Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
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1  A summary of our inspection

About the service we inspected

Shawfair Park Hospital is a private hospital facility in Edinburgh which offers a range of day-case hospital services. It is one of two services provided by Spire Healthcare Limited. Shawfair Park Hospital and Spire Murrayfield Hospital (Edinburgh) combine to offer patients a broad range of private healthcare services, including access to consultants and specialists, diagnosis and treatment.

The hospital aims to offer patients a modern and attractive hospital facility, with state-of-the-art equipment, to make the experience more comfortable and enjoyable.

About our inspection

This inspection report and grades are our assessment of the quality of how the service was performing in the areas we examined during this inspection.

Grades may change after this inspection due to other regulatory activity, for example if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

We carried out an unannounced inspection to Shawfair Park Hospital on Wednesday 29 and Thursday 30 April 2015.

The inspection team was made up of two inspectors: Winifred McLure and Sarah Gill, and a public partner, Stella MacPherson. A key part of the role of the public partner is to talk to patients and relatives and listen to what is important to them.

We assessed the service against five quality themes related to the Healthcare Improvement Scotland (requirements as to independent healthcare services) regulations and the National Care Standards. We also considered the Regulatory Support Assessment (RSA). We use this information when deciding the frequency of inspection and the number of quality statements we inspect.

Based on the findings of this inspection, this service has been awarded the following grades:

Quality Theme 0 – Quality of information: 4 - Good
Quality Theme 1 – Quality of care and support: 5 - Very good
Quality Theme 2 – Quality of environment: 5 - Very good
Quality Theme 3 – Quality of staffing: 5 - Very good
Quality Theme 4 – Quality of management and leadership: 5 - Very good

The grading history for Shawfair Park Hospital can be found in Appendix 2 and more information about grading can be found in Appendix 4.

Before the inspection, we reviewed information about the service. We considered:

• the service’s self-assessment
• the service’s annual return
• notifications the service had made to us, and
• the findings of the last inspection on 1 and 2 July 2014.
During the inspection, we gathered information from a variety of sources. This included:

- information leaflets
- minutes of the clinical governance committee meetings
- minutes of the infection control meetings
- minutes of the medical advisory committee meetings
- minutes of staff meetings
- organisational and hospital policies and procedures
- patient care records, and
- satisfaction questionnaires.

We spoke with a number of people during the inspection, including:

- the clinical effectiveness nurse
- an engineer
- the hospital director
- the human resources/training co-ordinator
- the infection control lead nurse
- the lead nurse for the hospital
- the marketing manager
- the matron
- a pharmacist
- staff nurses
- six patients, and
- the theatre manager.

We inspected the following areas:

- the inpatient ward
- the outpatients department
- the physiotherapy department, and
- the theatre suite.

**What the service did well**

We noted areas where the service was performing well.

- The service had good systems in place to manage information security.
- The service had comprehensive quality assurance systems in place.
- The service had a comprehensive system to manage the checking and maintenance of equipment.
What the service could do better
We did find that improvement was needed in the following areas.

- Shawfair Park Hospital should review policies and procedures and make sure that they reflect Scottish legislation and guidance.
- Shawfair Park Hospital should ensure infection control systems reflect best practice.

This inspection resulted in no requirements and six recommendations. See Appendix 1 for a full list of the recommendations.

Spire Healthcare Limited, the provider, must make the necessary improvements, as a matter of priority.

We would like to thank all staff at Shawfair Park Hospital for their assistance during the inspection.
2 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 1–2 July 2014

Recommendation

We recommend that the service should review the consultant biographies on the hospital website regularly. This will ensure that the details held are correct and there is sufficient information to enable patients to make a choice about using their services.

Action taken
The service has formatted a new template which will specify the details the consultants are to provide and requires a minimum number of words to be written relating to a consultants private practice. This will improve the information available for patients when making a choice about using their service. This recommendation is met.

Recommendation

We recommend that the service should review its ‘Please talk to us’ information leaflet. This will guide patients to Healthcare Improvement Scotland if they want to make a complaint.

Action taken
We saw that the ‘Please talk to us’ information leaflet had been reviewed and updated to guide patients to Healthcare Improvement Scotland if they want to make a complaint. This recommendation is met.

Recommendation

We recommend that the service should ensure consent forms and patient care records, if relevant, sufficiently detail the discussion of benefits and risks associated with the procedure being carried out.

Action taken
We examined patient care records and noted that not all had held discussion of benefits and risks associated with the procedure being carried out. This is discussed further under Quality Statement 0.3. This recommendation is not met (see recommendation a).

Recommendation

We recommend that the service should ensure that the policy for transferring critically ill patients is developed to specify where and what emergency equipment should be made available. The service should also ensure staff are aware of the process for transferring critically ill patients from general and cardiac departments.

Action taken
We found that the transfer policy had been made more detailed to specify where and what emergency equipment should be available to support such a transfer. This is discussed further under Quality Statement 1.6. This recommendation is met.
Recommendation

We recommend that the service should ensure all relevant policies and procedures are supported by Scottish legislation, with particular reference to the adult support and protection policy and the consent policy.

Action taken
During the inspection, we reviewed policies and procedures. This is reported under Quality Statement 0.3. **This recommendation is not met** (see recommendation b).

Recommendation

We recommend that the service should develop the medication policy and procedures to record that patients’ own medication, brought into the hospital for use during the day is current, prescribed for that patient and suitable for use.

Action taken
A new system is in place where the checking of patient’s own drugs are recorded and checked and the record will be kept within the patient’s clinical notes. **This recommendation is met.**

Recommendation

We recommend that the service should implement infection control systems and monitoring activities that reflect best practice guidance in Scotland.

Action taken
This recommendation is reported under Quality Statement 2.4. **This recommendation is not met** (see recommendation c).

Recommendation

We recommend that the service should standardise staff files to ensure it is clear that all recruitment checks have been carried out to an agreed quality. This should include proof of checks with professional bodies and references from the most recent employer.

Action taken
This recommendation is reported under Quality Statement 3.2. **This recommendation is not met** (see recommendation e).
3 What we found during this inspection

Quality Theme 0 – Quality of information

Quality Statement 0.3
We ensure our consent to care and treatment practice reflects Best Practice Statements (BPS) and current legislation (where appropriate Scottish legislation).

Grade awarded for this statement: 4 - Good

Spire Healthcare had a policy, available electronically, to guide staff through consent to medical treatment and associated record-keeping. Three types of consent forms were available to record agreement to medical treatment. These were for:

- adults with decision-making ability
- adults without full decision-making ability, and
- children.

Staff told us that consultants explained surgical procedures to patients. They also told us that consultants had responsibility to make sure patients understood proposed procedures and record their agreement. Staff we spoke with were aware of the different types of consent forms available. One consultant told us the layout of the consent form was good and allowed details of benefits and risks to be clearly recorded.

Patients we spoke with, during the inspection, stated that they were well informed about the procedures to be carried out that day. Patients can be given a copy of the consent forms for their own records, if they wish.

Staff in the physiotherapy department used consent forms to record the patient’s agreements to different treatments.

Areas for improvement

We reviewed nine consent forms for patients undergoing surgical procedures. These showed varied standards of completion by the consultants. Some consultants detailed benefits and risks of the procedure on the consent form, while others did not. When we asked staff about this, we were told that consultants could record consent discussions elsewhere in the patient care record. However, in one case we could not find any record of this discussion taking place (see recommendation a).

Senior management had recognised and recorded, in the clinical governance report for 2014, some non-compliance from medical staff with consent procedures. It was also proposed that the consent policy would be reviewed and updated.

We found the consent policy did not reference Scottish legislation and best practice documents. This consent policy should be updated (see recommendation b).

We noted that nurses involved in audit and checking consent procedures had not had relevant refresher or update training. It could be beneficial to offer nurses and theatre staff some training on this subject to remind them of related legislation and best practice in Scotland.

- No requirements.
Recommendation a

- We recommend that the service should ensure consent forms and patient care records, if relevant, sufficiently detail the discussion of benefits and risks associated with the procedure being carried out.

Recommendation b

- We recommend the service should ensure all relevant policies and procedures are supported by Scottish legislation, with particular reference to the adult support and protection policy and the consent policy.

Quality Statement 0.4

We ensure that information held about service users is managed to ensure confidentiality and that the information is only shared with others if appropriate and with the informed consent of the service user.

Grade awarded for this statement: 5 - Very good

Staff completed an online module about information security. During the inspection, we saw a graph which monitored completion rates and this showed that staff had completed their training for this subject by the due date.

An audit of ‘site security’ was carried out regularly by Spire Healthcare’s IT team and we saw the results of the audit for December 2014. It showed that all of the expected security measures for information handling and storage were in place. This included checking computers were password-protected and making sure patients’ details were only used when necessary.

Information security was monitored and we saw an example where a breach had been detected and actions had been taken to prevent any reoccurrence. This related to a minor clerical error, but demonstrated that the management team take information security seriously.

The provider had appropriate policies and procedures in place to guide staff on the subject of confidentiality and management of patient care records. This covered duties and responsibilities including, storage, destruction, access to records and the Caldicott principles for good practice.

A named Caldicott guardian had overall responsibility to ensure systems for confidentiality were maintained and patient information was kept secure.

From the patient care records, we saw that patient permission for information to be shared with third party, such as GPs, was asked for.

Area for improvement

Bed spaces, known as Pods, were used for patients having day surgery. However, we found that conversations could be overheard easily in these bed spaces. Staff told us that any private conversations would take place in a nearby private room. The service planned to alter this space to try to improve patient privacy and confidentiality.

- No requirements.
- No recommendations.
Quality Theme 1 – Quality of care and support

Quality Statement 1.1
We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Grade awarded for this statement: 5 - Very good
Patients could feedback about the quality of the service through a variety of methods, including:

- focus groups
- questionnaires
- telephone, through the enquiry line, and
- the ‘contact us’ section of the website.

We saw that the leaflet ‘Please talk to us’ was readily available around the hospital. This leaflet encouraged patients to give their views, either informally or formally, using the complaints procedure.

A number of different questionnaires were available for different departments. These included:

- the endoscopy department’s patient questionnaire
- the physiotherapy outpatient patient satisfaction questionnaire, and
- Spire Healthcare’s patient satisfaction survey.

These questionnaires were comprehensive and asked for feedback on a wide range of issues. The service is currently developing an outpatient questionnaire.

The service had recently introduced ‘You said, we did’ boards. These were displayed around the hospital and gave a snapshot of some issues raised by patients and the changes made as a result.

The patient satisfaction survey results for December 2014 were available. These results showed high levels of satisfaction and contained a number of positive comments. Results from the January 2015 physiotherapy outpatient questionnaire were also available. This also showed very high levels of satisfaction.

Areas for improvement
The ‘You said, we did’ boards could also include where the comments had come from (for example, a patient survey or focus group) and the date they were received.

The service could consider how to involve patients in the self-assessment and grading process. Staff were keen to use focus groups to further develop patient involvement, such as commenting on the self-assessment and grading.

- No requirements.
- No recommendations.
Quality Statement 1.6

We ensure that there is an appropriate risk management system in place, which covers the care, support and treatment delivered within our service and, that it promotes/maintains the personal safety and security of service users and staff.

Grade awarded for this statement: 5 - Very good

We spoke with the health and safety officer, who was able to show that the service had a clear organisational structure in place. We saw the minutes for the health and safety committee, this showed that each department’s health and safety representatives attended the health and safety committee meetings which were held every 3 months. Staff use the online ‘Access Academy’ to carry out mandatory training, which includes:

- fire
- health and safety, and
- manual handling.

Staff compliance with completing training is monitored closely by senior staff.

Datix is an online accident, incident, risk and complaints-reporting software package. The service used Datix to gather all relevant data to record, archive and report incidents. A scoring and rating system was used to assess each risk.

Each department had product safety data sheets and locally-managed Control of Substances Hazardous to Health (COSHH) risk assessments in place. A sign-off system was in place to ensure staff had read and understood this information.

We saw evidence of environmental risk assessments, including fire and water hygiene, and action plans for work to be carried out. Regular health and safety audits were carried out internally, and an external company carried out an audit every 2 years.

During the inspection, we checked four patient care records and found good standards of record-keeping. Entries were signed and dated and the time was also recorded. Different pathway records were held for patients, depending on the patient’s procedure. Essential details, such as next of kin and consent to treatment, were also recorded. The consent form was signed by the patient and the surgeon. We saw that individual risk assessments were available in the patient care record. These included:

- falls
- moving and handling
- pressure ulcer
- malnutrition, and
- use of bedrails.

We also saw risk assessment for venous thromboembolism (VTE), a blood clot which forms within a vein, and a theatre safety checklist.

The World Health Organization (WHO) has issued guidelines called ‘Safe Surgery Saves Lives’. This details best practice in performing surgery in a safe way. We followed a patient’s journey from the ward to theatre and the recovery room. We saw that staff carried out a
checklist to confirm the patient’s identity, date of birth, site of operation and other key information at each handover point. This is in line with the WHO safe surgery guidelines. The WHO safe surgery guidelines also recommend theatre staff have a ‘time out’ or ‘surgical pause’ before they start the surgery. During a surgical pause, staff check they have the correct patient and equipment, and are about to perform the correct procedure before starting. We saw a surgical pause took place involving all relevant staff and this was recorded on the surgical safety checklist.

During surgery, theatre staff should count all swabs, needles and instruments used. This means they can be counted again at the end of the surgery to make sure all are accounted for. Staff used a whiteboard to keep a running total during the operation and documented all swab and instrument counts. This allowed staff to make an accurate check. When the operation was finished, a copy of the swab and instrument count was kept in the patient care record. We saw a nurse accompany patients to and from the theatre department. We saw patients were closely monitored during the introduction of anaesthetic, during the operation and in the recovery room. Observations were recorded approximately every 5 minutes. This was good practice.

We saw that instruments used were tracked using an electronic system, which made it easier to ensure traceability of instruments used.

In an emergency, a patient may have to be transferred to a local NHS hospital for treatment. We found that the transfer policy had been made more detailed to specify what emergency equipment should be available to support such a transfer. An emergency bag was also available at the time of the inspection. Staff were able to explain to us that they had recently used the policy.

Area for improvement
From reviewing the patient care records, we saw risk assessments were present. However, depending on the treatment or procedures the patient had been admitted for, some were left blank. Staff explained that, as all their patients were day cases, these assessments were not routinely required. It is good practice to ensure that paperwork is scored through or removed if not applicable.

- No requirements.
- No recommendations.

Quality Theme 2 – Quality of environment

Quality Statement 2.3

We ensure that all our clinical and non-clinical equipment within our service is regularly checked and maintained.

Grade awarded for this statement: 5 - Very good

The hospital had operations policies in place which provide guidelines for the maintenance of clinical and non-clinical equipment. Corporate contracts, for the servicing of equipment, were controlled by the hospital engineer. An asset register allowed for the tracking of equipment. Building maintenance and equipment issues were reported through an online system which also generated work orders. Discussions with staff confirmed that they were familiar with the procedures for reporting repairs.
In the theatre suite, we saw evidence of equipment checks taking place. We saw a daily checklist for equipment to be used in theatres. Anaesthetic machines were also checked daily and recorded in folders provided.

In the ward, theatre and recovery areas, we saw that the emergency equipment and trolleys were checked and laid out in a way that made identification of equipment easy. This reduced risk in emergencies.

We saw evidence of fridge and room temperatures being checked and recorded.

**Area for improvement**

Folders were kept that recorded checks of anaesthetic machines. However, these could be more detailed to ensure the name of the person and the date they changed the soda lime, was recorded.

- No requirements.
- No recommendations.

**Quality Statement 2.4**

We ensure that our infection prevention and control policy and practices, including decontamination, are in line with current legislation and best practice (where appropriate Scottish legislation).

**Grade awarded for this statement: 5 - Very good**

Shawfair Park Hospital is a new, purpose-built building. In the areas of the hospital we inspected, the standard of cleaning was very good. We spoke with the hotel services manager, who was able to show us the systems and processes in place to clean the hospital, along with the associated records. These included:

- cleaning schedules
- daily walkabout and checking system with housekeeping staff
- monthly audits, and
- action plans.

Systems were also in place for ongoing cleaning, such as curtain changes and room deep cleans. We saw that housekeeping staff also carried out mattress audits.

We saw a range of infection prevention and control policies in place at the hospital. These give staff guidance on various aspects of infection prevention and control. All staff completed online infection control training as part of their induction and carried out mandatory training each year.

We saw evidence of completed clinical cleaning schedules. These were used to guide clinical staff to clean clinical equipment and set out what housekeeping staff did and did not do.

A lead nurse for infection control has responsibility for Shawfair Park Hospital and Spire Murrayfield Hospital. The lead nurse has 3 days each week allocated to infection control duties across both hospitals. This includes supporting staff, carrying out audit activity and surgical site infection surveillance.
Audits carried out included:

- hand hygiene – opportunity
- hand hygiene – technique
- linen, and
- sharps management.

In addition the minutes of meetings showed that the lead nurse attends:
the quarterly infection control committee which covers both hospitals, and
the clinical effectiveness committee for Shawfair Park Hospital.

Two infection control link nurses were also based permanently at Shawfair Park Hospital.
With support from the lead nurse, the link nurses promoted and guided infection control
practice day-to-day. Infection control activity was carried out along with their regular duties..
Infection control link nurse meetings were held locally.

Doctors at the service used flexible endoscopes. These are small cameras used to look
inside patients. Flexible endoscopes need to be properly cleaned before and after each use.
The decontamination of endoscopes is carried out in a suite designed for this purpose. All
other surgical instruments were decontaminated and sterilised at a facility located at Spire
Murrayfield Hospital. There is an electronic traceability system in place in at Shawfair Park
Hospital.

All patients we spoke with rated the cleanliness of the environment as ‘very good’ or
‘excellent’ and all observed good practice from staff in washing their hands.

**Areas for improvement**

Some infection control initiatives and audits were still being developed, in particular care
bundles for peripheral venous catheter (PVC) insertion and maintenance (see
recommendation c).

Shawfair Park Hospital is a day-case hospital, and therefore most patients are cared for on
patient trolleys. Housekeeping staff explained that it was difficult to check the trolley
mattresses as they were unable to open them up fully. Management staff told us that
housekeeping staff were carrying out visual checks. It is important that mattresses can be
checked for contamination both inside and out. The service should review the method for
checking mattresses to ensure that staff can confidently identify if a mattress is
contaminated. The service could consider purchasing mattresses which are easier to inspect
in the future (see recommendation d).

From reviewing infection control link nurse meeting minutes, we noticed a gap of nearly 9
months between meetings. Although the staff monthly newsletter had infection control
updates, we would expect link nurses to have more frequent contact and updates from the
lead nurse. This should also be documented (see recommendation e).

Clinical cleaning schedules were available and were being used in all areas. However, the
daily clinical cleaning schedules for theatre could be developed further to differentiate them
from the equipment checklist.

Although all staff completed online infection control training every year, the service should
consider developing face-to-face training to complement this.
No requirements.

**Recommendation c**
- We recommend that the service should implement infection control systems and monitoring activities that reflect best practice guidance in Scotland.

**Recommendation d**
- We recommend that the service should review the method for checking mattresses so staff can confidently identify if a mattress is contaminated.

**Recommendation e**
- We recommend that the service should have more frequent, minuted infection control link nurse meetings.

**Quality Theme 3 – Quality of staffing**

**Quality Statement 3.2**
We are confident that our staff have been recruited and inducted, in a safe and robust manner to protect service users and staff.

**Grade awarded for this statement: 5 - Very good**
The service had a recruitment and retention policy in place. All applicants submit an application form and are interviewed before a formal offer of employment is given.

We reviewed the staff files of six employees. All staff files contained:

- an application form
- interview notes
- occupational health checks
- two references, and
- professional registration information from the Nursing and Midwifery Council or the Health Professions Council.

All staff had an application checklist in their file and a Protecting Vulnerable Groups (PVG) Disclosure Scotland number.

All staff completed comprehensive induction, mentorship and annual mandatory training programmes specific to their staff role, which covered:

- health and safety
- fire awareness
- child and adult protection
- IT matters
- moving and handling
- infection control, and
- any role-specific mandatory training.
The matron explained the system and process for doctors’ applications for ‘practising privileges’ at the hospital. Practising privileges means the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital. We saw individual applicants were also interviewed by a member of the medical advisory committee. We reviewed five doctors’ personnel files, each included:

- an application for practising privileges
- annual appraisals, and
- checks on General Medical Council registration.

The matron reviewed and updated these files every 2 years.

The hospital continued to carry out retrospective PVG checks on current staff members.

**Areas for improvement**

Although significant improvement in standardising staff files had been made, some areas still needed to be standardised, including:

- copies of qualifications
- role descriptions, and
- offers of employment letters (see recommendation f).

Staff were completing their portfolios for NHS Education for Scotland’s Core Competencies for Anaesthetic Assistants. In its statement on assistant for the anaesthetist, the Association of Anaesthetist of Great Britain and Ireland says:

- ‘The Anaesthetic Assistant role should be undertaken by a registered practitioner who has achieved either those competencies specified in the curriculum of the College of Operating Department Practitioners or those specified in the NHS Education for Scotland Core Competencies for Anaesthetic Assistant document.’

Therefore, it is important that those undertaking the anaesthetic assistant’s role have completed the necessary competencies. We will follow this up at the next inspection.

- No requirements.

**Recommendation f**

- We recommend that the service should standardise staff files to ensure all recruitment checks have been carried out to an agreed standard. This should include proof of checks with professional bodies and references from the most recent employer.
Quality Statement 3.4
We ensure that everyone working in the service has an ethos of respect towards service users and each other.

Grade awarded for this statement: 5 - Very good
The service promoted Spire Healthcare Limited’s values and behaviours, which included:

- caring is our passion
- succeeding together
- driving excellence
- doing the right thing
- delivering on our promises, and
- keeping it simple.

These were incorporated into the ‘Enabling Excellence’ appraisal system which all staff completed every year.

The provider had an ‘Inspiring People’ award to recognise exceptional staff effort. This can recognise efforts from a small, local ward level to a much bigger, national level. During our inspection, we saw evidence of both.
Every year, employees at the hospital can take part in an annual staff engagement survey carried out by an independent research company. The aim of the survey is to show how staff members feel about their work and their manager.

All staff spoken with felt that they were treated with dignity and respect and were happy to raise issues at staff meetings or through their line manager.

We saw that all senior staff had been given a copy of the National Care Standards for Independent Hospitals. This helped to improve awareness of the national standards. Each head of department was also responsible for making sure their area complied with these standards. We saw evidence that staff were encouraged to read the standards and other relevant information, including the Duty of Candour and the ‘6 Cs’. The 6 Cs are a central element of ‘compassion in practice’, developed by the NHS England chief nursing officer and were launched in December 2012. The 6 Cs are:

- care
- compassion
- courage
- communication
- commitment, and
- competence.

All patients we spoke with felt they had been treated with dignity and respect, and rated the staff as ‘very good’ or ‘excellent’. Patients also gave very positive comments about hospital staff, including:

- ‘The staff are always polite and respectful.’
- ‘Very professional staff, always polite and courteous.’
- ‘The staff are lovely.’
Area for improvement
A staff survey was carried out in 2014 and showed some staff were unhappy with aspects of their work. Senior management were aware of this and were taking steps to address the issues highlighted.

- No requirements.
- No recommendations.

Quality Theme 4 – Quality of management and leadership

Quality Statement 4.2
We involve our workforce in determining the direction and future objectives of the service.

Grade awarded for this statement: 5 - Very good
The 2015 Spire Edinburgh hospital plan set out the objectives for the service. Various forums were used to involve staff in creating and commenting on this plan. Team leaders had regular off-site meetings with the chief executive to discuss and contribute to the plan. Regular staff updates were given with an open forum for questions and answers.

The structure of staff meetings meant that different staff groups could meet to discuss aspects of the plan. The senior management team’s weekly meeting considered the plan. Heads of department held a monthly meeting. We looked at minutes of these meetings and saw they were held regularly.

Senior nurses had a regular informal meeting which was used to discuss issues and support one another. This had been in place for over 18 months and was felt to be helpful for mutual support. Each staff member had objectives set which were in keeping with the overall hospital plan.

A staff survey was carried out in 2014 which showed some staff disagreed with the pay scale at the hospital. This led to a review of the pay-scale. Following the review, the service’s staff were paid in line with NHS staff, meaning some were given pay rises and improved terms and conditions. This example demonstrated that management had listened and responded to a staff concern.

Staff we spoke with felt they could contribute to the hospital plan and felt encouraged that management listened to their comments.

Areas for improvement
The staff engagement survey indicated that not all departments worked together comfortably. Senior management were aware of the need to foster team work and were taking steps to address this.

The frequency of staff meetings for some staff groups was found to be quite low. Staff told us this was often due to pressure of work preventing meetings from taking place.

Staff turnover remained high at this service with 28% of staff leaving in 2014. We note the total number of staff this percentage is taken from does not include some management staff who work at both Shawfair Park Hospital and Spire Murrayfield. However, senior staff agreed to look at this issue further and recognised that stabilising the workforce contributed toward quality of staffing.
No requirements.
No recommendations.

**Quality Statement 4.4**

*We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.*

**Grade awarded for this statement: 5 - Very good**

Before the inspection, the service submitted a comprehensive self-assessment to Healthcare Improvement Scotland. The service completed this self-assessment each year. It gives a measure of how the service has assessed itself against the quality themes and national care standards. We found very good quality information in Shawfair Park Hospital's self-assessment that we were verifying during our inspection.

We found that the service had comprehensive quality assurance systems in place. The quality assurance structure was made up of the following groups:

- accountable officers local information network (controlled drugs)
- the blood transfusion committee
- the clinical effectiveness committee
- the clinical governance committee
- the health and safety committee
- the infection control committee
- the management review team (serialisation and decontamination), and
- the medical advisory group.

The medical advisory group had overall accountability for clinical governance at the service. It was made up of representatives, including doctors and consultants, who work at Shawfair Park Hospital.

The clinical governance committee had responsibility for governance as required. The chair of the medical advisory group was also a member of the clinical governance committee.

We looked at a selection of minutes from the meetings which make up the governance structure. In particular, we reviewed the clinical effectiveness committee minutes and saw that the group discussed:

- cardiology
- the clinical scorecard
- complaints
- infection prevention and control
- inspections and reviews of the service
- paediatrics, and
- policy updating.
The minutes reviewed clearly identified any necessary actions, who was responsible and when the actions should be completed by. We saw that actions from previous meetings had also been discussed.

The service had a clinical scorecard developed by the corporate clinical governance group. The scorecard was used to monitor a number of key indicators to ensure the service delivered good care. It also highlighted areas for improvement. The scorecard covered indicators, such as:

- complaints
- infection control and surgical site infection surveillance
- the number of hospital-acquired pressure ulcers
- pain management
- patient falls, and
- risk and number of venous thromboembolism (blood clot-related) incidents.

The service had a complaints log which detailed all the complaints received from patients. The complaints log showed:

- the details of the complaint
- the outcome of the complaint, and
- whether it was resolved satisfactorily.

Complaints about the service were a standing item on the agenda of the heads of department group. The group was looking for any trends in complaints which could be actioned. The service also logged who any complaints were about. Any issues with the practice of a particular member of staff were discussed at the clinical governance committee and medical advisory group.

External accreditation for the endoscopy service was in progress. The physiotherapy service had also been accredited by the Injury Prevention and Rehabilitation Services.

**Areas for improvement**

The agenda for the clinical governance committee meeting had just been reviewed and some further adjustment was needed to ensure that all subgroup minutes were overseen at this meeting.

Incidence of blood clots occurring following surgery was being monitored. Management staff were continuing to try to make sure that orthopaedic consultants follow Scottish Intercollegiate Guidelines Network (SIGN) guidelines. Consultants who do not follow the SIGN guidelines could make this clearer to their patients. Audit of this practice could be checked to ensure evidence-based practice is followed as far as possible.

- No requirements.
- No recommendations.
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the Act, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Quality Statement 0.3

<table>
<thead>
<tr>
<th>Requirements</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>We recommend that the service should:</strong></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>ensure consent forms and patient care records, if relevant, sufficiently detail the discussion of benefits and risks associated with the procedure being carried out (see page 10).</td>
</tr>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 11.4 – Deciding on your treatment)</td>
</tr>
<tr>
<td></td>
<td>This was previously identified as a recommendation in the July 2014 inspection report for Shawfair Park Hospital.</td>
</tr>
<tr>
<td>b.</td>
<td>ensure all relevant policies and procedures are supported by Scottish legislation, with particular reference to the adult support and protection policy and the consent policy (see page 10).</td>
</tr>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 11.7 – Deciding on your treatment, Standards 12.1 and 12.4 – Clinical effectiveness)</td>
</tr>
<tr>
<td></td>
<td>This was previously identified as a recommendation in the July 2014 inspection report for Shawfair Park Hospital.</td>
</tr>
</tbody>
</table>
### Quality Statement 2.4

**Requirements**

None

**Recommendations**

**We recommend that the service should:**

<table>
<thead>
<tr>
<th>c</th>
<th>implement infection control systems and monitoring activities that reflect best practice guidance in Scotland (see page 16).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 13.2 – Prevention of infection)</td>
</tr>
<tr>
<td></td>
<td>This was previously identified as a recommendation in the July 2014 inspection report for Shawfair Park Hospital.</td>
</tr>
<tr>
<td>d</td>
<td>review the method for checking mattresses so staff can confidently identify if a mattress is contaminated (see page 16).</td>
</tr>
<tr>
<td>e</td>
<td>have more frequent, minuted infection control link nurse meetings (see page 16).</td>
</tr>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 13.2 – Prevention of infection).</td>
</tr>
</tbody>
</table>

### Quality Statement 3.2

**Requirements**

None

**Recommendation**

**We recommend that the service should:**

<table>
<thead>
<tr>
<th>f</th>
<th>standardise staff files to ensure all recruitment checks have been carried out to an agreed standard. This should include proof of checks with professional bodies and references from the most recent employer (see page 18).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 10.2 – Staff)</td>
</tr>
<tr>
<td></td>
<td>This was previously identified as a recommendation in the July 2014 inspection report for Shawfair Park Hospital.</td>
</tr>
</tbody>
</table>
## Appendix 2 – Grading history

<table>
<thead>
<tr>
<th>Inspection date</th>
<th>Quality of information</th>
<th>Quality of care and support</th>
<th>Quality of environment</th>
<th>Quality of staffing</th>
<th>Quality of management and leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/07/2013</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
</tr>
<tr>
<td>01-02/07/2014</td>
<td>5 - Very good</td>
<td>4 - Good</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
</tr>
</tbody>
</table>
Appendix 3 – Who we are and what we do

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland. We are also responsible for the registration and regulation of independent healthcare services.

Our inspectors check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. They do this by carrying out assessments and inspections. These inspections may be announced or unannounced. We use an open and transparent method for inspecting, using standardised processes and documentation. Please see Appendix 5 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (we call this ‘the Act’ in the rest of the report),
- the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011, and
- the National Care Standards, which set out standards of care that people should be able to expect to receive from a care service. The Scottish Government publishes copies of the National Care Standards online at:www.scotland.gov.uk

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act and the associated regulations. We also take into account the National Care Standards that apply to the service. If we find a service is not meeting the requirements of the Act, we have powers to require the service to improve.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure things that are important to patients
- are firm, but fair
- have members of the public on our inspection teams
- ensure our staff are trained properly
- tell people what we are doing and explain why we are doing it
- treat everyone fairly and equally, respecting their rights
- take action when there are serious risks to people using the hospitals and services we inspect
- if necessary, inspect hospitals and services again after we have reported the findings
- check to make sure our work is making hospitals and services cleaner and safer
- publish reports on our inspection findings which are always available to the public online (and in a range of formats on request), and
- listen to your concerns and use them to inform our inspections.
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, we suggest you contact the service directly in the first instance. If you remain unhappy following their response, please contact us. However, you can complain directly to us about an independent healthcare service without first contacting the service.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: comments.his@nhs.net
Appendix 4 – How our inspection process works

Inspection is part of the regulatory process.

Each independent healthcare service completes an online self-assessment and provides supporting evidence. The self-assessment focuses on five quality themes:

- **Quality Theme 0 – Quality of information**: this is how the service looks after information and manages record-keeping safely. It also includes information given to people to allow them to decide whether to use the service and if it meets their needs.
- **Quality Theme 1 – Quality of care and support**: how the service meets the needs of each individual in its care.
- **Quality Theme 2 – Quality of environment**: the environment within the service.
- **Quality Theme 3 – Quality of staffing**: the quality of the care staff, including their qualifications and training.
- **Quality Theme 4 – Quality of management and leadership**: how the service is managed and how it develops to meet the needs of the people it cares for.

We assess performance by considering the self-assessment, complaints, notifications of events and any enforcement activity. We inspect the service to validate this information and discuss related issues.

The complete inspection process is described in Appendix 5.

Types of inspections

Inspections may be announced or unannounced and will involve physical inspection of the clinical areas, and interviews with staff and patients. We will publish a written report 8 weeks after the inspection.

- **Announced inspection**: the service provider will be given at least 4 weeks’ notice of the inspection by letter or email.
- **Unannounced inspection**: the service provider will not be given any advance warning of the inspection.

Grading

We grade each service under quality themes and quality statements. We may not assess all quality themes and quality statements.

We grade each heading as follows:

- excellent
- very good
- good
- adequate
- weak
- unsatisfactory

We do not give one overall grade for an inspection.

The quality theme grade is calculated by adding together the grades of each quality statement under the quality theme. Once added together, this number is then divided by the number of statements.
For example:

**Quality Theme 1 – Quality of care and support: 4 - Good**

Quality Statement 1.1 – 3 - Adequate  
Quality Statement 1.2 – 5 - Very good  
Quality Statement 1.5 – 5 - Very good

Add the grades of each quality statement together, making 13. This is then divided by the number of quality statements (there are 3 quality statements), making 4.3. This is rounded down to 4, giving the overall quality theme a grade of 4 - Good.

However, if any quality statement is graded as 1 or 2, then the entire quality theme is graded as 1 or 2 regardless of the grades for the other statements.

**Follow-up activity**

The inspection team will follow up on the progress made by the independent healthcare provider in relation to the implementation of the improvement action plan. Healthcare Improvement Scotland will request an updated action plan 16 weeks after the initial inspection. The inspection team will review the action plan when it is returned and decide if follow up activity is required. The nature of the follow-up activity will be determined by the nature of the risk presented and may involve one or more of the following elements:

- a planned announced or unannounced inspection
- a planned targeted announced or unannounced follow-up inspection looking at specific areas of concern
- a meeting (either face to face or via telephone/video conference)
- a written submission by the service provider on progress with supporting documented evidence, or
- another intervention deemed appropriate by the inspection team based on the findings of the initial inspection.

A report or letter may be produced depending on the style and findings of the follow-up activity.

More information about Healthcare Improvement Scotland, our inspections and methodology can be found at:  
Appendix 5 – Inspection process

We follow a number of stages in our inspection process.

**Before inspection**

The independent healthcare service undertakes a self-assessment exercise and submits the outcome to us.

We review the self-assessment submission to help inform and prepare for on-site inspections.

**During inspection**

We arrive at the service and undertake physical inspection.

We have discussions with senior staff and/or operational staff, people who use the service and their carers.

We give feedback to the service’s senior staff.

We undertake further inspection of services if significant concern is identified.

**After inspection**

We publish reports for patients and the public based on what we find during inspections. Healthcare staff can use our reports to find out what other services do well and use this information to help make improvements. Our reports are available on our website at [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

We require services to develop and then update an improvement action plan to address the requirements and recommendations we make. We check progress against the improvement action plan.
## Appendix 6 – Terms we use in this report

### Terms and explanation

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>provider</td>
<td>A provider is an individual, partnership or business that delivers and manages a regulated healthcare service.</td>
</tr>
<tr>
<td>service</td>
<td>A service is the place where healthcare is delivered by a provider. Regulated healthcare services must be registered with Healthcare Improvement Scotland.</td>
</tr>
</tbody>
</table>
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.