.

We saw evidence of multidisciplinary working both within the hospital and with partner organisations.

Staff demonstrated a good understanding of mental capacity assessments and a specific form was used to record when patients were assessed as not having capacity to make a decision.

Evidence-based care and treatment

- Radiology carried out audits on pre-processing markers, a procedure used to ensure that the site to be x-rayed is clearly and correctly indicated.
- Radiology used the 'iRefer' guidelines, issued by the Royal College of Radiologists, to ensure that all examinations they carried out were justified.
- The radiology department was working towards United Kingdom Accreditation Service (UKAS) accreditation against the Imaging Services Accreditation Scheme (ISAS) standard. ISAS was developed by The Royal College of Radiologists and the College of Radiographers as a patient-focused assessment and

accreditation programme to help diagnostic imaging services ensure that their patients consistently receive high quality services from competent staff working in safe environments.

- Outpatients worked to the National Institute for Health and Care Excellence (NICE) guidelines for the use of routine preoperative tests for elective surgery.

Patient outcomes

- We were told that there was no standard operating procedure or policy to cover what actions should be taken to alert a patient's consultant and GP in the event of an unexpected finding during a diagnostic imaging procedure and decisions on how to deal with this information were made by the radiologist involved. This meant that the hospital could not be sure that there were robust procedures to ensure information about unexpected findings was passed on to doctors looking after a patient.
- Radiology carried out a quality of life audit on patients six and 12 months after they had had MRgFUS treatment. In an audit of the 48-hour MRI reporting target two radiologists were found not to be completing their reports within the timeframe. The radiography manager and the lead radiologist drew up action plans for the radiologists concerned to improve their performance. We asked for copies of the action plans but they were not supplied, so we were not able to assess how effective they had been.
- Audits of MRI report turnaround times during three periods, totalling 42 days, in April, May and June 2015 showed that 39% of reports had exceeded the 48-hour target. As a result of this a process had been put in place to alert radiologists by email or text message when they had a study in their list waiting for a report. The audit was planned to be repeated after three months to assess whether turnaround times had improved.

Pain relief

- Patients who were receiving treatment from the oncology department all told us that they were provided with adequate pain relief to control their symptoms, with extra medicine available to use should they require it. They also had access to a 24-hour, seven-day telephone number that they could call if they needed advice about managing their pain.

Competent staff

Outpatients and diagnostic imaging

- Staff in outpatients and diagnostic imaging told us they had annual appraisals with their managers, through the ‘enabling excellence’ staff review scheme. We asked for figures for staff in outpatients and diagnostic imaging who had had appraisals, and were supplied with two documents reading “100% of Outpatient Nursing Staff have had appraisals in 2015” and 100% of the radiology team have had appraisals” respectively. This did not allow us to assess the appraisal process properly.
- We were given copies of documents used during ‘enabling excellence’ staff reviews. They gave staff an opportunity to prepare for the meeting, showed positive examples of behaviour from staff and areas where improvements were required and agreed targets for development.
- Consultants only held practising privileges for procedures they were authorised to carry out in their parent NHS trust, and had to provide evidence of their authority every two years. If they failed to update their evidence in time their practising privileges were suspended until the evidence was provided. Three consultants had been suspended at the time of our inspection, two were out of date with their insurance indemnity and one consultant was out of date with their NHS appraisal by 15 months.
- During our inspection the outpatients manager told us that they had recently had an email from the hospital management informing them of the suspension of two consultants’ practising privileges because their authority had lapsed. This email was forwarded to all outpatients staff to ensure that they were aware of the status of the consultants.
- The newly-appointed outpatient manager told us that they were arranging training for staff in clinical skills such as phlebotomy and, where needed, IT skills.
- New staff in the imaging department received corporate and departmental inductions then were buddied with an existing member of staff until they were deemed competent. There was no formal time limit on the buddy working stage.
- The radiology manager had recently attended a course called ‘IR(ME)R – proofing your department’ which dealt with safety issues encountered when using ionising radiation. IR(ME)R refers to the ‘ionising radiation (medical exposure) regulations’ which govern safety measure to protect people from harm when radiation

such as x-rays is in use. Competency documents for radiography staff had been updated as a result of them attending this course. The hospital had funded the manager’s attendance on this course.

Multidisciplinary working (related to this core service)

- Radiology used a nationally recognised data sharing network to transfer patient images to NHS hospitals.
- Radiology staff took part in the weekly theatres planning meetings and told us that communication between them, the wards and outpatients department was effective and reliable.
- Outpatients held multidisciplinary team meetings about complex services such as bariatric patients and those being assessed for joint replacements. These meetings included occupational therapists, physiotherapists, pharmacists, nurses, healthcare assistants and nursing sisters.
- The hospital had its own pathology laboratory to analyse specimens taken from patients, and had a service level agreement with a nearby NHS acute trust to support them with investigations that could not be carried out on site.

Access to information

- Policies and procedures were available on the hospital’s intranet and as hard copies in outpatients and radiology. Staff were able to access these when they needed to.
- Staff in radiology were able to quickly locate and show us maintenance reports and contracts for diagnostic imaging equipment in their department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Radiology used a specific consent form when they had patients who did not have capacity to consent to their own treatment. We were shown a copy of this form and found that it contained a record of the patient’s mental capacity assessment, confirmation that the patient had not refused treatment while they had capacity, details of family and carers who had been involved in discussions and details of the healthcare professional who had completed the assessment and the form. This meant that patients who did not have capacity to make their own decisions were protected and that proper records were kept of decisions made on patients’ behalf.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good 

Without exception patients spoke positively about the care they had received from staff at the hospital.

Staff treated patients and relatives with dignity and respect and patients felt well cared for. Patients had their treatment clearly and carefully explained to them and staff took patients' needs and views into account when delivering care.

Staff had time to talk to patients and displayed positive, personable attitudes. Patients told us they were made to feel at home and treated like friends.

Compassionate care

- We spoke with a patient's relative who had also been a patient at the hospital in the past. They described it as an "excellent experience" with a high level of care, and told us that they would recommend the hospital to their friends and family without hesitation.
- We observed a patient undergoing a CT scan. The radiology staff treated the patient with dignity and respect and explained the process that would take place. They took time to answer questions and made sure the patient was at ease before starting the procedure.
- All of the patients we spoke to told us they had received good, compassionate care from staff in the outpatients department.
- One patient who was receiving treatment for cancer told us that the care they were receiving in outpatients was "outstanding".
- Patients who were receiving courses of treatment in the temporary oncology suite told us that the nurses were compassionate, friendly and caring. Patients told us that the nurses made them feel at home in the unit, that they were "wonderful", "fabulous" and really good at their jobs. They told us that the nurses would sit and chat to them while they were having treatment if the patients wanted to, and that they were treated as a person not a patient.

Understanding and involvement of patients and those close to them

- One patient told us that they had asked for more information after being given a diagnosis of a serious medical condition. A specialist nurse had spoken to and supported them at length in a private room.
- We spoke with four patients who were attending their first appointments for pre-operation assessment. They all told us that they had been given plenty of useful information about the process before attending.
- Patients who were being treated in the oncology suite all told us that the nurses explained every step of their treatment, the possible side effects and how to deal with them if they occurred.

Emotional support

- One patient's parent told us that as well as looking after their child, staff in outpatients "also looked after me as I was terrified".
- We spoke with one former inpatient who was attending a follow-up appointment. This patient told us that they had always been provided with the best care and information, particularly on admission and discharge.
- One patient who was receiving a course of treatment for cancer told us that the oncology nurses always made sure their spouse had everything they needed while accompanying them for treatment.

Are outpatients and diagnostic imaging services responsive?

Good 

Appointments ran on time and results of tests were provided within agreed timescales.

Admissions were planned on a rolling seven-day-ahead pattern. Out of hours services were provided for urgent imaging requests.

Facilities were available for paediatric patients and for sensitive conversations to be held with patients.

Chemotherapy was being provided in a temporary facility which did not afford a good degree of privacy for patients.

Service planning and delivery to meet the needs of local people

- Chemotherapy was provided in a temporary treatment suite while a nearby building which had been converted

Outpatients and diagnostic imaging

to a permanent chemotherapy unit. The temporary suite had three treatment bays which could be screened off with curtains. There were no private rooms allocated to the service. Patients told us that privacy was sometimes an issue as when there was more than one patient receiving treatment at the same time conversations from adjoining bays could be clearly overheard.

- One patient told us they had complained to the hospital about the conditions in the temporary chemotherapy unit because it was cramped and the lack of privacy meant that they could not have conversations with the nurses about their treatment. They had had a letter of apology from the hospital.
- One patient told us that it was very awkward using the toilet in the temporary oncology suite as there was a ridge where the door led out to the toilet corridor, and the nurses had to help lift chemotherapy equipment over this, in a small space, to allow patients to get through.
- We were told by senior managers the new Oncology suite would be completed by end October 2015 and ready for patient use.
- Several oncology patients told us that the reclining chairs in the temporary chemotherapy suite were very comfortable and made long stays more bearable while they were receiving treatment.
- Part of the hospital refurbishment included a new ground floor endoscopy unit. We were told by staff and managers that data was being collated in preparation to apply for JAG Accreditation. The JAG scheme sets acceptable standards for competence in endoscopic procedures and quality assures endoscopy units, training and services through independent assessment.
- Radiology worked to a target of 48-hour reporting for MRI scans, which meant that patients' doctors had the results of scans quickly.
- Radiology were able to offer a process called magnetic resonance guided focussed ultrasound ('MRgFUS') to treat uterine fibroids as a non-invasive alternative to surgery.

Access and flow

- Outpatients had started to offer some minor procedures and were planning to add more, such as sclerotherapy varicose vein treatment, to their list to improve the service they offered to patients. These procedures had traditionally been carried out in theatres.

- Patients told us that appointments in the chemotherapy unit always ran exactly on time.
- Radiography operated a 24-hour, 7-day out of hours on-call service for urgent imaging requests. This service did not include CT scanning.
- Daily capacity meetings were held between wards, theatres, outpatients and diagnostic imaging managers to plan admissions seven days ahead.
- One patient's relative told us that they had had to change an appointment time due to an injury and that the hospital had been very accommodating and the process had been simple and problem-free.
- We were told that outpatients had started to see patients waiting for joint replacements on weekends to assist with patients on waiting lists.
- Patients were generally given an OPD appointment between 1-2 weeks from the point of referral.

Meeting people's individual needs

- Radiology occasionally provided services for children. When this happened the department had access to two paediatric specialist radiologists.
- Radiology borrowed appropriate toys from one of the hospital's own wards on the occasions they had young children as patients.
- Administration staff in radiology did not have a robust process for giving patients preparation information sheets before they attended for their procedures. This was evidenced in our conversation with the staff and in details of a complaint that was recorded in the minutes of a radiology staff meeting.
- One room in outpatients was designated for sensitive conversations between staff and patients. This room was not used for routine consultations and was equipped with privacy screens and dimming lights.

Learning from complaints and concerns

- Patient feedback forms were displayed in the outpatients department. A post box was available near to the forms for replies to be collected and kept secure. Staff told us the box was emptied and the contents reviewed at regular intervals.
- Patient's feedback forms were discussed at team meetings and acted upon where appropriate.

Are outpatients and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Requires improvement

Hospital and corporate vision and values were not embedded in the hospital, OPD and diagnostic imaging service.

Patient satisfaction surveys were available but patients were not routinely asked for feedback on the standards of care and treatment they had received.

Incidents and governance matters were regularly reviewed and learning was shared. Risk recording was inconsistent we were not reassured that it was robust and effective.

Managers were approachable, supportive and visible. Staff of all levels felt involved in the teamwork of the hospital. Staff were involved in two-way forum meetings with senior managers and with project work to improve services offered by the hospital. Staff told us there was a culture of mutual support among everyone who worked at the hospital.

Vision, strategy, innovation and sustainability and strategy for this this core service

- The hospital vision was to be the first independent hospital of choice in the city which was aligned to the vision and values of their parent company, Spire Healthcare plc.
- However, the vision and values were not visibly displayed in OPD and diagnostic imaging services during our inspection. None of the staff we talked to made any reference to the vision or values or how they employed them in their day to day work. This suggested that the hospital and corporate vision and values were not well embedded in the hospital.

Governance, risk management and quality measurement for this core service

- We were shown copies of two risk registers for radiology. We asked the hospital to clarify why there were two different registers for the same department. This information was not supplied by the hospital.
- We were shown a copy of the hospital's general risk assessments record. Outpatients had recorded five general risks, 12 clinical risks and 12 risks relating to the Control of Substances Hazardous to Health (COSHH) regulations.

- There were two low, two medium and four high clinical risks. The remaining clinical risks were recorded as having been identified in July 2013 but had not been given a rating and no comments had been added to evidence what action had been taken to mitigate it. One of the remaining risks was described as "Paediatrics [children] having interventional procedure in OPD". Because of this we were not reassured that the risk register was regularly reviewed or that the senior management team were properly focussed on the potential risks.
- None of the COSHH risks had been given a risk rating. Ten of them had comments stating "locked in cupboard", two referred to gloves being used to avoid irritation and one related to a substance no longer used on the unit. One entry, relating to a pump spray used during analysis of specimens, had an assessment date in September 2010 but had no comments. This meant that we were not assured that the risks had been properly assessed.
- Three of the general risks were graded as low or very low and two were medium. There were no high or very high risks.
- The risk register for radiology identified 11 general risks, 16 clinical risks and two manual handling risks.
- The two manual handling risks had not been given a grading. One was a duplicate of a 'high' clinical risk and the other was a risk of injury to staff while carrying heavy equipment.
- Of the general risks one had been graded as low, nine as medium and one as high. The high risk related to preventing unauthorised access to the magnetic resonance imaging (MRI) suite and appropriate mitigation had been put in place.
- Of the clinical risks six were low or very low, six were medium and four were high. The high risks were: exposure to ionising radiation; risk of harm during a procedure to examine a woman's uterus and fallopian tubes using x-rays; the risk of a patient falling during transfer from their bed to the CT scanner and a technical risk of damage or harm if metallic objects are taken into the MRI room. All of these risks had appropriate measures in place to mitigate them and prevent avoidable harm to patients.
- We spoke with two members of staff who took part in the on-call rota and could be working alone, but who were not aware of the existence of the lone working policy.

Outpatients and diagnostic imaging

- Clinical governance committees met monthly to share learning from reported incidents and complaints. We were given copies of the minutes of these meetings for January to June 2015 and saw that amongst other subjects, risk assessments, serious adverse events and any legal cases were discussed. Updates were given each month on the progress of matters raised at previous meetings.
- An IR(ME)R radiation protection audit was carried out in May 2015, which resulted in nine recommendations. We were shown the audit and the hospital's response form. Seven recommendations had been completed, one had been part completed and one was still outstanding but in progress. This showed that the radiology department was responding quickly to the results of the audit.
- The chair of the MAC at the time of our inspection was the lead radiologist. They had a clear understanding as to the requirements of the service and another source of expertise for staff to go to.
- Periodical newsletters for consultants and staff contained information on incidents and learning outcomes from investigations.

Leadership/culture of service

- The newly-appointed outpatient department manager was being mentored by the previous manager, who still worked within the hospital. They were identifying areas for personal development and being supported by other managers. Formal management training was provided by Spire and would be undertaken when the manager had finished their initial mentoring stage.
- The outpatient manager told us that they felt happy to go straight to the hospital director with concerns and had done so on occasions. They said that the director and all the senior managers were approachable and could be relied on to resolve matters.
- Staff in the outpatients department told us that morale was high and had improved since the restructure of the management team meant that they had their own manager.
- The radiology manager also told us that they would be happy to take any concerns to the hospital director.
- All the staff we spoke to told us that the hospital director and head of clinical services were visible and usually visited all the hospital's departments twice daily. Staff also told us that the senior managers and director were supportive and approachable.

Culture within the service

- Staff told us that the hospital operated a “no blame, let's learn” culture regarding incident reporting.
- Every member of staff we spoke to told us that there was a culture of mutual support between the staff and the consultants and of caring for patients. One member of staff told us the atmosphere was “like a little cottage hospital”, that everyone knew everyone, cared and had time to look after patients and each other.
- We spoke to four administrative staff who told us they were included in and felt they were valued members of their teams.

Public and staff engagement

- Information leaflets detailing the procedure should a patient wish to complain were available in outpatients reception but were not prominently displayed. When we asked the reception staff about them they did not know that the leaflets were there.
- Patient satisfaction survey forms were held by outpatient reception but were not displayed where patients could see them.
- We were given a copy of a smaller outpatients patient satisfaction survey form and were told that these were given to NHS patients but not to private patients. This meant that the hospital was able to report how satisfied NHS patients who had been referred to them were so that the referring NHS trust could monitor performance.
- We were given two copies of the minutes of the radiology team meeting held on 27 April 2015, which included information about staff and management moves, the radiation protection action plan, modality, policies, incident and learning outcomes, infection prevention and control, audits, training and development, the then forthcoming CQC inspection and the department's work towards ISAS accreditation. The two copies of the minutes were different: some information had been removed from one of the copies. We asked the radiology department manager why this had happened, we did not receive an explanation.
- Members of the radiology team told us they had been involved in the MRgFUS project from its start through to implementation of the service. They felt included in the process and that their opinions were valued.

Outpatients and diagnostic imaging

- Monthly two-way communication forums were held between hospital managers and staff. Staff told us that they attended these and found them informative. Attendance records were not kept for these meetings.
- Information was cascaded to outpatient staff verbally and by email, and if important it was supported by a signed acknowledgment from staff members.
- The outpatient manager attended the heads of departments' meetings and passed information from those meetings on to outpatients staff verbally. We were given copies of the minutes of some of these meetings held between January 2014 and April 2015.
- Newsletters were produced for staff and for consultants and distributed by email and as printed copies. We were given copies of newsletters which had been issued monthly from January to October 2014. The November and December 2014 newsletters were combined into

one issue and in 2015 they had been issued quarterly. Both newsletters contained items on developments at the hospital, staff achievements, charity events, learning from incidents and training opportunities and requirements. Staff newsletters also contained details and photographs of any consultants who were new to the hospital.

Innovation, improvement and sustainability

- We were told about and saw evidence of several improvements that had been made to the services provided at the hospital, such as the provision of MRgFUS treatment, weekend clinics to assist with waiting lists at partner organisations and additional minor surgical procedures being carried out in the outpatients department.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The hospital **MUST** maintain complete sets of patient records on site from pre-assessment to discharge and ensures patient confidentiality is maintained at all times.
- The hospital **MUST** ensure all staff adhere to hospital directives including consultants when risks have been identified and measure put in place to protect patients.

Action the hospital **SHOULD** take to improve

- The hospital **SHOULD** ensure the risk register reflects all risks across hospital services, is regularly reviewed and action plans are in place to address identified risks.

- The hospital **SHOULD** ensure all medications and managed as per Spire Medication Policy.
- The hospital **SHOULD** improve incident reporting across all areas of the hospital including pharmacy.
- The hospital **SHOULD** ensure clinical audits include findings, actions and demonstrate patient outcomes so care improvements can be measured clearly.
- The hospital **SHOULD** ensure the Lone Working Policy applies to all staff working at the hospital and includes staff working out of hours.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014

Good Governance - Regulation 17 2 (c)

The Provider did not ensure that hospital staff had access to all necessary information, including maintaining an accurate, complete and contemporaneous record in respect of each patient and of decisions taken in relation to the care and treatment provided. And that patient confidentiality was maintained at all times.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014

Good Governance - Regulation 17 2 (b)

The provider did not ensure there were robust governance arrangement in place to ensure that all consultants with practicing privileges at Spire Parkway Hospital adhere to Hospitals directives when risks had been identified and action was required to monitor and mitigate the risk.