

Spire Healthcare Limited

# Spire Gatwick Park 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	
Services for children and young people	Requires improvement	
Outpatients and diagnostic imaging	Good	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Gatwick Park Hospital is run by Spire Healthcare Limited which is a part of Spire Healthcare Group Plc. An acute hospital with 55 beds, Spire Gatwick Park Hospital provides private hospital services to self-funding and insured patients and NHS patients referred under the Standard NHS Acute Contract, predominantly from the Surrey and Sussex area.

The organisation offers a range of services and facilities including: two bed HDU (Level 1 enhanced care); a dedicated endoscopy unit; a dedicated day care unit; an in-house ISO accredited sterile services department; a 64-slice CT and 3T MRI scanner; and onsite pharmacy and pathology. The hospital has three operating theatres that are in use six days a week; with usual daily allocations of two to three sessions between 08:00 and 21:00. The Care Quality Commission (CQC) carried out a comprehensive inspection on 09 and 10 June 2015 and undertook an unannounced inspection on 15 June 2015.

We inspected this hospital as part of our independent hospital inspection programme, using the Care Quality Commission's new inspection methodology. Spire Gatwick Park Hospital provides adult elective surgery, outpatients and diagnostic imaging, services to children and young people and endoscopy. For the purpose of the comprehensive inspection, we undertook an on-site review of surgery, children and young person's services and outpatient services and have included our findings of the small volume of medical care, and end of life care from within these core services. The hospital does not provide maternity or termination of pregnancy services.

Overall, we judged the hospital to require improvement. This is because we identified concerns in relation to safety, and issues affecting the effectiveness of care.

Our key findings were as follows: Overall Service Leadership

- Staff told us they were supported by visible, accessible and approachable managers.
- There were systems of governance to ensure any issues affecting safety and quality of care were identified and managed.
- The hospital did not maintain complete and comprehensive records as required by the relevant regulations due to consultants taking their own outpatient clinic notes away with them.

Cleanliness and infection control

- The hospital was meeting government guidance in relation to infection control, and care was delivered in a clean environment.
- Floor coverings in some areas did not meet government guidance and presented a potential risk of infection.

Staffing Levels

- There were adequate numbers of appropriately skilled and experienced staff to meet patients' needs.
- Children and young people were cared for by registered sick children's nurses and consultants treating children had their competency verified.

Outcomes for patients

- Hospital policies, care and treatment were in line with guidance from the National Institute for Health and Care Excellence (NICE), the Department of Health and learned societies.
- There was insufficient data collected to allow adequate monitoring of the treatment outcomes of children and young people and for patients having cosmetic surgery.

# Summary of findings

## Nutrition and hydration

- Patients had access to appropriate food and drink in sufficient quantities.
- However, patients were starved for longer than recommended before surgery.

## Actions we have told the provider they must take:

- Review its arrangements for the retention of outpatient records at the hospital.

## Actions we have told the provider they should take:

- Ensure all staff have access to the electronic incident reporting system and know how to use it.
- Sustain new systems introduced after our initial visit that ensure medicines are stored at temperatures that maintain them in optimum condition.
- Ensure all staff are up to date with mandatory training, including Basic Life Support.
- Carry out an appropriate risk assessment for the cleaning of carpets, and ensure that replacement plans comply with Department of Health HTM Health Building Note 00-09: 'Infection control in the built environment'.
- Review the arrangements for maintaining records in an easily usable condition.
- Review its arrangements for pre-operative starving of patients.
- Review the arrangements for the provision of 'as needed' pain relief for patients.
- Ensure that all elements of the World Health Organisation Surgical Safety Checklist are consistently completed and that compliance is audited.
- Consider how it can differentiate between the feedback from children and young people from that of other patients.
- Consider how it measures and monitors the outcomes of treatment for children and young people.
- Identify what mandatory skills staff require in order to effectively care for children and young people.
- Review its policies, procedures and literature to ensure that the definition of children is consistent.
- Ensure consultants holding electronic patient records are registered with the Information Commissioner's Office.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# 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?

The safety of services required improvement. Not all staff were able to report safety incidents easily and medicines were not always stored at appropriate temperatures although the provider took action to rectify this. We saw a number of floor surfaces that were inappropriate for a clinical environment. The World Health Organisation's Surgical Checklist was not consistently adhered to. Outpatient records were not retained by the hospital, which meant that there were no comprehensive patient records that were accessible by all staff. We found some weaknesses in the way that patients were assessed before surgery. However, we found care was delivered by adequate numbers of appropriately trained staff in clean, hygienic surroundings. We saw evidence of learning and implementing changes to practice following the analysis of safety incidents.

Requires improvement



### Are services effective?

The effectiveness of services required improvement. Patients were being starved and restricted from fluids for periods which were longer than required, which could impact their wellbeing and the outcome of surgery. The management of 'as needed' pain relief for day case patients required review. There was a lack of systems in place to obtain data and monitor their outcomes of care for children and young people. However, we saw evidence that NICE guidelines and other national guidance were used in practice.

Requires improvement



### Are services caring?

The service provided was caring. Patients received compassionate care in an environment that afforded them sufficient privacy and dignity, and were supported throughout their care and treatment. Patients advised us that they received compassionate care from friendly and approachable staff, this corresponded with our observations.

Good



### Are services responsive?

Services were responsive to patients' needs and they experienced treatment which was delivered in a timely way and took into account their individual requirements. Outpatient clinics were provided in daytime, evenings and at weekends so patients were able to access appointments at their convenience. There were clear systems in place for receiving, investigating and learning from complaints.

Good



# Summary of findings

## Are services well-led?

Services were well-led. Overall, there were robust governance arrangements. Staff described receiving strong leadership, with senior management being visible and accessible to staff. There was evidence of an open culture, and staff were very positive about their work and were aware of the provider's strategy and values. There were systems in place for gathering patient feedback, however these were adult orientated and did not differentiate between adult and children's services.

Good



# Summary of findings

## Our judgements about each of the main services

### Service

### Rating

### Why have we given this rating?

#### Surgery

Requires improvement



Surgical services require improvement because floor coverings were not appropriate for a hospital environment. Not all staff knew how to report safety incidents. The amount of time that patients were starved before surgery was often too long. We found some weaknesses in the way some patients were assessed before surgery. There is scope for improving systems for monitoring patient outcomes following cosmetic surgery. However, we found that patients were treated in a compassionate and timely way by adequate numbers of appropriately trained staff to meet their needs. The hospital environment was clean and equipment was well maintained.

#### Services for children and young people

Requires improvement



Services for children and young people requires improvement because local policies, procedures and guidelines were inconsistent in their definition of a child. There was limited data collected to measure the outcomes of care for children and young people and feedback systems were adult orientated. There was no designated, child-friendly area for treating children. Not all staff caring for children had specific training to do so. However, children were cared for by registered sick children's nurses who had access to appropriate equipment. Consultants treating children had their competency verified. The majority of staff had received training in safeguarding children.

#### Outpatients and diagnostic imaging

Good



Outpatient and diagnostic services were good overall. We saw patients receive compassionate care in accordance with national guidance from a range of clinical staff and therapists. Waiting times were minimal and clinics ran at weekends and evenings to allow patients to be seen at convenient times. Diagnostic equipment, including that using ionising radiation, was properly calibrated, used and maintained. However there were inadequate arrangements to ensure that consultant outpatient notes were retained to ensure a comprehensive patient record available to all staff who needed to

# Summary of findings

access it. Some clinic rooms were over crowded and there was inappropriate floor coverings for this environment which presented potential infection risks.

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Requires improvement 

# Spire Gatwick Park Hospital

## Detailed findings

### Services we looked at

Surgery; Services for Children and Young People; Outpatients and Diagnostic Imaging;



# Detailed findings

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## Background to Spire Gatwick Park Hospital

Spire Gatwick Park Hospital is run by Spire Healthcare Limited, which is part of Spire Healthcare Group Plc.

Spire Gatwick Park Hospital opened in March 1984 and was initially a joint venture involving a group of local GPs and Caledonian Airways. The hospital was operated by BUPA until 2007 when Spire Healthcare took over. Spire Gatwick Park Hospital is located in Horley, Surrey and is registered as an acute hospital with 55 beds, and is the largest independent hospital in the area. Spire Gatwick Park Hospital provides private hospital services to patients predominantly from the Surrey and Sussex area.

The organisation offers a range of services and facilities, including: two bed HDU (Level 1 enhanced care); a dedicated endoscopy unit; a dedicated day care unit; an in-house ISO accredited sterile services department; a 64-slice CT and 3T MRI scanner; and onsite pharmacy and pathology. The hospital has three operating theatres that are in use six days a week, dependent upon demand, with usual daily allocations of two to three sessions between 08:00 and 21:00.

In the 12 month period from January to December 2014, there were 6,368 visits to the operating theatre, with the most commonly performed procedures being: colonoscopy, diagnostic oesophago-gastro-duodenoscopy, multiple arthroscopic operations of the knee, phacoemulsification of lens with implant, and diagnostic endoscopic examination of the bladder.

We carried out an announced inspection of Spire Gatwick Hospital using our new methodology between 9th and 10th June 2015. We also carried out an unannounced inspection of the hospital on 15th June 2015. The inspection team inspected the following core services:

- Surgery
- Outpatients and Diagnostic Imaging
- Services for Children and Young People

## Our inspection team

Our inspection team was led by:

**Inspection Manager:** Elaine Biddle, Care Quality Commission

# Detailed findings

The team included four CQC inspectors and a variety of specialists including: an orthopaedic trauma surgeon, a consultant physician, an imaging specialist, a surgical nurse, a paediatric nurse, a cosmetic surgery nurse and an expert by experience.

## How we carried out this inspection

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

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

Prior to the announced inspection, we reviewed a range of information and asked other organisations to share what they knew about the hospital. These included the

Clinical Commissioning Groups (CCG), NHS England, Local Area Team (LAT), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We carried out the announced inspection visit between 9th and 10th June 2015. An unannounced visit was carried out on the 15th June 2015.

We held focus groups with a range of staff including: nurses, doctors, therapists, administrative and clerical staff. We also spoke with staff and patients individually. We observed how people were being cared for, talked with carers and/or family members, and reviewed patient records.

## Facts and data about Spire Gatwick Park Hospital

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

- Diagnostic and screening procedures.
- Surgical procedures.
- Treatment of disease, disorder or injury.
- Family planning.
- Services in slimming clinics.

Referrals are received from self-funding patients, patients with medical insurance, and NHS patients commissioned by the Clinical Commissioning Group (CCG).

Spire Gatwick Park Hospital provides adult elective surgery, outpatients and diagnostic imaging, services to children and young people and endoscopy.

For the purpose of a comprehensive inspection we undertook an on-site review of surgery, children and young person's services and outpatient services and have

included our findings of the small volume of medical care, and end of life care within these core services. The hospital does not provide maternity or termination of pregnancy services.

The hospital is BUPA approved and has a bowel cancer centre, breast cancer centre and MRI unit.

The BUPA Health Screening service has an ISO accreditation and its pathology department is accredited by Clinical Pathology Accreditation (CPA). The hospital's sterile services department is accredited by Société Générale de Surveillance (SGS) under ISO 13485.

The hospital outsources some of its pathology services. Pathology tests that are not processed in house or within Spire Network, are processed through a pathology partnership service at a local hospital. A local NHS trust is used for contingency purposes, certain specialist tests, as well as a number of referral laboratories. All are monitored for CPA/ISO14189 compliance and External Quality Assessment (EQA).

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Surgery</b>	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
<b>Services for children and young people</b>	Requires improvement	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
<b>Outpatients and diagnostic imaging</b>	Requires improvement	Not rated	Good	Good	Good	Good
<b>Overall</b>	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

# Are services safe?

## Our findings

The safety of services requires improvement. This was because we found that consultants' took their outpatient records away from the site. This meant that a comprehensive and current record of the patient's care was not retained by the hospital as required by the regulations. We also found that patient records were not always well maintained so they could be readily used. In the case of electronic patient records, there were no systems to check that consultants were registered with the Information Commissioner's Office, which would provide some assurance around the security of electronic information.

We also found that floor coverings in the hospital did not meet national guidance and presented a potential for the transmission of infection.

Medicines were not always stored at temperatures recommended by the manufacturer ensuring optimum

condition although the provider took immediate action to rectify this. Not all staff could access, or were trained to use the electronic incident reporting system. This meant that a safety incident may go unreported and therefore opportunities for learning would be missed.

The World Health Organisation's Surgical Check List was not fully implemented which meant the safeguards it supported could not be fully realised. We identified some concerns in relation to the pre-operative assessment of patients, which could mean some patient risks would not be identified and adequate mitigation put in place.

However, we found that patients were cared for in clean surroundings by adequate numbers of appropriately trained staff. Equipment used was properly maintained to ensure its safety. We observed that safety incidents were investigated and learning points identified. Changes to practice were made as a result of the analyses of safety incidents to prevent future occurrences.

# Are services effective?

## Our findings

We found that the effectiveness of services requires improvement. This was because patients were starved for longer than recommended before surgery, which could negatively affect their well-being and recovery. The management of 'as needed' pain relief for day case patients needed improving to ensure that patients could access adequate pain relief when required.

There was insufficient data collected to allow adequate monitoring of the treatment outcomes of children and young people and for patients having cosmetic surgery. This impeded the ability to identify any areas of concern requiring investigation and possible action.

However, we saw that hospital policies, care and treatment was in line with guidance from the National Institute for Health and Care Excellence (NICE), the Department of Health and learned societies. There were systems in place to review new guidance, which ensured patients received care that reflected best practice. Patients had access to a range of therapists and specialist nurses who worked collaboratively with other staff as a multi-disciplinary team to ensure patients received the care they required.

There were systems to support staff through induction and appraisal, which ensured they had the competencies to do their job and that they remained professionally registered when applicable. Nursing staff and consultants who looked after children were appropriately qualified, but not all staff had received any specialist training in the management of children and young people.

## Are services caring?

### Our findings

Patients told us, and we observed services being delivered in a caring and compassionate way that upheld patients' dignity and privacy. Staff were noted to be friendly and approachable and patients said they appreciated this.

Formal feedback from patients indicated they considered the care provided to be excellent, although the feedback systems were adult orientated and did not allow for the views of children and young people to be considered independently.

Patients were given adequate information about their care and treatment in a format that was appropriate to their needs. Patients told us staff took time to listen and to respond to their concerns.

## Are services responsive?

### Our findings

Services at the hospital were responsive to patient needs, and those of people close to them. Treatment was delivered in a timely way with minimal waiting times. Outpatient clinics were held at the weekend and in the evening so patients could book appointments at their convenience. Care was patient-centred and planned to

meet individual needs. There were adequate parking facilities, and friends and relatives could obtain refreshments. Patients knew how to raise concerns, and the hospital had clear policies for receiving, investigating and learning from complaints.

Although there were measures to ensure that the care environment was child friendly when needed, there were no designated areas for treating children.

## Are services well-led?

### Our findings

Overall, services at the hospital were well-led. There were robust governance arrangements that ensured any issues affecting safety and quality of patient care were known, disseminated, managed and monitored.







Staff were overwhelmingly positive about their experience of working at the hospital and showed commitment to achieving the provider's strategic aims and demonstrating

their stated values. Staff told us they were supported by managers who were visible and approachable. They described an open culture with an emphasis on delivering the best care possible and where innovation was encouraged.

However, there was some confusion in the definition of a child, as this was not consistent across the hospital's policies, procedures and guidance. This could mean that these policies are incorrectly applied.



# Surgery

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Spire Gatwick Park Hospital is registered as an acute hospital with 55 beds. The hospital has three operating theatres (two with laminar flow) that were in use six days a week, dependent upon demand, with usual daily allocations of two to three sessions between 08:00 and 21:00. There was also a dedicated endoscopy unit.

On the ground floor there were two ward areas with 29 single rooms, and a two bed HDU (Level 1 enhanced care). On the first floor there was also a 16 bedded day care unit with an additional eight single rooms. The HDU accepted level one patients only with patients requiring level two or three care being transferred to NHS hospitals.

In the 12-month period from January to December 2014, there were 6,368 visits to the operating theatre, with the most commonly performed procedures being: colonoscopy, diagnostic oesophago-gastro-duodenoscopy, multiple arthroscopic operations of the knee, phacoemulsification of lens with implant and diagnostic endoscopic examination of the bladder.

Between January 2014 and December 2014, the hospital had treated 1,300 NHS patients. 778 of these had been day case procedures with 522 as inpatient procedures. During our inspection we visited all of these areas. We spoke with 44 members of staff, 14 patients and collected the views of four patients through comment cards.

We looked at 18 patient health records, which included four theatre records and four archived records. We looked at various documents held by the hospital and reviewed the way that the hospital managed and monitored its surgical service.

# Surgery

## Summary of findings

The hospital had a corporate governance structure and framework, which was being used to monitor the safety, quality and outcomes of the care being given at the hospital.

NICE guidelines and other national guidance were used in clinical practice. These documents were reviewed centrally by the National Clinical Governance Committee. Updates were made to corporate policies and guidance documents and there was communication regarding changes required at a hospital level.

People experienced treatment and surgery that was delivered in a timely way and took into account their requirements. NHS patients were being treated consistently within the 18 week targets for referral to treatment times.

Patients and their families advised us that staff were kind, considerate and respectful. We observed interactions between the staff, consultants and patients and saw that staff were attentive and caring in their attitude, provided assurance and support where needed and anticipated when additional care was required.

Patient views were gathered using a continuous programme of Spire patient surveys and the NHS Friends and Family Test (FFT). Service improvements were made in response to these surveys. The April 2015 Friends and Family Test results showed that 97% of patients rated the care and attention from nursing staff at the hospital as either 'excellent' or 'very good'. With 97% of respondents saying they were either 'extremely likely' or 'likely' to recommend the hospital to their friends and family.

There were improvements required with some aspects of patient care and safety. This included incident reporting and infection control regarding the management of carpets in clinical areas. Improvement was required regarding the safe and secure storage of medicines, and some improvement was required in documenting patient health records.

The hospital also needed to make improvements in the delivery and monitoring of briefing and debriefing sessions in theatre. There was scope for improvement in health screening and patient choice around cosmetic surgery procedures.

Staff were extremely complimentary about their managers and were all positive about the recent changes in management at the hospital.

Staff told us that they enjoyed working at the service and described an open culture where managers were accessible and open to ideas from staff along with any concerns they had. Staff told us that they felt valued by the organisation.

# Surgery

## Are surgery services safe?

Requires improvement 

All staff had access to the electronic incident reporting system, although some had not received training to use the system. However, there was evidence that staff were learning from incidents and that this learning was being disseminated to staff through unit meetings.

Clinical areas were carpeted which posed an infection control risk. The carpet cleaning and maintenance was not suitably robust, however the maintenance of carpets had been risk assessed and was on the hospital's risk assessment register although the support services manager was unaware of this.

Medicine management was not robust. Room temperatures where medicines were stored were recorded daily but often exceeded the recommended storage limit of 25 degrees centigrade. This meant the hospital was unable to demonstrate that medicines had been stored at the correct temperature to maintain their efficacy.

Staff received the majority of their training through electronic learning. Staff felt that the training was of good quality. 90% of nursing staff had completed ALS, ILS or BLS training.

The filing of patient health records required improvement. We found that notes within health records were poorly filed with many loose bits of paper that were not ordered or easy to locate. We found that the Resident Medical Officer (RMO) was writing on continuation sheets, as there was very little room on pathway documentation for free text, or any variation from the pathway. Operation notes were on loose sheets of paper that had not been filed/secured in fourteen of the eighteen health records we looked at.

The hospital gathered information on falls, and incidents of venous thromboembolism (VTE) and pressure ulcers for all patients treated in the hospital and set targets to improve patient safety. Briefing and debriefing sessions were part of the theatre processes but were not routinely audited.

The hospital had equipment readily available, which was well maintained. Electrical equipment was maintained and checked for safety. Staff were able to access speciality equipment such as bariatric equipment when it was required.

Nursing staff told us that their main concern was the use of agency staff on shifts. The hospital had been in the process of recruiting permanent posts and were looking at ways to improve in this area. Theatres were staffed in accordance with The Association for Perioperative Practice (AFPP) guidance.

Resident Medical Officers (RMO) were present in the hospital seven days a week and were able to be called overnight. They were able to contact consultants at any time where advice was required.

Senior nursing and medical staff we spoke with were aware of their responsibilities under the Duty of Candour. Comprehensive information booklets were available for staff to reference.

### Incidents

- The hospital had policies and procedures in place for dealing with adverse incidents, and policies were readily available for staff to access on the hospital's intranet.
- An electronic reporting system had been in use in the hospital for 2 years. The system had a facility for staff to report ('reporter') which was escalated to the Head of Department ('reviewer') and the hospital Matron had final oversight ('appraiser').
- We found that some staff had not received training in using the electronic reporting system, which meant they had to ask another staff member to complete an incident form on their behalf. For example, when we asked a member of the administration staff about the electronic reporting system, they told us, "It's really a nurse's job, but if something happened and I wanted to report it, I'd tell my manager and she would do it." The hospital's Clinical Governance and Quality lead told us there were several groups of staff who had not received training, but it was planned for the near future, corroborated this. A paper system for reporting adverse incidents ran alongside the electronic system for medical staff that preferred the paper system. Despite the fact that some staff had not received training in using the system, we found no evidence that incidents went unreported.

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- The hospital aimed to report all adverse incidents within four days of occurrence. Between January and December 2014, Gatwick Park reported 83% of adverse incidents within four days of the incident, which did not meet the provider's own target of 85%. Data for 2015 up to the date of inspection shows 92.4% compliance, better than internal target.
- The Clinical Governance Committee (CGC) who reported to the Medical Advisory Committee (MAC) reviewed adverse incidents. The top three incidents recorded in the hospital between January and December 2014 related to: medicines, pathology samples and equipment. Learning from incidents was shared verbally with staff during unit/team meetings.
- We saw evidence that the provider reported incidents appropriately to the Strategic Executive Information System (STEIS) for patients receiving NHS funded care and the Care Quality Commission (CQC) for privately funded patients.
- In the last year between the period of 1st June 2014 until 31st May 2015, the surgical division of the hospital reported 341 incidents. The highest reported incidents were categorised as: medication/drug incidents (79), pathology and pathology samples (39), clinical equipment malfunction (27), clinical documents (17), patient slip, trip or fall (16), surgical site infection (14), blood transfusion (13), post-operative complication (12), clinical breach of care (11), procedure complication not surgical (10), unplanned return to theatre (8), treatment or care delay (8), and unexpected transfers to NHS hospitals (8).
- Four incidents during this period had been recorded as Serious Incidents Requiring Investigation (SIRI). These were related to: one death within 48 hours of anaesthetic, one patient who developed a Pulmonary Embolism (PE), one patient who required an unexpected return to theatre, and one cardiac arrest and subsequent death of a patient in a local NHS hospital. The hospital had completed investigations into these incidents and was able to provide evidence of the learning from the investigations that had resulted in changes of practice.
- The hospital recorded 234 clinical incident reports between January and December 2014. Four of these clinical incidents were Serious Incidents Requiring Investigation (SIRI).
- The hospital had not reported any 'Never Events' between January 2014 and March 2015. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented).
- The hospital did not have regular mortality and morbidity meetings because deaths were an infrequent occurrence. Deaths were reviewed by the CGC. There was one unexpected death in 2013/14. In February 2015 a patient deteriorated in the day care unit post-operatively and died one month later. These deaths were reviewed appropriately.
- Senior nursing and medical staff we spoke with were aware of their responsibilities under Duty of Candour. Comprehensive information booklets were available for staff to reference. The hospital had made one duty of candour disclosure around surgery in the past 12 months and was able to provide evidence of this.
- We spoke with two health care assistants, one operating department practitioner (ODP), a theatre recovery nurse, and an anaesthetist about the reporting systems in use. They were all aware of the process for reporting incidents. They told us that they received feedback and learning from incidents through staff meetings. Staff were able to describe changes in practice following learning from incidents, although the anaesthetist was unable to recall any learning that had been fed back to them concerning incidents.
- An example was that because of incident analysis patient temperatures were now recorded during their operations. At the time of our inspection, catheter insertion and care was being reviewed in theatres as a result of learning from incident trends.

## Safety thermometer

- The hospital gathered information on falls, venous thromboembolism (VTE) and pressure ulcer incidents for all patients treated in the hospital, and set targets to improve patient safety. At the time of our inspection, this information was recorded and reported to the hospital's Clinical Audit and Effectiveness Committee.
- Between January and December 2014, venous thromboembolism (VTE) risk assessment compliance was 96% in line with the provider's target of 95%.
- During this period, there was 100% compliance with prescribing venous thromboembolism (VTE) chemoprophylaxis for eligible hip and knee arthroplasty surgery, better than the provider's target of 95%.

# Surgery

- However, chemical VTE prophylaxis was given within the recommended timescale in only 58% of eligible hip and knee arthroplasty patients, which was significantly worse than the provider's target of 80%. These performance targets were discussed with the consultants concerned in order to address this issue. Latest data (Q2 2015) shows an improvement of 100% compliance with this measure, against the internal target of 80%.
- During this period 98% VTE prophylaxis courses (where prescribed) were given for the recommended course duration, better than the provider's target of 95%. There was 0.21% incidence of VTE in hip and knee arthroplasty patients, better than the provider's target of 0.4%. There were also zero incidences of VTE in non-hip/knee procedures against the provider's target of 0.02%.
- The Q1 2015 data showed that the hospital had achieved 60% in the venous thromboembolism (VTE) chemo-prophylaxis audit. This was worse than the Spire target of 80%. However, the last quarter audit results Q2 2015 showed that the hospital had achieved 100% in the venous thromboembolism (VTE) chemo-prophylaxis audit. This was better than the Spire internal target of 80%.
- VTE screening rates were at least 95% in every quarter of the reporting period (Jan to Dec 14). This meets the NHS Standard Contract quality requirement (95%). Data to show the rates of private and NHS patients separately were not available. For the period July to September 2014, the proportion of patients risk assessed for VTE is similar to what is expected when compared to other independent acute hospitals that CQC holds this type of data for.
- Between January and December 2014, the service recorded 1.33 inpatient falls per 1000 bed days, which was better than their target of 1.9.
- Pressure ulcer incidents for the same period showed that there were 0.22 grade 2 and above pressure ulcer incidents per 1000 bed days, which was worse than the provider's target of 0.07. The latest available data (Q1 2015) showed an improvement with no pressure ulcer incidents.
- There was a 'Quality Board' in the corridor outside the wards on the ground floor with information about infection control (HAI rates) and outcomes of the patient satisfaction survey. Other patient safety information was not displayed.
- We reviewed three sets of patient health records in theatre and found that venous thromboembolism (VTE) assessments had been completed for all three.

## Cleanliness, infection control and hygiene

- Domestic cleaning was undertaken by the hospitals support services team. Support services staff cleaned ward areas using checklists to ensure that each area was cleaned to the standard expected. Audits of the cleanliness of these areas were undertaken every three months. Audits were undertaken by the hospital infection control lead and the support services manager.
- We looked at ward areas, patient rooms and en-suite facilities, corridors and waiting areas. We found that all the areas we looked at were visibly clean. With the exception of some areas of carpeting which were stained. We spoke with support services staff who were all able to describe their roles, and understood methods for cleaning areas, which ensured that they were not cross contaminating areas during this process.
- Cleaning staff used single use mop heads and cloths to avoid cross contamination. We observed staff using and disposing of equipment correctly.
- Clinical staff were responsible for cleaning the clinical equipment in the departments. We observed staff cleaning equipment between patient episodes. Staff used green labels that they dated and signed to indicate that equipment had been cleaned and was ready for use. All of the clinical equipment that we observed was visibly clean and labelled correctly.
- Nursing staff also completed cleaning checklists. Checklists were daily, weekly, and monthly depending on requirements. We looked at the checklists on both ward areas and saw that they had been completed correctly.
- Curtains were changed between four and six month intervals. Records were kept of curtain changes and the frequency. We viewed records that were comprehensive and completed correctly.
- Staff completed annual infection control training in an electronic learning system format. Support staff had further face-to-face learning with the infection control lead.
- The staff we observed were complying with the hospital policies and guidance on the use of personal protective equipment (PPE) and followed a 'bare below the

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elbows' policy. We observed staff washing their hands in accordance with the guidance published in the 'Five Moments for Hand Hygiene' published by the World Health Organisation (WHO) (2014).

- We saw records that showed that legionella management was in line with Health Technical Memorandum HTM 04-01 A and B guidance.
- Infection control audits were performed using a model taken from the Infection Prevention Society. We looked at the last ward audit on 27th May 2015, which had an overall score of 94%, and the last theatre audit on 22nd May 2015, which had an overall score of 85%. The audit included an action plan, which recorded the person responsible for the action and a completion date.
- Carpets in clinical areas with no risk assessments in place had been raised as an issue on the audit, along with poor protocols for the cleaning of carpets.
- Staff described a very proactive infection control lead nurse, who had run practical sessions on subjects such as hand washing over and above mandatory infection control training.
- The patient led assessments of the care environment (PLACE) scores for the hospital and published by PLACE on 27th August 2014. The hospital scored 94% on the cleanliness part of the assessment which was worse than the national average of 97%. The most recent patient led assessments of the care environment (PLACE) scores for the hospital were published by PLACE on 11th August 2015. The hospital scored 97% on the cleanliness part of the assessment, which was in line with the national average of 97%.
- A further PLACE audit had been carried out at the hospital on May 2015 with the results having been submitted to PLACE, but was awaiting publication.
- There had been an increase in surgical site wound infections in the last two quarters data at the hospital (3 out of 90 patients). As a result, the hospital's Infection Protection and Control Lead had been involved in making improvements to practice. The hospital had implemented NICE guidelines (CG74) Published date: October 2008 'Surgical Site Infection'. Changes to practice included improved antibiotic guidance, insertion of catheters in theatre, and providing pre-operative antimicrobial cleanser.
- Surgical Site Infection Rates for hip procedures were below the Spire target in the last quarter audit results

(Q1 2015) of below or equal to 0.6% with an audit score of 2.9%. For knee procedures, there had been no incidents of surgical site infection for Q1 2015 or throughout 2014.

- When audited, Surgical Infection Rates were broken down by specialty and surgeon. Between 1st June 2014 and 31st May 2015, the hospital had reported two surgical infections in gastrointestinal surgery, two in general surgery and ten in orthopaedic surgery.

## Environment and equipment

- All ward areas were carpeted which was not an easy to clean surface; parts of the carpet were stained. The Department of Health (DOH) Health Building Note 00-09: Infection control in the built environment 3.115 states that, "Carpets should not be used in clinical areas. This includes all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances".
- Hospitals that had carpets at the time of issue were not advised when to replace and how the replacement should comply to the Department of Health (DOH) "Health Building Note 00-09: Infection control in the built environment". Until then full risk assessments should be carried out and measures put in place to minimize risks.
- The Support Services Manager was aware that carpets caused a potential infection control risk. However, the carpeted areas were not risk assessed and were not on the hospital risk register. Risk assessments including infection prevention control (IPC) input from the provider's microbiologist must be in place for all carpeted areas.
- Carpets were cleaned every six months by an external contractor. We were shown the invoice for the last carpet clean which was two weeks prior to our inspection. We were told that when spillages occurred, the hospital used a small hand held carpet cleaner to deal with small patches of carpet. We were told that during deep cleaning carpets were steam cleaned.
- The carpet in the lift was a trip hazard and infection control risk as it was uneven in places, and held together with tape which made the surface difficult to clean. There was a risk assessment in place for the risks associated with the trip hazard. However, the support services manager was unaware of this assessment and we could not locate the issue on the risk register.

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- Waste management was seen to be in line with 'Safe Management of Waste' (2011) Department of Health (DH) guidance.
- We looked at 20 pieces of equipment across all ward areas and found that they had been tested for safety and were labelled with the next date that they required testing. Electrical equipment was checked and maintained through a contract with Electronics and Medical Engineering (EME) Eastbourne.
- We were shown maintenance books on ward areas. These were checked daily by estates and when work was completed, it was signed off. All of the equipment we looked at was in good working order. We were told that where equipment needed to be sent away for mending it would be replaced if needed.
- Mattresses were checked for tears when each room was cleaned. This was on a checklist for support service staff to record, the records we looked at showed that this was being completed.
- There were risk assessments held on the wards. They were completed for risks such as latex allergies, sharps injuries, and blood spillage. Risk assessments were in date and had a date for review. Control of Substances Hazardous to Health (COSHH) risk assessments had also been completed and were accessible for staff to read at the nurse's station. Staff had signed all risk assessment sign off sheets to indicate that they had read and understood the risk assessment.
- The hospital had bariatric equipment including beds, trolleys, armchairs, commodes and hoists. The ward sisters told us that they had no issues obtaining this equipment where required. We were told that the bariatric lead nurse assessed patients for their equipment requirement on admission.
- Resuscitation trolleys in ward areas and theatres were checked either daily for unlocked equipment or weekly for locked equipment. We saw that the checklists had been completed. Equipment on the trolleys was within its expiry date and dust free.
- The hospital had three operating theatres and supporting rooms. Two of these theatres had laminar flow in place. The department also had four recovery bays. There was a lack of storage in the department, which meant that equipment was stored in corridors.
- The equipment in theatres was checked daily in line with 'Checking Anaesthetic Equipment' (2012) Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.
- Pressure relieving pads and equipment were used in theatres to protect patients from pressure injuries. Body warming equipment was also used to maintain patient's body temperature during lengthy procedures.
- The most recent patient led assessments of the care environment (PLACE) scores for the hospital were published by PLACE on 27th August 2014. The hospital scored 93% on the condition, appearance and maintenance part of the assessment, which was better than the national average of 92%.

## Medicines

- We looked at the medicine storage rooms in the Day Care Unit and on Wakehurst ward. Medicine storage rooms were secured using a mechanical keypad. Medicines were securely stored in locked cupboards and fridges. The nurse in charge held the keys.
- Fridge temperatures were recorded daily and were consistently within the recommended temperature (2 - 8 degrees centigrade).
- Room temperatures were recorded daily but often exceeded the recommended storage limit of 25 degrees centigrade. For example, daily room temperature records for the medicines storage room in the Day Care Unit showed the room temperature exceeded 25 degrees centigrade on four out of the ten days between 1st and 10th June 2015. Temperature monitoring forms included what actions should be taken if temperatures were outside this range; this included notifying the pharmacist. However there was no record that any action had been taken on these days. Nursing staff told us they alert maintenance personnel, but they were unable to tell us about any specific action the maintenance staff had taken. When we spoke to the hospital pharmacist, they advised that they had not received any alerts about excessive room temperatures. This meant the hospital was unable to demonstrate that medicines had been stored at the correct temperature to maintain their efficacy.
- When we returned to the hospital for the unannounced part of our inspection, we found that steps had been taken to mitigate the risk of medicines being stored in temperatures outside the safe range. The matron had adapted policies to make them clearer in order that staff understood how to escalate readings outside the range. The hospital had instigated 24 hour monitoring of the rooms concerned and also been sourcing new thermometers to ensure readings were correct.

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- The secure storage arrangements for controlled drugs (CD) complied with legislation. Nursing staff told us it was their policy to check the number of CDs in stock daily. Records of CD checks on Wakehurst ward showed the checks were consistently completed daily, but records of CD checks in the Day Care unit showed the checks were not done regularly. For example, CDs were checked on three occasions in April 2015, five occasions in May 2015 and twice between 1st and 10th June 2015. We audited the contents of the CD cupboard against the CD register in the Day Care unit and found it was correct.
- Medicine administration records were completed accurately in the patient records we looked at.
- The hospital had its own pharmacy, which provided medicines to the wards, theatres and 'take home' medicines for patients. A pharmacist was on site between 09:00 and 17:00 Monday to Friday and between 09:30 and Midday on Saturday. A pharmacist was on call 24 hours a day, seven days a week to provide an 'out of hours' service when required.
- The pharmacy was locked, and keys were kept in a key safe on the wall outside the pharmacy. The key safe was accessible to all pharmacy staff. Keys for the CD storage cupboards were kept in a key safe inside the pharmacy. The CD key safe was accessible by pharmacists only. The hospital had protocols in place for the management of the key pad access, outlining who had access and how often the combination was changed. Following our inspection, a risk assessment for the security management of the pharmacy was written and evidence of this provided to CQC.
- Outside of pharmacy opening hours, the RMO and senior nurse on duty had access to the pharmacy via separately held keys. Any stock removed was signed in and out of the emergency stock book. Access to pharmacy out of hours was considered the final resort as there is a separate 'to take out' (TTO) medicine cupboard in the hospital in order to reduce the need for entry into pharmacy out of hours.
- CCTV cameras covered both front and rear entrances to the hospital. Pharmacy was double locked and alarmed out of hours.
- The pharmacy maintained a separate CD register for each controlled drug stored. Monthly CD audits were implemented in May 2015; previous to this they had

been quarterly. We looked at the system for requisition of CD by wards and theatres. We tested the integrity of the audit trail by selecting an entry and checking the requisition receipts. We found they were correct.

- A pharmacist told us the only reportable incidents relating to CDs were vials that were broken on receipt into the hospital. This was corroborated by the quality and governance lead who reviewed all incidents.
- Information given to us by the provider showed there were 31 medication incidents reported between 1st December 2014 and 31st March 2015. The most frequently occurring incidents related to: administration error (8), prescribing error (7) and management/security (6).

## Records

- Inpatient health records for patients treated privately at the hospital were stored on the hospital site for three months following an episode of care. Following the three month period they were removed to an offsite storage facility. Where records were required from the offsite storage they were requested and delivered the following day. If health records were required more urgently they could be collected outside of normal delivery runs.
- NHS patient health records were transported from the relevant NHS trust. All records for the patient's episode of care at the hospital were photocopied on their discharge from hospital, and copies were added to their NHS health records. The original records would be filed in the hospital's medical records storage facility in the same way as private patient notes were stored.
- We found that notes within health records were poorly filed with many loose bits of paper that were not ordered or easy to locate. We found that the resident medical officer (RMO) was writing on continuation sheets as there was very little room on pathway documentation for free text, or any variation from the pathway. Operation notes were on loose sheets of paper that had not been filed/secured in 14 of the 18 health records we looked at.
- The hospital completed health record audits, which they reported on quarterly at Clinical Audit and Effectiveness meetings. Twenty sets of health records were selected randomly each month for audit purposes. Records were



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checked for compliance with National Early Warning Score (NEWS), temperature recording, pain, VTE, pregnancy testing, consultant documentation, and that patients fasted within guidelines.

- Learning from these audits had included prophylactic VTE prescribing, and intra-operative temperature control. The hospital had introduced a 'bear hugger' system to record patients' body temperatures alongside their blood pressures from the 1st June 2015 because of this learning. At the time of our inspection, it was too early for the hospital to report on whether this action had improved intra-operative temperatures.
- The last quarter audit results (Q1 2015) showed that the hospital had achieved 83% in the patient record audit. This was worse than the Spire target of 90%. However, the last quarter audit results (Q2 2015) showed that the hospital had achieved 97% in the patient record audit. This was above the Spire target of 90%.
- Patient fall rates had fallen below the Spire target in last quarter audit results (Q1 2015) of below or equal to 2% with an audit score of 3%. Staff were reviewing incident reports in order to establish any learning from these in order to improve in this area.
- The speed at which incidents are investigated and closed was a new Spire internal target for 2015. The hospital was worse than the Spire target in the last quarter audit results (Q1 2015) of 75% with an audit score of 65%. Q2 results were 89% and were better than the target. This measure is the number of incidents closed within 45 days of reporting onto the electronic reporting system.
- We found that patient identifiable data had been stored securely throughout our inspection.

## Safeguarding

- The hospital had safeguarding policies and procedures readily available for staff on the intranet.
- We spoke with staff on the wards and in theatre who told us that they had received recent training on Safeguarding Vulnerable Adults, the Mental Capacity Act and the Deprivation of Liberty Safeguards. This training was provided online as an e-learning package.
- Staff were able to describe a safeguarding referral they had raised and could demonstrate a clear understanding of this process.
- The hospital had a safeguarding lead nurse. All staff we spoke with knew who the lead nurse was, and when they would ask them for assistance or advice.

- 75% of nursing staff had received training in Safeguarding Vulnerable Adults between January and May 2015. 98% of consultants were up to date with their Safeguarding Vulnerable Adults training.

## Mandatory training

- We spoke with staff throughout the hospital and they all told us that training was readily available.
- Most of the mandatory training was electronically delivered and we were told by staff that the quality of the computer based training was good and that they found the learning useful.
- Staff told us that where there was not time to complete mandatory training during working hours, the hospital paid staff to complete this at home. All of the staff we spoke with were happy with this arrangement.
- Staff told us that their training was up to date and that managers reminded them when training was due. We spoke with ancillary and administrative staff who confirmed they attended all the mandatory training in addition to role specific training.
- 98% of staff had completed Manual Handling training in 2014. In the first part of 2015, 75% of staff had completed their annual update of this training.

## Assessing and responding to patient risk

- All hospital theatres should follow the World Health Organisation's Surgical Safety Checklist. This incorporates a briefing, sign in, time out, sign out and debriefing. The briefing should take place at the beginning of the theatre list with all theatre staff present to discuss the list in full. The sign in, time out and sign out then take place in theatre for every case. The debriefing should then take place at the end of the list. Usually the briefing and debriefing is on separate documentation that is kept by the theatre and audited. At the Spire Gatwick, the WHO checklist was within the pathway documentation.
- Although the department had documentation for briefing and debriefing, they did not audit compliance with briefings. Two consultants we spoke with told us that they felt that the pre-list briefing was well executed and consistently applied. However, both felt the team brief following surgery required improvement. Therefore the system as it stands is not robust enough and the provider should consider auditing and monitoring the process which includes auditing the briefing and debriefing sessions.

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- The WHO checklist documentation was audited by the hospital. Audits showed that between May 2014 and May 2015 the hospital had audited 1,391 WHO checklists. Of those audited 65 (6%) did not have completed WHO checklists. We looked at 18 health records during our inspection and found that two of these had incomplete WHO checklists.
- We witnessed a cardiac arrest call test during our inspection. Key people holding pagers were alerted and the call bell system alerted nursing staff to the location of the emergency.
- Staff who held pagers in the hospital included: the nurse in charge, heads of department, the resident medical officer (RMO), a porter, and theatre recovery staff. There were emergency bells in each patient's room.
- The National Early Warning Score (NEWS) used for initial assessment of acute illness was used and applied consistently in all of the records we looked at. There was an appropriate trigger within this documentation for staff to seek medical input.
- Pre-operative assessments were completed either in pre-operative assessment clinics or by patients completing a pre-operative assessment form prior to admission. Patients either posted this back to the hospital prior to admission, or brought it with them on the date of admission.
- Between 1st June 2014 and 31st May 2015 there were four incidents reported of patients who had their operations cancelled on the day of surgery. Three of these had been due to patients being unfit for surgery on the day. We were not able to evidence that these cancellations would have been prevented through pre-operative assessment.
- The HDU accepted level one patients only. Patients requiring care that needs to be given in a high dependency or critical care unit were transferred to NHS hospitals.
- The hospital did not have any criteria for admission to its two-bedded High Dependency Unit (HDU). Admission to the unit was planned at the request of a consultant.
- There was criteria for escalation of deteriorating patients which included transfer to an NHS hospital. We noted there had been eight emergency transfers in the past year. The policy was detailed and robust, and staff we spoke with had a good understanding of the escalation process.
- The HDU was staffed by nurses with appropriate skills. Three registered nurses had ITU/HDU qualifications. A further three registered nurses had completed 'Spire Competencies' (internal programme) for supporting HDU patients.
- 34% of nursing staff were up to date with Basic Life Support (BLS) training, with 30% trained in Immediate Life Support (ILS). 26% of nursing staff also had been trained in Advanced Life Support (ALS), giving a 90% total for nursing staff trained in either BLS, ILS or ALS.
- 98% of consultants were up to date with BLS, and 100% of Anaesthetists & RMO's were up to date with ALS training.
- Standards and Recommendations for Pre-operative Practice (Association for Pre-operative Practice 2011) states that a formal written process should be in place for taking patients to theatre. This means that a written notice with all patient details should be taken from theatre to the ward and both the ward nurse and theatre practitioner check against this notice. The hospital currently does not complete this process but instead rings the ward to request that the patient is brought to theatre. Although there have been no adverse incidents recorded as a result of this practice, the department should have risk assessments in place to mitigate risks from not following these guidelines.
- The management of patient's tissue injury risks in the operating theatre was managed in line with NICE Pressure Ulcer Care Clinical Guideline 179.
- There was scope for improvement with how patients undergoing cosmetic surgery were assessed for surgical procedures. We noted in one set of patient health records for a patient attending a breast augmentation that the patient had a history of depression. We saw that the patient's health records did not document any discussions or checks around the patients mental health prior to surgery. We asked the special nurse about this and were told that this was a decision made by the consultant and that they did not have a role in this decision. RCS Professional Standards for Cosmetic Practice 2013 point 5.2.4 discusses the importance of a psychological assessment for patients undergoing cosmetic procedures. In this instance, this guidance had not been followed.

## Nursing staffing

- There were 53 beds that required nursing support (29 inpatient on Wakehurst and Penhurst ward, 24 in Day

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Care and two in HDU). Spire Gatwick Park Hospital used the 'Shelford Tool', a Safer Nursing Care Tool (SNCT) that is as an acuity-based toolkit, endorsed by the National Institute for Health and Care Excellence (NICE) to be used alongside the NICE Guidelines on safe staffing. It was adapted locally to reflect the nature of the environment and cohort of patients.

- The nursing staff rota was organised over three shifts in every 24 hours; the 'early' shift was 07:00 until 15:00, the 'late' shift was 13:00 until 21:00 and the 'night' shift was 20:30 until 07:00.
- The number of staff on duty on each shift depended on the number, acuity and dependency of patients, but typically the number of staff for each shift was;
- Early: three registered nurses and one or two health care assistants.
- Late: two or three registered nurses and one health care assistant.
- Night: two registered nurses and one health care assistant.
- Nursing staff told us there were usually around 15 patients on the ward. On 9th June 2015 the nurse handover sheet listed 15 patients on the ward, on 10th June 2015 the nurse handover sheet listed 18 patients on the ward.
- The day care unit opened between 07:00 and 21:00 Monday to Friday and on some Saturdays. Typically the number of staff rostered during the unit's opening hours was one or two registered nurses sometimes supported by one healthcare assistant. We spoke with a senior nurse in the day care unit who told us there was no staffing/acuity tool in use, but clinical judgement was used to plan the number of staff required. We were told the unit worked short of staff (usually due to unplanned absence) "once every couple of weeks". These incidents were not routinely reported as adverse incidents on the electronic incident reporting system. The hospital provided assurance that a recognised staffing tool was in place and used to assess staffing levels, but this demonstrated it was not understood by all ward staff.
- Between January and December 2014 the agency usage for registered nurses averaged 8% in inpatient departments and 3% in theatres within the hospital. The second registered nurse on night shifts was often an

agency nurse. We saw evidence of local induction for agency nurses. The clinical service manager told us regular agency nurses were often used, which gave some continuity.

- We attended a nurse handover between shifts and saw effective communication between nursing staff about the needs of patients. Printed nurse handover sheets were also used.
- There were 33.6 whole time equivalent (WTE) nurses in post within the surgical area. These were allocated as 14.6 WTE in the wards, 4 WTE in the day surgery unit, and 15 WTE in theatres. The wards had recently recruited and would have 18.6 WTE in post by the end of July 2015.
- Between January and December 2014, the sickness rate among registered nurses averaged 1.7% in inpatient departments and 2.3% in theatres within the hospital.
- The vacancy rate for registered nurses was 10% for inpatient departments and 17% in theatres at 31st December 2014.
- Between January and December 2014, staff turnover for registered nurses was 21% in inpatient departments and 28% in theatres within the hospital. Where agency staff were used in theatres, the hospital ensured that they used a regular agency and where possible regular staff who were familiar with the department. Where agency staff were used, they had completed an induction including AfPP guidance (The Association for Perioperative Practice).
- Dependent on the complexity of the theatre list, there were generally four members of staff in each theatre. This included one operating department practitioner (ODP), two trained nurses, and one health care assistant (HCA).

## Surgical staffing

- Anaesthetists were available via a consortium. However, most surgeons worked with their preferred independent anaesthetist. The hospital had three first operating department assistants as employed members of staff. Other first assistants used were those bought in by consultant surgeons. The theatre manager kept records of all first assistants that worked at the hospital and ensured that they evidenced that these staff were up to date with their required competencies before they could assist in surgery.

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- The anaesthetists working at the hospital were all practising within the NHS. The NHS provided evidence that they were up to date with appraisal and re-validation.
- We reviewed the records of four consultants who had a scope of practice agreement that identified which procedures they could perform.
- Resident Medical Officers (RMO) covered the hospital seven days a week through a rota system and were able to be called overnight. RMOs worked for seven-day stretches and handed patient care over on a Monday lunchtime to the next RMO. We were unable to observe a handover meeting, but were told that these involved each patient being discussed along with any issues or important information requiring sharing from the previous week. A pro-forma was in place for this handover.
- RMOs were appraised through their employing agency had received Advanced Cardiac Life Support (ACLS) training and had attended simulated cardiac arrest situations in the hospital.
- RMOs were able to contact consultants where required, and reported that they were always able to do this when they needed to and found consultants very helpful and approachable.
- Consultants told us that they saw their patients most days. Day surgery staff told us that consultants visited patients first thing in the morning before lists commenced and some also attended patients prior to their discharge home. The arrangements for longer stay patients were informal and staff told us that although RMOs saw patients every day consultants did not always do this.
- Appraisal and GMC verification was a rolling programme at the hospital. All consultants' appraisal and GMC registration expiry dates were logged on an automated database, which alerted administrators when new proof of registration and appraisals were due. In addition, all consultants underwent a biennial review with the Hospital Director, Matron and MAC chair who signed off the consultant when their GMC license and appraisal were checked.

## Major incident awareness and training

- The hospital had in place business continuity plans. We spoke with the theatre and estates staff who described

- what would happen in order to safeguard patients during any facilities failure. They gave an example of an electrical failure and the hospital's backup generators were used to ensure patients in theatre remained safe.
- Staff told us how scenario training was undertaken where procedures for major incidents such as fire were tested. They gave examples of practicing evacuations on the wards.
  - We noted there had been eight emergency transfers in the past year

## Are surgery services effective?

Requires improvement 

There was scope for improvement in the way that the hospital managed patient pain relief. 'As needed' medication for day case surgical patients was not routinely prescribed. The recording of the effectiveness of pain relief was not consistent.

The amount of time that patients were Nil by Mouth (NBM) before surgery required improvement. Patient starve times were being monitored. Patients were being starved and restricted from fluids for longer times than required which could affect their wellbeing and the outcome of their surgery.

The hospital consent forms complied with current Department of Health guidance. However, there was scope for improvement with the completion of consent forms as two out of the eight consent forms we looked at were not completed correctly.

We saw evidence that NICE guidelines and other national guidance were used in clinical practice. NICE guidelines and other national guidance documents were reviewed centrally by the National Clinical Governance Committee quarterly. Updates are made to corporate policies and guidance documents and communication made regarding changes required at a hospital level.

The hospital collected data on patient outcomes. However, there was scope for improving systems for monitoring patient outcomes following cosmetic surgery.

Staff received an induction on starting at the service along with appraisals twice a year. The hospital was ensuring staff had competencies in place to perform their roles.

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We saw good examples of multidisciplinary team working with staff on the wards having daily MDT ward rounds.

## Evidence-based care and treatment

- National Institute of Health and Care Excellence (NICE) guidelines and other national guidance documents were reviewed centrally by the National Clinical Governance Committee quarterly. Updates are made to corporate policies and guidance documents and communication made regarding changes required at a hospital level
- Monthly safety bulletins were sent to hospital departments which included a summary of national safety alerts and updates to policies and a list of relevant NICE guidelines issued that month pending central review. This ensured that staff are aware of the latest information
- Policies were referenced to evidence the relevant guidelines that were being followed through the policy or guidance. For example, The Royal College of Surgeons guidelines were demonstrated through the policy around environment, equipment and medical support.
- Care of patients passing urine, including the insertion of catheters in theatre before patients left, was managed in line with Royal College of Nursing 'Catheter Care Guidance' (2012).
- The bariatric team were following NICE guidance around patient criteria for surgery. This meant that they accepted patients with a BMI of 35 and above with co-morbidities, or patients with a BMI above 40 without co-morbidities. The service also accepted patients with diabetes that had a BMI between 30-35.

## Pain relief

- The hospital did not have a pain team or pain nurse specialist. A medicines management committee met regularly which was managed by pharmacy. The minutes of these meeting showed that pain management was included in the agenda.
- Patients we spoke with felt supported with their pain relief. One patient said, "They always ask about pain relief every time they come in, and they give me whatever I need".
- The recording of the effectiveness of pain relief was not consistent. This was partly due to pathway paperwork which did not have room for staff to record detailed information. There were pain tools within patient

pathway documentation, although these tended to be tick box and did not have room for staff to record the effectiveness of any pain relief they had given. For example, we looked at one patient pathway in which the nurse documented that the patient concerned had complained of pain and was given analgesia. There was no further written evidence of whether the analgesia had been effective and whether the nurse had returned to the patient to discuss their pain levels.

- The hospital recorded patient pain on the NEWS chart as part of the patient record. An internal audit showed compliance to be better than the hospital's target of 95% at 98% for Q2 2015. However, our inspection team found that where patient's pain levels were raised as an issue and recorded on pathway documentation the outcomes related to this were not recorded. Therefore it was unclear from documentation whether patient's pain levels had been resolved.
- We reviewed the training records for three theatre recovery staff and found that they had received training on syringe pumps and patient controlled analgesia (PCA).
- Staff told us that they felt that there needed to be a more proactive approach to pain relief and its management, particularly in day surgery cases.
- Staff said that not all day surgery patients had 'as needed' (PRN) analgesia prescribed. In five medication charts checked, three had no PRN analgesia prescribed. The hospital have a RMO on site at all times to prescribe analgesia to patients as needed. However, this may present a risk of delayed intervention where analgesia was required.

## Nutrition and hydration

- Clinical Practice guidelines endorsed by NICE state that the intake of water for up to two hours, and a minimum pre-operative fasting time of six hours is recommended for food (solids and milk) before induction of anaesthesia for elective surgery is safe in healthy adults, and improves patient well-being.
- The hospital monitored patient starve times as patients being starved and restricted from fluids for longer times than required could affect their wellbeing and the outcome of their surgery. The hospital's own target was set at 45% of patients being starved within best practice guidelines. Latest data showed that in March 2015, 50%

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of patients met with best practice guidelines around starvation times with 65% achieving this during June 2015. This meant that the hospital were performing better than their own targets in this area.

- We discussed the reasons that staff felt that this standard was not always being met and were told by staff that it was because patients were not following guidance or because surgeons were changing their list order.
- Patients arrived at the hospital at block times. For most cases around 07:00 or 12:30. Surgeons and anaesthetists would see patients at this time before going to theatre to start their list. Staff reported that there was no flexibility around these times and that patients coming in at 07:00 had been told to starve from midnight. This meant that patients at the end of lists could remain NBM for a number of hours. However, we were shown information provided to patients which advised patients to fast for one hour for clear fluids and five hours for food before admission to minimise the time patients remain NBM. This showed that not all staff appreciated the information provided to patients and that there was a risk of confusion which could result in extended starve-times.
- We were told that the ward had worked with one anaesthetist to look at the communication with staff regarding changes to the order of the list. This meant that this one anaesthetist would come to the ward and share the list order with them so that staff were clear on NBM timescales and could feed and hydrate patients accordingly. Staff told us that this worked well and saved time otherwise they had to ring theatres many times a day to get information on whether patients were able to eat or drink.
- The hospital was able to access advice from dieticians where required.
- Hospital PROMs data showed scores in the three areas measured were similar to the England average. The Oxford Hip Score, a functional assessment of movement, for hip replacements was also near the average.
- The last quarter audit results (Q1 2015) showed that the effective discharge audit was 43% which was worse than the Spire target of 55%. A root cause analysis for this result had been started in order for the hospital to make improvements.
- The last quarter audit results (Q1 2015) showed that the hospital had achieved 58% for patient temperature control in theatre which was worse than the target of 80%. The results of this audit were presented at the MAC and individual anaesthetists had been spoken with regarding their practice.
- The last quarter audit results (Q2 2015) showed that the hospital had achieved 80% for patient temperature control in theatre which was in line with the target of 80%.
- There was a system in place for post-operative support following cosmetic surgery procedures. The specialist nurse said that if patients had concerns they would call the main switchboard who would put the call through to them. When they were not around the call would be put through to the wards. Systems were in place for documenting these calls and notes were held in the patient record.
- Patient satisfaction and outcomes were monitored for all patients via the patient satisfaction survey, but there was no monitoring of outcomes or specific patient surveys conducted for patient satisfaction following cosmetic procedures. The cosmetic nurse specialist was unable to describe the procedure for revision of procedures, and was not sure how they would escalate problems if a patient was not happy with the outcome of their surgery.

## Patient outcomes

- The hospital was completing National Joint Registry (NJR) documentation and reporting on the national data programme.
- Patient Reported Outcome Measures (PROMS) data was completed for hips and knee outcomes and reported on a national data programme. PROMs measured health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

## Competent staff

- There were systems in place to enable staff to maintain and develop skills relevant to their area of work.
- Staff received an appraisal called 'Enabling Excellence' twice a year. Between appraisals staff received informal one to one conversations although these were not documented. Staff were positive about their appraisals and talked about the training and development opportunities that they had gained through this process.

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- Staff joining the hospital attended a corporate and local induction programme.
- Trained nurses and health care assistants had completed competency assessments to ensure that they were able to complete tasks safely and competently. These competencies had recently been updated to include more practical based assessments. We looked at six staff files which contained completed competency assessments.
- The hospital had link nurses for orthopaedics, HDU, gynaecology, resuscitation, blood transfusion, VTE, diabetes, dementia, safeguarding, breast care, wound care, cosmetics and bariatric. These were nurses with a special interest, who shared their knowledge and advised other members of the team.
- During staff induction, the bariatric nurse spoke with staff about the care needs of patients undergoing bariatric surgery. For example, the importance of using correct sized blood pressure cuffs and equipment, and details about the differences in the surgical procedures.
- The breast care specialist nurse was working alongside the breast care link nurse to develop a training package for staff in breast care. They were members of the Breast Care Nurses Association and attended conferences on a quarterly basis to share and learn from best practice.
- The hospital gave evidence of high rates of re-validation for all staff groups. With a 100% rate of validation of professional registration for doctors and dentists under practicing privileges and a 95% rate of validation for Allied Health Professionals.
- The bariatric nurse attended quarterly MDT meetings which included a specialist dietician, a bariatric psychotherapist, an anaesthetist (Society of Obesity and Bariatric Anaesthesia (SOBA) qualified), and a surgeon. The dietician and psychotherapist are not employed by Spire, but attend on an ad-hoc basis and saw every bariatric patient pre-operatively.

## Seven-day services

- Pharmacy was open 09:00 to 17:00 Monday to Friday and 09:00 to Midday on Saturdays. Pharmacy staff worked on the wards between 08:00 and 09:00 daily. There was an on-call service outside these hours.
- Pathology was open 08:30 to 17:30 Monday to Friday and 09:00 to 13:00 Saturday. There was an on-call service outside these hours.
- Theatres operated 08:00 to 21:00 Monday to Friday and 08:00 to 16:00 on a Saturday. There was also an on-call service outside these hours.
- The hospital operated a two tier clinical and management on-call system. There was a clinical nurse on-call with an on-call member of the Senior Management Team outside of normal working hours.
- The hospital had an RMO on site 24 hours a day seven days a week. The RMO could contact consultants who provided a 24 hour on-call (off site) cover for their patients. If they were unavailable at any time, they organised a consultant colleague with admitting rights to provide cover in their absence.

## Access to information

- All risk assessments, care plans, health records and test results were kept in paper format. Nursing records were kept in ward areas. We noted that records contained loose bits of paper which made it difficult to find information.
- On going care needs were written by staff and sent to relevant teams or health professionals on patients discharged from the ward. This included referrals to district nurses, and discharge letters for General Practitioners (GPs). These were mostly sent home with patients for them to deliver to their GP surgeries.
- Test results, x-rays, and clinical letters were held electronically. RMOs and consultants were able to access these when required.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

## Multidisciplinary working

- GPs were not always made aware of patients booked to have surgery at the hospital unless the hospital required information about a patient pre-operatively.
- On discharge from the hospital GPs were sent a copy of the discharge summary which contained details of medications, the episode of treatment and any follow up information or appointments.
- Referrals to district nursing teams were made via a paper form. Ward staff called district nurses to discuss patients care needs before they were discharged.
- Wakehurst and Penhurst wards completed a daily ward round which involved members of the multidisciplinary team (MDT). We observed part of this round and found that patients were discussed in detail and that all members of the MDT were involved in these discussions.

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- The hospital's consent policy was issued by Spire Healthcare in November 2014.
- The hospital consent forms complied with current Department of Health guidance. Consent forms identified the procedure to be undertaken, its associated risks and there were documented records of the health care professional responsible for consulting the patient and also recorded signatures from patients indicating that they were providing consent to undergo any proposed procedure.
- We looked at eight completed consent forms in patient's records and seven were fully completed. One was not dated. Patients we spoke with told us they were given a copy of the completed form.
- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before they were carried out.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment.
- By the end of May 2015, 81% staff received training in the requirements of the Mental Capacity Act (2005).
- There were no Deprivation of Liberty Safeguards applications or authorisations made by the hospital in 2013/14 or the year to date.

## Are surgery services caring?

Good 

The hospital had systems in place that allowed patients to feedback their experience of care at the hospital. The results of the surveys indicated that the respondents considered the hospital provided excellent, compassionate care by friendly and approachable staff.

Patients and their families were cared for by kind and compassionate staff who supported them.

Patients we spoke with during the inspection confirmed that staff were kind, considerate and respectful. We observed interactions between the staff, consultants and patients and saw that staff were attentive and caring in their attitude, providing assurance and support where needed and anticipating when additional care was required.

We found the hospital provided services and information to actively involve patients and those close to them. For example patients told us that they had received ample information during their stay and that the staff and consultants took the time to listen to them and their concerns. We were told how staff took time to counsel patients and allay their fears.

We saw that the hospital had systems and processes in place that supported staff in providing a good service. For example, ensuring that patients had contact numbers on discharge that they could call if they had any concerns or questions on their return home. There were adequate staff on duty which gave them time to interact with patients and their families.

### Compassionate care

- The most recent patient led assessments of the care environment (PLACE) scores for the hospital were published by PLACE on 27th August 2014. The hospital scored 89% on the privacy and dignity part of the assessment which was better than the national average of 88%.
- The April 2015 Friends and Family Test results showed that 97% of patients rated the care and attention from nursing staff at the hospital as either 'excellent' or 'very good'. With 97% of respondents saying they were either 'extremely likely' or 'likely' to recommend the hospital to their friends and family.
- By the end of May 2015, 75% of staff had completed the 'Compassion in Practice' on-line training.
- The hospital promoted open visiting hours, with friends and relatives given a priced menu to enable them to eat at the hospital with patients.
- Staff we spoke with demonstrated an understanding of different cultures and were able to discuss how they would provide variances in care needs.
- We saw staff from all staff groups speaking to patients in a respectful manner. Staff were welcoming and friendly to patients arriving for treatment and we saw staff escorting people to where they needed to be if they asked for directions.
- We saw an anaesthetist being supportive and friendly to a patient who was feeling nervous about their procedure.
- We saw staff explaining procedures and asking for verbal consent before taking peoples baseline observations.



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- Staff we spoke with in focus groups all told us that they would feel able and confident to raise concerns if they saw a colleague behaving in a disrespectful or unkind manner towards patients.
- We saw patient's dignity and privacy respected at all times. We saw staff in theatres being mindful of patient's dignity when they were in a vulnerable condition.
- On the wards we saw staff knocking and waiting for a response before they entered patient's rooms.
- We did not hear staff discussing patients where they could be overheard. We also saw that staff protected patient information. For example although the day surgery unit had a white board behind the nurse's station they only wrote patients names on this when they had consent to do so. Patients who had not consented were only identified by their initials. This demonstrated that staff had considered patients confidentiality.
- One patient on the day surgery ward told us, "Even though there is only a curtain at the front of this bay no one can overhear conversations because everyone is very careful to speak quietly. I was very pleased when a nurse asked me in private if I was nervous or scared. I thought that was a very nice touch".

## Understanding and involvement of patients and those close to them

- We saw staff explaining patient's treatment and care with them. For example we listened whilst one nurse explained to a patient what medications they were taking home, how often and for how long they should take them, what the medication did, and what side effects they might experience. This nurse explained to the patient that one side effect of their analgesia was that it may cause constipation. They went on to discuss with the patient how they could alter their diet and which foods they should include in their diet to prevent this from happening.

## Emotional support

- We saw nurses and support staff checking on patient's well-being regularly, we also saw staff sitting in patient's rooms talking with them and reassuring them.
- Patients undergoing bariatric surgery were seen by a psychotherapist prior to treatment. The bariatric nurse also had a programme of education for these patients so that they understood the impact the surgery would have on their lives.

- The breast care specialist nurse was working on setting up a support group for patients following breast surgery.
- The hospital had clinical nurse specialists for bariatric, breast care and cosmetic surgery. This offered patient's individual time with experienced nurses to discuss aspects of their care, and to feel supported emotionally through the process.

## Are surgery services responsive?

Good



The hospital was compliant with government requirements to eliminate mixed-sex accommodation. Patients admitted to the hospital only shared facilities when clinically necessary, such as in the ambulatory care unit or in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity.

People experienced treatment and surgery which was delivered in a timely way and took into account their requirements. NHS patients were treated consistently within the 18 week targets for referral to treatment times.

The hospital had clear processes in place for dealing with complaints. Patients we spoke with understood how to complain. Staff were aware of the complaints process and were able to discuss changes of practice with us that had occurred following complaints investigations.

Although staff were aware that some patients had complex needs, such as those with dementia and learning difficulties, they had not received specific training. "Compassion in Practice" on-line training was mandatory and included caring for these patient groups. This was partly because the nature of the service offered meant that few patients with reduced capacity accessed the service.

## Service planning and delivery to meet the needs of local people

- From January 2014 to December 2014, the hospital admitted 1,876 overnight inpatients, 4,493 day case inpatients and managed 6,368 patients through theatre.
- There had been 10 cases of unplanned transfer of an inpatient to other hospitals in the reporting period (January to December 2014). Overall, there was a consistent rate of unplanned transfers over the same

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period. For the time period July to September 2014 there were no cases of transfer to another hospital. CQC has assessed the proportion of patients transferred to another hospital to be similar to other independent acute hospitals we hold this type of data for.

- There were no cases of unplanned re-admission within 29 days of discharge in the reporting period (January to December 2014). For the time period July to September 2014 there were no cases of unplanned re-admissions within 29 days. CQC has assessed the proportion of unplanned re-admissions within 29 days to be 'better than expected' compared to the other independent acute hospitals we hold this type of data for.
- Consultants completed patient discharge letters. These were duplicated with two going home with the patient, one for them to keep, one to give to their GP, and one stayed in the patient's health records.
- The hospital offered open visiting time for all patients.
- The hospital had a large car park with plenty of parking spaces available throughout the day, parking was free of charge.
- When patients were booked in for treatment at the hospital, an information booklet was sent to them which outlined details of the hospital and aspects of their care.
- On discharge from the wards all patients, including cosmetic surgery, were given a discharge pack. This included a booklet which explained the discharge process, the signs of urgent concerns following surgery with instructions to contact the hospital, advice about aftercare such as levels of activity, passing urine, pain control, bowel care, suture care and wound dressings.
- Data was collected on patients calling in following discharge, but not for patients presenting in NHS hospitals following discharge from the Spire. This meant that the hospital was unable to identify complications following surgery for patients who were subsequently treated or given advice from other care providers.
- Patient information leaflets were available at the hospital, these were in English. The hospital had recognised an absence of information leaflets in other languages and formats, for example easy read. The hospital was working to source these leaflets at the time of inspection.

## Access and flow

- Patients had timely access to assessment, diagnosis and urgent treatment. There were no delays in accessing surgical intervention once the patient was identified and had accessed the hospital's booking systems.
- Patients all told us they had been able to arrange their surgery at a convenient time for them. One patient told us that their surgery had been arranged at short notice but they told us that they were happy with this arrangement.
- Surgery was predominantly elective and planned in advance, there were few instances of unplanned surgical interventions.
- During the past year there had been eight cases of patients returning unexpectedly to theatre and this was managed without inconveniencing other patients.
- Planned elective surgical admissions were scheduled to take into account the need for the appropriate investigations to be carried out.
- During January 2014 until December 2014 the hospital had treated 1,300 NHS patients. 778 of these had been day case procedures with 522 as in-patient procedures.
- Referral to treatment times (RTT) for NHS patients undergoing surgery was within the national expected timescale of 18 weeks for all patients. In January 2015 the average wait for treatment from the referral date was 13.5 weeks, in February 2015 this was 14.3 weeks and in March 2015 patients waited on average 14.5 weeks for treatment from their referral date.
- Following their initial consultation the hospital saw some patients for pre-operative assessments. Patients were initially seen by a consultant who completed a booking form which went to theatres for booking. Some patients were then seen in pre-assessment clinic.
- Patients completed a pre-assessment form which was risk assessed. Patients were then invited to a pre-assessment clinic or were pre-assessed by telephone depending on their level of risk. We were told by staff that on occasions patients bought their pre-assessment form with them on the day of surgery, they were then assessed by the admitting nurse on arrival. In these instances, it could be possible that the patient was not assessed for risks associated with their health until the day of their surgery.
- We asked how staff ensured that patients had completed this form accurately and fully understood the questions within this documentation. We were told that

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the service currently had no way to mitigate this risk, but that they were working on a proposal to ensure that all patients were reviewed pre-operatively by a registered nurse.

- We were told that if the hospital needed further pre-operative information from GPs or specialists, they could request it, however this was not done as a matter of routine.
- Staff involved in the pre-assessment of patients told us that they felt that the service could be improved by making the paperwork more comprehensive and in booklet form. They also felt a health screen should be completed with a consultant, which was not currently done.
- The bariatric service at the hospital did not treat NHS patients. The number of private patients seen had increased in the last year. This service treated 21 day surgery cases and 43 inpatients.
- The initial consultation with patients undergoing bariatric surgery was with the nurse specialist to discuss the details of the surgery, co-morbidities, medical concerns and medications. The patient was then referred to the surgeon who made a decision on the appropriate surgery to be carried out. Following this, the patient underwent assessments by both the dietician and psychotherapist before surgery was undertaken.
- Following surgery, follow-up care involved daily telephone contact with the specialist nurse for seven days post operatively, followed by a consultation at seven days post operatively. Gastric band patients were then seen every four weeks. Patients having other procedures were seen at six weeks, twelve weeks and then every twelve weeks following this.
- The consultant made the initial assessment regarding the suitability of patients for cosmetic surgery procedures. If accepted for surgery, cosmetic patients had a 30 minute initial consultation with the cosmetic nurse where they discussed the patient's expectations and what was achievable and completed a risk assessment. The cosmetic nurse was unaware of any criteria around patient suitability for surgery.
- Cosmetic surgery patients had a 30 minute initial consultation where they discussed the patient's expectations and what was achievable and completed a risk assessment. Patients also attended a

pre-assessment clinic where their medical history was considered. The hospital operated on 186 day case patients and 64 inpatient cases of cosmetic surgery between January 2014 and December 2014.

- The breast care specialist nurse saw all patients attending breast surgery. They attended consultant clinics, supplied patients with information, visited patients pre-operatively, and discussed recovery and post-operative care with patients. They also attended follow up clinic appointments and were available to give advice to patients following surgery.
- We spoke with staff who told us that they liaised with social services and the patient's GP to ensure there was a safe discharge plan in place. This was then documented in the integrated surgical care pathway.
- Patients ringing the hospital with post-operative concerns were recorded on a 'post discharge call record sheet'. This sheet contained information about the patient, why they had called, and what advice they had been given. We were told that this information was not logged or analysed for trends.
- Patients were followed up by specialist nurses and were given contact numbers so that they were able to access advice following discharge.

## Meeting people's individual needs

- We were told that patients' individual needs and requirements were assessed and documented during the pre-assessment clinic appointment, although not all patients attended this clinic.
- If any specialist requirements were identified the patient would be referred to the consultant, anaesthetists and senior nursing staff to ensure that their needs could be met while they were an inpatient at the hospital.
- The surgical care pathways included documenting that suitable arrangements were in place for a safe discharge. This included ensuring that family and carers needs and responsibilities were taken into consideration. For example community services were considered and discussions documented if the person's carer would be able to meet the patient's discharge needs. Patients that we spoke with confirmed that staff had discussed their discharge arrangements with them.
- The service had access to translation services. However not all staff were aware of how to access these. One consultant that we spoke with was unaware of any arrangements that were available to them with regards to translators.

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- Staff that we spoke with were able to tell us about the enhanced surveillance they give to patients admitted with dementia. However, they told us that they did not have patients with dementia often, as the single rooms in the hospital made it too difficult for staff to constantly monitor patient's movements and requirements.
- Staff had some understanding around managing patients with a learning disability. However, they did not have access to resources on the ward such as leaflets in easy read formats or communication tools.
- The hospital was compliant with the Government's requirement to eliminate mixed-sex accommodation. Patients admitted to the hospital only shared facilities when clinically necessary such as in the ambulatory care unit or in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity. The day surgery ward had individual bays for patients with a curtain giving them privacy from the ward corridor. Patients in this ward shared toilet facilities which were segregated.
- Each single room had a nurse call bell, television, telephone, and free wireless internet connection. Rooms also had their own temperature control. Welcome packs within rooms told patients about the facilities available to them.
- Patients had private rooms on Penhurst and Wakehurst wards which allowed them to have private conversations and time alone to reflect.
- When patients were booked in for treatment at the hospital an information booklet was sent to them which outlined details of the hospital and aspects of their care.
- Patients considering or undergoing bariatric surgery went through a programme of education pre-operatively where the procedures and aftercare were explained in detail. We were shown the information which included a presentation outlining safety and possible complications of bariatric surgery.
- We how the hospital might get further information about patients prior to cosmetic surgery, for example liaising with general practitioners (GPs). We saw no evidence in patients' health records that further information had been requested from other sources. The specialist nurse told us that this would be the responsibility of the surgeon. We were unable to speak with any cosmetic surgeons to clarify this during our inspection.
- Patient menus offered a good variety of breakfast choices, lunch included soup, a selection of sandwiches and Panini's and baked potatoes. Dinner was three courses with three choices of starter, four main meal choices including vegetarian, and four dessert options.
- Staff were able to source food for patients with special requirements and could obtain produce such as Halal meat with 24 hours' notice. We were shown the flagging system which alerted support services staff when a patient assessed in pre-assessment clinics would require special dietary requirements.
- Support staff on the ward areas were aware of which patients required special dietary requirements.
- Patients were asked to make menu choices in the morning for lunchtime service and in the afternoon for dinner service. Patients we spoke with were satisfied with the quality of the food and the choices available to them.
- The Support Services Manager spoke with a few patients each week and wrote in a diary the comments that they made about hospital food. They told us the comments would then be discussed with chefs during team meetings. If complaints were made about the food, these would be discussed with kitchen staff. Support Services Assistants told us that where a patient made a complaint about the food they would report this to the chef who would come to the ward to discuss any issues with the patient concerned.
- One patient we spoke with told us, "The food here is fine and has always been served with a smile. Staff are always pleased to fetch you a drink whenever you need one".
- The most recent patient led assessments of the care environment (PLACE) scores for the hospital were published on PLACE on 27th August 2014. The hospital scored 95% on the food quality part of the assessment which was better than the national average of 89%.

## Learning from complaints and concerns

- The hospital had a complaints policy and procedure available for staff to access .
- The surgical division had received 41 complaints between May 2014 and April 2015. The hospital had a record of these complaints along with any actions and learning for staff as a result of the complaint.
- Patients that we spoke with knew how to make a complaint. Patients were given an opportunity to raise concerns with any staff members while at the hospital

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and specifically to matron or the hospital director on their daily walk round. Patient leaflets detailing complaint procedures were available on the wards and at the main reception desks.

- Concerns raised through the patient discharge questionnaire and annual patient satisfaction survey were followed up in post-discharge calls to patients.
- Complaints were reviewed at the senior management team meeting. Complaint themes were discussed at the clinical governance committee. Department specific complaints were discussed within teams.
- Complaint themes were also discussed with department managers at hospital leadership team meetings. Statistics, themes and some specific complaints were reviewed at the medical advisory committee.
- Staff we spoke with were able to describe changes of practice following learning from complaints.

## Are surgery services well-led?

Good



We found there were suitable arrangements for the management team to assess and manage risks, and to monitor the quality and safety of care and treatment. However, not all risks had been identified as part of governance processes.

Staff were extremely complimentary about their managers and were all positive about the recent changes in management at the hospital.

Staff told us that they enjoyed working at the service and described an open culture to us where their managers were accessible, and open to ideas. Staff felt they could discuss any concerns they had with managers and that they felt valued by their organisation.

Patient views were gathered using patient surveys and friends and family testing. Results of these were analysed and service improvements made as a result.

Staff were encouraged to make suggestions and explore different ways of working as part of a continuous drive for improvement. However, some ideas highlighted by staff as innovative were practices that had been used in other hospitals for some time. For example, improvements to patient starve times.

## Vision and strategy for this service

- Spire Healthcare's vision was, "To be recognised as a world class healthcare business". Their stated mission was, "To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care".
- Their values were, "Caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on our promises, and keeping it simple".
- They also subscribed to the 6C's of nursing, 'competence, caring, compassion, commitment, communication, and courage'.
- All of the staff that we spoke with were aware and understood the vision and values of the organisation. All of the nurses we spoke with were able to describe the 6C's of nursing to us.
- Staff understood how and why changes to the service had happened. They felt involved and consulted in decisions made within the service.
- Our interviews with patients and staff outlined that staff were working in a way that showed a commitment to the hospitals values and the 6C's of nursing. Nursing staff were proud and passionate about the care that they were providing for their patients. Patients felt that staff were caring and compassionate.

## Governance, risk management and quality measurement

- Ward managers and nurse leads told us that they had attended root cause analysis (RCA) and risk training to ensure that RCAs were managed robustly and correctly.
- The hospital held clinical audit and effectiveness meetings quarterly. We reviewed the minutes from these meetings. The meetings were attended by the clinical governance and quality lead along with senior managers from each department. During the meetings staff discussed the last quarters audits along with any action logs from findings/learning from audits.
- An anaesthetist that we spoke with was able to describe audits of venous thromboembolism (VTE) assessments, patient warming, and renal function. They told us that they did not attend any formal audit meetings but would be provided with reports from audits as they were circulated amongst staff.

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- The hospital had a risk register where it recorded any risks to the service with actions and action plans to mitigate these risks. However some risks were not on the risk register.

## Leadership of service

- Staff were all complimentary regarding leadership within the hospital.
- There had been a recent re-organisation of department leads and a new hospital matron had been appointed.
- Staff were very pleased with the appointment of the matron and felt that there had been an improvement in the service and staff felt very supported in their roles. Senior staff described the matron as a “good sounding board” when they wanted to discuss judgements around clinical care.
- Staff told us that senior managers were very approachable and were walking the hospital floor daily and speaking with staff and patients.
- The hospital director had an open door policy. All of the staff were aware of this and felt confident in talking with the director about any concerns they had.
- One member of staff in a focus group told us, “It’s an open culture here; I would feel able to challenge or tell anyone top to bottom if they’ve missed something”.
- Staff all told us that they felt very valued by the organisation and the staff that they worked with.
- The hospital director was supported corporately with registered manager training sessions.

## Culture within the service

- Staff told us that they enjoyed working at the hospital. One member of staff told us, “I absolutely love working here. Colleagues help me to learn, we all work well as a team, we are flexible, and I get to work across all of the wards so I never get bored and there are always new things to learn”.
- Where patients had written plaudits which named specific members of staff these were photocopied and given to the staff member to keep in their personal records. Staff we spoke with appreciated that they were told when they had been praised for their work.
- Staff were keen to tell us how much they enjoyed working at the hospital. They all said that the teams were supportive and that they worked cohesively

together. Some staff we spoke with told us that they worked across all of the ward areas. They said that they enjoyed this as it kept them updated on each area and gave them the opportunity to learn new skills.

- Junior staff told us that they would feel confident in approaching senior staff if they saw them not adhering to best practice, for example if they saw them approach a patient to provide care without washing their hands. They told us that senior staff actively encourage them to discuss issues with the member of staff if they saw any poor practice.
- One member of staff told us, “There are days when you have to deal with tired and negative consultants. Then you have to be responsible for your own positivity and just make sure that everything works smoothly”.

## Public engagement

- Patient views were gathered using patient surveys and friends and family testing. Results of these were analysed and service improvements made as a result.
- Complaints were also analysed and patients who made negative comments on feedback forms were called and their complaints discussed. Learning from these were disseminated to staff and service improvements made where needed.
- We were shown where improvements had been made as a result of patient feedback. For example the service had developed discharge bags to hold discharge information in for patients, and discharges were now discussed during every ward round with the patient and the multi-disciplinary team (MDT).
- The hospital had developed a 'you said, we did' board where it displayed what they had done to improve services following patient feedback.




## Staff engagement

- The hospital staff told us that they were encouraged to come forward with any concerns or with ideas to improve practice.
- The hospital had 'Inspiring People Awards' which were presented to staff who had shown a commitment to improve patient care and experience. Staff nominated their colleagues for these awards.
- Staff attended forums where they were given updates and offered the opportunity to make comments about the hospital and its functions.

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- Staff satisfaction surveys for 2014 showed 74% of consultants and 75% of staff responded with good/very good or agree/strongly agree to the questions in the survey. The staff survey had a 86% response rate, better than the Spire average of 74%.
  - The five highest scored results in the staff survey were 'I believe what I do at work makes a positive difference to my hospital' (92%), 'I get personal satisfaction from the work I do' (91%), 'I can rely on my manager to be there if I need help or support' (89%), 'I feel like I really fit in with the rest of my team' (88%), 'I can rely on colleagues in my team to be there for me if I need help or support' (88%).
  - The five lowest scored results in the staff survey were, 'Other departments understand the impact their actions have on my team' (39%), 'There are sufficient numbers of staff in my team to care for the number of patients we're looking after' (51%), 'Different teams within my hospital work effectively together' (55%), 'I feel appreciated and recognised for my contribution by consultants in my hospital' (57%), 'My team have the equipment and resources we need to do our jobs well (62%).'.
- ### Innovation, improvement and sustainability
- Staff were encouraged to be innovative, however some ideas that staff were highlighting as innovative were practices that had been used in other NHS Trusts and independent hospitals for some time. For example, improvements to patient starve times.
  - The hospital had taken steps to improve areas highlighted as requiring improvement during audit. An audit of all surgical patient operations conducted in September 2014 included data from: surgeons, procedure, anaesthetists, compliance to VTE, chemoprophylaxis prescribing, intraoperative temperature recording and theatre starve times. The results evidenced non-compliance in several areas. However, Q1 2015 results showed improvement and target achievement for all of these measures.
  - The nursing services manager had made improvements to the competency assessments for nurses. They had improved the competencies already in place by adding more practical skills to the assessments.
  - The bariatric nurse specialist had searched for and resourced the wards with a 125ml container as a physical reminder to patients and staff of how much they could consume at each meal time. They had also created a communication tool between themselves and the nursing team to manage bariatric equipment that was required for patients.
  - The breast care specialist nurse was setting up a support group for patients and working to improve documentation.
  - Staff were extremely complimentary about their managers and were all positive about the recent changes in management at the hospital.
  - Staff told us that they enjoyed working at the service and described an open culture us where their managers were accessible and open to ideas. Staff told us that they felt valued by their organisation.

# Services for children and young people

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Not sufficient evidence to rate	
Responsive	Good	
Well-led	Requires improvement	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Spire Gatwick Park provided outpatient services for children and young people aged from birth to 18 years of age. The services include: consultations, venepuncture, plaster cast applications, minor surgery, micro-suction, ECG (electrocardiography), dressings, suture removal, physiotherapy and x-ray examinations.

The hospital provides day case only services for children and young people aged between three and 18 years of age. These were predominately within the ENT (ear, nose and throat) and orthopaedic departments. 157 children between the ages of three to 16 underwent paediatric surgery in 2014. All admissions were for elective surgery with all children and young people screened before admission by a Registered Sick Children's Nurse (RSCN). Children with comorbidities were not accepted for admission.

In 2014 the outpatient department saw 2,944 children. In the past six months seven children between the ages of 10 and 15 received minor surgical interventions in the outpatients department.

The hospital did not have a dedicated children's ward but used the four single rooms nearest to the nursing station and theatres which were allocated as children's beds.

During our inspection we spoke with two patients and their parents, 19 staff including: consultants, senior management team, the clinical lead for paediatrics, senior nurses, nurses, allied health workers, support staff and the peripartetic paediatric nursing service. We looked at case

notes of six day patients and reviewed other documentation such as policies, training records and risk assessments, which related to the care and treatment of children and young people within the hospital.



# Services for children and young people

## Summary of findings

Given the limited service offered, children and young people received good care at Spire Gatwick Park hospital.

At the end of May 2015 the hospital had undertaken a comprehensive review of their paediatric service and had taken appropriate action to ensure children and young people received a safe service. The review was based on evidence-based national guidance and the updated corporate Spire Healthcare paediatric policy. Following the review only children suitable for day surgery were admitted and operations were only carried out in the mornings allowing sufficient time for the child to recover before going home. Prior to the review there had been little local auditing of the paediatric service. This meant there was little information available to enable the service to measure their current clinical effectiveness in order to identify constraints and drive improvements. We found that until recently all responsibility for the appropriate care and treatment of children and young people within the hospital had been delegated to the peripatetic nursing service. Recently a registered children's nurse had been allocated one day a week as children's lead to oversee the service.

The hospital had a service level agreement with a peripatetic paediatric nursing service who undertook all paediatric nursing interventions for day-case patients and provided advice and support for the rest of the hospital. The paediatric nursing service provided sufficient registered children's nurses to staff to the hospital's own policy of one children's nurse to four patients allowing for the nurses to take breaks or leave the ward to collect other children from theatre.

Record keeping, paediatric risk assessments and the documentation of the care children and young people received in the hospital was generally good. However consultants took the outpatient medical records out of the hospital which meant that the hospital did not maintain a complete and comprehensive record of the consultation, care and treatments each child received.

We found that the hospital had an incident reporting system in place however the low numbers of children seen meant that there were few reported incidents. All

the staff and consultants we spoke with were aware of the process for reporting incidents. There were processes in place for investigating incidents and ensuring that any lessons from incidents were disseminated to staff.

Risks to children and young people were assessed, monitored and managed on a day-to-day basis in all departments where they were seen and treated. These included environmental checks, risk assessments, monitoring signs of deteriorating health and managing medical emergencies. The use of paediatric medicines was limited to over the counter analgesic remedies and the use of paediatric drugs in theatre.

The hospital did not provide dedicated areas for children to be seen or to receive treatment. This meant that staff could only make minor adjustments to the environment before children were admitted such as age appropriate bed linen and a paediatric trolley in recovery. There was a small play area in the outpatients' waiting room. The clinical areas where children were seen and treated were all visibly clean with arrangements in place for monitoring cleaning standards. There was hand gel available in all clinical areas and reminders for staff and visitors to use it.

Consultants with paediatric experience in their specialty were in attendance at the hospital when a child was admitted. The paediatric policy called for a RMO (Resident Medical Officer) with recent paediatric experience and relevant qualifications in paediatric resuscitation and safeguarding to always be available. However whilst the hospital restricted the care to day surgery the RMO's services were not usually required. There was effective multidisciplinary working with local GPs although there was little communication with other children's services in the community. The children's lead was developing links with the local children's safeguarding board.

The hospital did not have any means for identifying feedback from parents and children from the generic patient questionnaires offered to all patients on discharge. The two parents we spoke with were complimentary about the service and facilities. Individual preferences and needs were always reflected in how care was delivered. All the staff were committed to providing a friendly, caring and compassionate

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service for children and their parents. More than one member of staff told us “We’re all parents too so we know what it feels like and how we would want to be treated”.

Staff were aware of the organisations vision and values which were prominently displayed throughout the hospital. However the specific vision and values for the children’s services were less clear. The strategic direction for the hospital’s paediatric service was dependent on the outcome of the recent paediatric review which was linked into an organisational review of paediatric policies, procedures and standard operating practices to ensure compliance with national guidance, legislation and recognised best practice. The strategic review of children’s services was driven by quality and safety and took into account the requirement for the service to be fiscally viable.

The organisation had recently reviewed and simplified the governance arrangements. Paediatric compliance was acknowledged as a risk on the hospitals Risk Register.

All staff reported good management support from their line managers. The majority of staff we spoke with had received children’s safeguarding training and nursing staff had undertaken basic paediatric life support training. However apart from the physiotherapy and radiology service they had not undertaken specific training, education or guidance on caring for children. They told us that the peripatetic service did everything for the children and there was no need for any intervention from the hospital’s own staff.

## Are services for children and young people safe?

Requires improvement 

We found that some of the safety aspects of the care provided to children and young people at Spire Gatwick Park Hospital required improvement.

The records of children who had been admitted as day case patients were completed appropriately. However the medical records for children and young people seen in outpatients were not readily available as they remained the property of the consultant and were taken off the premises. This meant that the hospital did not have an effective system in place to securely maintain a complete record for each child attending the hospital as outpatients. The hospital had no record of the medical decisions and discussions with the patient, and no confirmation that the records were stored or kept secure once they left the premises or that patient confidentiality was maintained.

When children were admitted to the hospital there were sufficient suitably trained registered children’s nurses available on the ward. The hospital used a peripatetic paediatric nursing service to undertake all of the ward based nursing activities for their paediatric inpatient day cases. The service also offered advice and support to other areas in the hospital where children were seen and treated such as outpatients. However there were few staff with certified paediatric competencies available in the hospital to support the care and treatment of children in the outpatient department when the peripatetic paediatric nursing service was not present.

### Incidents

- The hospital had in place policies and procedures for dealing with untoward incidents. The policies were readily available for staff to access on the hospital’s intranet.
- However we noted that the reporting mechanism was complex with staff filling in paper copies and only designated staff having access to the electronic reporting system. This meant there was a risk of duplication, delay in inputting or issues being missed or not escalated appropriately.

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- Between January 2014 and December 2015 there had been no 'never events' or reports of serious incidents that involved children or young people. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Since January 2015 there had been two reported incidents that occurred in the outpatients department that related to children or young people. There were no themes identified.
- We spoke with consultants, nurses, ancillary staff and allied healthcare professionals; they told us they would have no hesitation in reporting incidents and gave examples where issues had been reported and action taken as a result. For example a member of the reception staff had injured themselves on the swing doors of theatre. They told us that it was reported and by the time they came on duty the next day a sign had been put in place warning staff about the doors. Staff told us that any learning from incidents was disseminated through briefings, team meetings, emails and newsletters.
- We were told that any issue relating to mortality and morbidity would be fed into the hospital's Clinical Governance meetings. However due to the low volume of children and young people seen and treated in the hospital and the process for screening out children with co-morbidities prior to admission, there had been no reported cases of child mortality occurring in the hospital. Therefore child mortality reviews would take place by exception.

## Cleanliness, infection control and hygiene

- Spire Gatwick Park Hospital had policies and procedures in place to manage infection control. This included infection prevention, decontamination and waste disposal. The policies were readily available on the hospital's intranet and the peripatetic paediatric service had access to the policies if needed.
- There were systems in place to monitor infection prevention and control within the hospital. We saw from clinical governance minutes that infection control issues were discussed and actions agreed and reviewed. For example in July 2014 the results of a staff hand hygiene audit, housekeeping infection control and sterile supply services audits were discussed together with any action plans. There was no child specific information or infection prevention and control audits available.
- The de-contamination service was compliant with best practice overall. However, an audit undertaken in February 2015 identified that a number of corrective actions were required. We saw there was an action plan in place to address the issues and provide new autoclaves in the sterile services department.
- There were no reported infections involving children or young people over the past 12 months. This indicated that the hospital's policies and procedures for managing infection control were effective.
- All public areas of the hospital including the wards, outpatients and theatres were visibly clean and tidy. We noted that many of the clinical areas were carpeted which made cleaning problematical and was therefore an infection control hazard.
- Cleaning checklists were in place throughout the hospital. This provided assurance that all areas were maintained and cleaned appropriately on a regular basis.
- We saw that toys in the children's play area in outpatients were easy to clean. A check list was in place to ensure that the toys were thoroughly cleaned each week. However in the X-Ray department there were soft toys available to distract younger children when they were undergoing investigations. There were no systems in place to ensure these were regularly cleaned or replaced.
- We noted that the areas not accessed by patients such as the clinical treatment rooms, linen cupboards and sluice areas were also kept clean and tidy. For example the surfaces in the treatment rooms were kept clear of clutter and in the linen cupboards floors were kept clear to make cleaning easier and prevent contamination. Clinical waste was appropriately bagged, labelled, stored and disposed of through an approved waste collector.
- During our inspection we noted hand sanitizer gel was in place at the entrance to clinical areas, outpatients and on the wards. We observed staff complying with the

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hospital's infection control policies such as hand hygiene, the use of personal protective equipment such as aprons and gloves and following the bare below the elbow policy.

- Throughout the hospital the general environment was in good repair which reduced the risks of infection. Children were accommodated in single rooms each furnished with their own en-suite facilities and wash hand basins. Dispensers for disinfectant soap and paper hand towels were available by each hand washing basin. This meant there were less opportunities for cross contamination.
- 95% of all staff had completed training in infection control in 2014 this included the peripatetic paediatric nursing service.

## Environment and equipment

- The hospital did not have dedicated facilities to see and treat children.
- On the day case ward, the four beds closest to the nursing station and theatre were allocated for the use of children and young people. We were told that when children's admissions were planned, the housekeeping staff changed bedding with age appropriate duvets and provided a soft toy.
- There were no arrangements in place to prevent unauthorized access. We were told that parents usually stayed with the child for the duration of their stay on the ward. The peripatetic paediatric nursing team monitored the four allocated bedrooms. Guidance for staff on the security of children whilst in the hospital was included in the updated corporate paediatric policy.
- There was not an identified paediatric area in theatres although theatre staff told us that they tried to use the first bay and had a paediatric specific trolley.
- There were two paediatric resuscitation kits, one in outpatients and one on the day care ward. We saw evidence that the resuscitation equipment was age specific and regularly checked according to the hospital's policy. Theatres had their own paediatric resuscitation equipment.

- We spoke with anaesthetists and consultants who told us there was suitable and sufficient equipment available in theatres to support the type of surgery undertaken. They told us about new equipment that was available for children's ear surgery.
- The hospital told us that a number of areas required investment to ensure a positive patient experience and staff working environment. For example, the outpatient consulting room capacity was a challenge at times with busy clinics taking place across two different hospital areas. Storage was acknowledged to be a concern particularly in theatres. Improvements to these areas had been included in the hospital's renovation plan with a refurbishment budget agreed.

## Medicines

- The hospital had a Medicines Management Committee that met bi-monthly to discuss drug related incidents, medicine management policies, drug audits and drug alerts. An action log was kept of actions to be undertaken. We noted there were no issues relating to medication management of children and young people in the copies of minutes we reviewed.
- The local policy for the children and adolescent service included guidance for staff on paediatric medicines management.
- The hospital had various medicines management policies. The paediatric pain management policy and the children and adolescent service policy included guidance for staff on drug administration for children and young people.
- We were told that because of the limited paediatric service very few paediatric medicines were required or administered by staff on the ward. We spoke with the pharmacist who told us that only over the counter analgesia and antibiotics were dispensed from the pharmacy.
- The pharmacy was open 09:00 to 17:00 Monday to Friday with pharmacy staff working on the ward between 08:00 and 09:00, and 09:00 to Midday on Saturday. Outside of these times there was an on-call pharmacy service.
- On the day of our inspection there were no children admitted as day cases and no opportunity to observe

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paediatric medication administration. However we reviewed the medication charts from previous admissions and found drug administration to be well documented.

- The consultants we spoke with told us that the consultant or the anaesthetist would prescribe any medication such as analgesia. This would then be checked and administered by the registered children's nurse who would raise any queries around dose or administration directly with the consultant.
- Consultants told us that intravenous fluids would very rarely be given because of the low risk nature of the surgery undertaken and the short time children were under anaesthetic. One consultant gave the example of a child having their tonsils removed who would be under anaesthetic for 15 minutes and drinking fluids as soon as they had recovered and were back on the ward.

## Records

- All patients who paid for their treatment themselves or through insurance had full medical records available onsite for a period of three months post operation. After this period, notes could be retrieved from the Spire secure storage facility within 24 hours.
- For patients who received their care funded by the NHS, full medical records were available both on the wards and in outpatients.
- We were told that any child seen by the nurses in outpatients for a dressing, plaster cast or removal of sutures (stitches) had medical records available. If for any reason the records were not available, a risk assessment was carried out on the safety of proceeding without notes. The outpatient appointment may be delayed or postponed to ensure the treatment was safe.
- However, in the outpatients department we were told that consultants held their own notes, either electronic or in hardcopy for all private patients and were permitted to take the hospital's medical records offsite. The terms and conditions under which consultants provided services at the hospital required them to make their outpatient notes available to the hospital on request. If medical notes needed to be reviewed by the hospital, they were done so on the premises.
- We were told that the consultant's own outpatient notes were the responsibility of the consultant, and that any electronic notes they kept were encrypted and password protected. Consultants were advised to register with the ICO (Information Commissioner's Office).
- However this meant that the hospital did not have arrangements in place for full control over the outpatient notes recorded by consultants. The outpatient notes did not form part of the patient's hospital record, and once they were removed off site were only accessible to the consultant unless a formal request were sent by the hospital.
- The hospital could not demonstrate that they maintained and held securely an accurate, complete and contemporaneous record in respect of each child or young person; which included a record of the care and treatment provided to the child and of any decisions taken in relation to the care and treatment provided. On occasions minor surgical procedures were undertaken on children in outpatients. Records include a risk assessment and consent form as well as the procedure documented on the surgical register kept in the clinic room.
- The hospital could not verify what circumstances the medical records were transported, stored or kept once the consultant left the premises to ensure they were kept secure and confidentiality was maintained.
- Consultants we spoke with told us that duplicate records could be made and sent to the GP, the patient and the hospital with the consultant keeping the original. They told us that electronic records could be viewed but not sent because of the different systems used in the NHS and private sector.
- We checked the records of six children and young people who had been admitted over the past two weeks. We found that the hospital used a paediatric day case pathway, which started with the admission assessment and ended with the patient's discharge. The forms included assessments, observations, investigations, risk assessments, checklists and documented the journey of the child through the surgical procedure. Also in use were pre-admission medical questionnaires, paediatric early warning system (PEWS), consent and medication charts.
- We looked at the pre-assessment information and saw that any tests and investigations undertaken were

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clearly documented with the child's medical and social history recorded prior to them being admitted for surgery. Risk assessments were available and completed during pre-assessment and then followed up on the ward. Each of the six care records we reviewed on the day care ward was well completed.

- We did not see any evidence that paediatric records had been audited to monitor they were consistently completed appropriately.
- The surgical sections of the records we examined were fully completed and included completed a checklist similar to the World Health Organization (WHO) surgical safety checklists.

## Safeguarding

- The hospital had a policy relating to safeguarding children and young people that was readily available and accessible to all staff, including the peripatetic paediatric nursing team. The policy referred to national guidance and best practice processes. Safeguarding children was also included in the updated corporate paediatric policy.
- The updated paediatric policy stated that no child or young person must be examined by a doctor or practitioner unless a chaperone was present. This was in addition to the parent or legal guardian in order to protect both children and staff.
- Over the past year CQC had not received any formal notification from the provider of any safeguarding allegations of incidents involving children or young people.
- We spoke with the Children's Lead and the Matron who were both new in post. As the safeguarding lead for the hospital, they told us they intended making contact and developing links with the local authority children's safeguarding lead.
- The hospital provided data that indicated 97.1% of all staff had completed relevant child protection training in 2014. All staff undertook level one training with those who had direct contact with children or specific paediatric responsibilities undertaking level two and three training.
- Staff told us that child protection training was included in their mandatory training confirmed this, and the

different levels related to whether they had direct contact with children. They described the referral process for alleged or suspected child abuse and knew how to access support in dealing with a referral. Consultants told us that they had undertaken level three children's safeguarding and would have no problem in raising concerns with the Matron and local safeguarding leads. We heard that consultants who were paediatric leads for the hospital also undertook this role in the NHS.

- There was evidence available to verify that all consultants who saw and treated children in the hospital had undergone recent appropriate safeguarding training.
- The staff from the peripatetic paediatric nursing service supplied the hospital with details of their current children's safeguarding training.

## Mandatory training

- The Matron, Children's Lead and the staff we spoke with on the wards and in outpatients confirmed that mandatory training was available and that staff were actively encouraged to complete it with the training monitored through staff appraisals.
- Over 95.7% of all staff had completed their mandatory training during 2014, with nursing, pharmacy and radiology staff consistently performing lower than the other staff groups.
- Staff from the peripatetic paediatric nursing service were not included in the hospital's mandatory training programme. They supplied certificates and documentary evidence confirming they remained current in paediatric nursing issues, as well as more general training requirements such as Manual Handling, Fire Safety, Health and Safety and Infection.
- We spoke with ancillary and administrative staff who confirmed they attended all the mandatory training in addition to role specific training such as customer care and computer skills. They told us that although they had not received any specific training on caring for children they knew how to talk to children and would contact their manager or the peripatetic paediatric nursing service if there was a problem.

## Assessing and responding to patient risk

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- The hospital did not have the facilities to manage children or young people under the age of 16 who required overnight care or critical care support. The updated corporate paediatric policy included admissions guidance that set out the agreed criteria for the admission of children.
- We were told that all children were admitted under the care of a consultant and were assessed by the peripatetic paediatric nursing service on an individual basis to ensure the hospital could meet their needs. This demonstrated that the hospital carefully screened children during the pre-admission consultation to exclude operating on any child assessed as a surgical risk.
- We were told that should a child's condition deteriorate they were transferred as an emergency to the nearest NHS hospital. The hospital had appropriate agreements in place to transfer an unwell child or to arrange retrieval by a specialist NHS children's unit. One consultant we spoke with confirmed that any emergency such as secondary bleeding would go to the local NHS trust. They confirmed that the local NHS hospital would let them know if a child arrived in the emergency department as they maintained an NHS practice in the local hospital and were in close contact with the emergency department.
- We saw that the hospital used a paediatric early warning system (PEWS) to alert them should a child's condition start to deteriorate. In the records we reviewed the PEWS record had been completed appropriately. The chart gave staff directions for escalation and the action to take. There were different PEWS charts for the differing age ranges for example from 18 months to eight years and from nine to 15 years upwards. We saw that the PEWS were completed on admission and then at planned frequencies during the child's stay. There was no evidence of auditing of the PEWS scores and the actions taken.
- The hospital had in place a resuscitation policy on dealing with paediatric emergencies and sufficient trained staff onsite at all times when children were being treated or visiting the outpatient department.
- We noted that following discharge home the child or their parents were contacted by the peripatetic nursing

service to ensure they were recovering as expected. They were given emergency contact details of the consultant, the local NHS and the peripatetic nursing service if needed.

- We noted that the provision of paediatric services was on the hospital's clinical risk register. The risk register noted that there was new guidance published on the care of children in the independent sector, which the hospital may not be compliant with. In response to the risk, the hospital had conducted a review of the paediatric service and established a paediatric review group to have an overview of the children and young people's service.
- There was a range of paediatric risk assessments in place for the various procedures and treatments offered to children.

## Nursing staffing

- The hospital used a peripatetic paediatric nursing service to undertake all ward based nursing activities for their paediatric inpatient day cases. This service provided a minimum of two registered children's nurses for the children's surgical list and had an agreement to treat between four and 10 children each session. However, we were told that in reality there were rarely more than four children in the day care ward at any one time.
- We noted that the updated corporate paediatric policy advocated two children's nurses to be on duty when children were admitted. The policy required the department to carry out a risk assessment when there was only one registered children's nurse on duty during a paediatric operating list. The policy stipulated that the risk assessment should consider the need for a second children's nurse or adult nurse with paediatric competencies to cover when the children's nurse left the ward to collect a child from theatre or took a break.
- Both the Matron and the children's lead nurse told us that any children's list was carefully planned and coordinated with the peripatetic paediatric nursing service to ensure there would be adequate registered children's nurses available for the type of surgery being undertaken.
- The service level agreement between Spire Gatwick Park and the peripatetic paediatric nursing service stipulated

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that the services provided would include pre-admission screening, orientation to the ward for children less than 12 years, in-patient care, and discharge and follow up support offered by telephone.

- Paediatric-trained staff such as registered children's nurses were not on duty in the outpatients department when children were being seen. Staff told us that the paediatric nursing service supported them if they were undertaking minor operations in outpatients on children less than 12 years.
- Hospital staff and consultants praised the peripatetic paediatric nursing service. They told us the company offered a good service and they were always available for telephone advice and support. Consultants told us they were 'Excellent', '[the peripatetic service manager] knows about everything from pain control to risk management'.
- We saw from the minor operations surgical register kept in outpatients that the paediatric service had attended twice to support children having minor procedures in the past six months. There were no occasions recorded where children under 12 had not been attended by a registered children's nurse when having a minor procedure in outpatients.
- There were no staff in theatre with a children's nursing qualification or certified paediatric competencies. We spoke with a member of theatre staff who acknowledged that none of the theatre staff had undertaken paediatric training but told us "we are all parents or grandparents and know how to look after children". However this did not provide assurance that all staff treating or caring for children and young people in theatre and recovery had appropriate training regularly updated in caring for children. Although clinicians and theatre staff had resuscitation, safeguarding and technical skills, this did not include the personal and communication skills necessary to treat children and their parents properly (National Service Framework for Children 2004).
- The role of the MAC included periodically reviewing existing practicing privileges and advising the hospital on their continuation. The hospital had a paediatric lead consultant who was also the paediatric safeguarding lead at the local NHS trust.
- The hospital provided a list of 68 consultants with practicing privileges at the hospital who had applied to see and treat children. Not all of these maintained an active children and young persons' practice at the hospital. The children's lead agreed that the register required updating.
- We were told that the Radiologist was the paediatric lead at the local hospital and where possible received the paediatric referrals for X Rays at Spire Gatwick Park Hospital.
- There was a RMO (Registered medical officer) site throughout the day and night including weekdays and weekends. However, the consultants told us that although the RMO was always on site, in practice they did not see or treat any of the children. This was because the children were only ever seen as day patients or in the outpatients when they would be under the sole care of the admitting consultant or the anaesthetists.
- Both the Matron and the consultants we spoke with told us that the anaesthetists who saw and treated the children also had substantial NHS paediatric experience and qualifications.
- The consultants provided 24-hour on-call (off site) cover for their patients. If they were unavailable at any time they organised a consultant colleague with admitting rights to provide cover in their absence.
- However in practice there was little requirement for the consultants to provide out of hours and weekend paediatric cover as all the children were seen and treated as day patients and the consultants would not leave the hospital until the last child was discharged home. The operation lists were planned to take place in the morning to allow ample time for each child to recover from their surgery and be discharged home. The consultants told us that the patient and/or their parents were given the consultants contact details together with telephone numbers of who and where to contact if there were any concerns.

## Medical staffing

- The hospital maintained a Medical Advisory Committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if deemed competent and safe to do so.



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- The hospital's weekly on call rota included the senior management team, clinical nurse, theatre staff, pathology, pharmacy, imaging, physiotherapy and maintenance. The hospital operated a two tier clinical/management on-call system with a clinical nurse on-call together with an on-call member of the Senior Management Team.

## Major incident awareness and training

- The hospital had major incident and business continuity plans in place.
- Staff told us how scenario training was undertaken where procedures for major incidents such as fire were tested. They gave examples of practicing evacuations in theatre and on the wards. However, it was not clear from our discussions with staff and managers if the peripatetic paediatric nursing service was included in major incident awareness training such as evacuation and fire training to ensure they were aware of the appropriate local protocols.
- The hospital had in place policies and protocols for the emergency transfer of children to the local NHS hospital in the case of complications that required level two or more critical care. We noted there had been no emergency transfers of children in the past year.

## Are services for children and young people effective?

Requires improvement



Spire Gatwick Park Hospital had a range of policies and guidance to support staff when caring for children and young people. The paediatric policy had recently been reviewed and was based on legislation and best practice guidance. All staff caring for children and young people had access to the policies and local guidelines on the hospital's intranet.

Although consultants and staff told us about the positive outcomes for children who received care and treatment in the hospital, there were no systems in place to formally obtain data and monitor their outcomes. The only information collected was around incidents and complaints did not provide the hospital with data on the clinical effectiveness of any intervention.

There were systems in place to effectively manage children's pain control. Children and young people were supported to maintain adequate nutrition and hydration while in hospital.

Although throughout the hospital, staff worked collaboratively to promote the health and well-being of children and young people, there was a great reliance and delegated responsibility put on the peripatetic paediatric service. Apart from mandatory training and specific training undertaken by staff in the radiography and physiotherapy departments staff had not undertaken any further training, development or qualifications in the care and support of children. Consultants working with children at the hospital were required to demonstrate their competence and experience in treating children under their practising privileges agreement.

There were systems and process in place to ensure that appropriate consent was obtained before any child or young person received care and treatment at the hospital, however there was little information readily available in child friendly formats to explain the care and treatment the child was likely to experience.

The hospital did not always have ready access to patients' medical notes. This was because the consultants held their own outpatient notes, either electronically or in hard copy for all private patients, and took them away with them. This meant that the hospital did not always have immediate access to the decisions or discussion that took place during medical consultations at the hospital.

## Evidence-based care and treatment

- The hospital had in place a range of paediatric policies and procedures, which were supplied by the Spire corporate provider. The policies, procedures and protocols were based on the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) guidelines. Both the Spire hospital staff and the staff from the peripatetic paediatric nursing service had access to the policies and local guidelines on the hospital's intranet.
- The Spire Healthcare National Clinical Governance Committee undertook quarterly reviews of new legislation, best practice guidance and advice from the Royal Colleges. We were told that the corporate paediatric policy had been revised following new guidance from the Association of Independent

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Healthcare Organisations Guidance (AIHO) 'Clinical Guidance on the Care of Children in Independent Hospitals', published in May 2015. Spire Gatwick Park Hospital was in the process of assessing the service they offered in relation to these revised paediatric standards.

- Staff were informed of any revised guidelines and updates to current practice through monthly bulletins and email updates.
- A lead registered children's nurse had been appointed a month before the inspection to work one day a week. The lead registered children's nurse was responsible for ensuring the paediatric policies and protocols were evidence-based, child and family centred, however the full review of paediatric policies had not yet taken place.
- We spoke with the lead children's nurse and the Matron who confirmed the current arrangements in place for caring for children under the age of 18 in the hospital.
- As a result of the review of paediatric services the hospital had set up a Paediatric Group which fed directly into the Clinical Governance Committee. The first meeting had been held in March 2015 where the review of the paediatric service was discussed together with the actions taken to date on ensuring compliance with current best practice. We noted that the manager from the peripatetic paediatric service was part of the Paediatric Group and had an input into the development of the service.
- The service level agreement with the peripatetic paediatric service stipulated that the care of children would be provided in line with current legislation, established medical practice or medical guidelines.

## Pain relief

- The hospital had in place an appropriate policy for the management of pain in children. However we noted that other policies such as the 'Management of Medicines' and 'Intravenous Fluids' policies, referred to children or young people but then referred staff back to the 'Children's Pain' policy and the 'Children and Adolescent Services' policy.
- Drugs other than analgesia were administered to children such as antibiotics.

- We observed that a pain assessment chart was embedded in the paediatric day surgery care pathway. The pain assessment tool used 'smiley faces' where the child was asked to choose a face that best described their own pain.
- Pain was monitored through surgery to post discharge when a child or their parents were asked if the child had good post discharge pain control. We were told that the analgesia generally used was over the counter children's analgesia, which parents were encouraged to purchase prior to admission.
- We were told the consultant and the anaesthetists were always available in the hospital following surgery should there be any issue with pain management prior to discharge.

## Nutrition and hydration

- The child day care pathway included a brief query as to any nutritional or dietary requirements. A full nutritional assessment was not usually carried out for day care patients.
- The hospital provided an appropriate menu for all in-patient children and young people. The menu included a choice of food with any special dietary requirements catered for. We saw a sample of the children's menu, although in reality staff told us that children could order what they liked. This was confirmed by talking with the chef who gave examples of the food he had made to order, such as peanut butter and jam sandwiches.
- The menu card was given to children to select their choices in the morning, hot meals were served twice a day. Drinks, sandwiches and snack boxes were also available throughout the day.
- The hospital had a five star rating in the local authority 'Food Hygiene Certification Scheme'. This gave assurance that all best practice in food hygiene standards were adhered to.
- Although pre-operative fasting times were a concern for adult patients, this was not an issue for children because they were always seen first on operating lists.
- This demonstrated that children and young people were supported to maintain adequate nutrition and hydration while in hospital.

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## Patient outcomes

- There was little available data on the outcomes for children and young people following surgical interventions at the hospital.
  - We spoke with consultants who saw and treated children in the hospital. They told us that they carefully screened patients to exclude those with co-morbidities or any contra-indications. As a result they did not have unplanned transfers or re-admissions.
  - As a private hospital, Spire Gatwick Park Hospital did not participate in the majority of national audits undertaken by the NHS. The service told us that although the surgical audit data was not reported formally Spire Healthcare collected data through the clinical incident reporting system. Little of the data collected related to the care and treatment of children and young people specifically.
  - The information from the past year showed there were no unplanned returns to theatre, with four planned re-admissions within 29 days of discharge. The available data indicated that the hospital was either similar or better than expected when compared with other hospitals offering a similar service. This included re-admission rates, returns to theatre and unplanned transfers to other hospitals. This indicated that in general patients received treatment and support that achieved good outcomes. However, this information related to surgical interventions as a whole, rather than specifically children and young people.
  - A generic child day care pathway covered all surgical interventions on children and young people.
  - We case-tracked six children's care plans on the day care ward and found appropriate care and treatment had been provided for the patients.
- We spoke with staff both individually and in groups and they told us that Spire Gatwick Park Hospital supported them with their learning needs. We spoke with ancillary and administrative staff and they told us they received the training and supervision necessary for them to do their job such as customer care in addition to the mandatory training for all staff.
  - We heard individual stories of staff undertaking further development with the support of the hospital such as developmental and vocational courses. For example, a physiotherapist told us of a specific course on treating children they had attended. They told us they then disseminated the learning from this course to the other physiotherapists during team meetings and training sessions.
  - However, there was little specific training or education for staff in the care of children and young people. The hospital relied heavily on the peripatetic paediatric nursing service to provide all specialist care, treatment and advice.
  - We spoke with the lead nurse from the peripatetic paediatric nursing service who told us that several study days had been arranged for the staff at Spire Gatwick Park such as consent and Gillick Competencies. However these were not documented in the training records we saw.
  - On the day care ward staff told us they had nothing to do with the care and treatment of children on the ward. They told us that the paediatric service undertook all interventions with the children. One staff member told us "I might direct them [Children and their parents] to the ward but that's about it". Staff on the wards did not feel that they needed any specialist training in the care of children, as this did not form part of their work.
  - In outpatients we were told that all staff had completed the mandatory child protection training and basic life support training. The qualified nurses undertook Paediatric Intermediate Life Support training but did not have any additional training or competencies in the care and treatment of children. When invasive paediatric interventions took place a paediatric nurse was available through the peripatetic paediatric nursing service.

## Competent staff

- The hospital provided opportunities for staff induction, learning development and appraisal. The hospital used computerised learning to provide much of their mandatory training. This was supplemented with face to face learning especially where practical skills were indicated such as resuscitation training. Staff told us the e-learning training included a quiz at the end of each module which "Makes you think".

# Services for children and young people

- The consultants in outpatients were not always assisted by a paediatric trained nurse if the child was over 12 years of age and the interventions were considered non-invasive or were consultant led.
- The updated Spire paediatric policy stipulated that staff with the relevant paediatric competencies must care for young people who choose an adult care pathway.
- Apart from the peripatetic paediatric nursing service, there was only one nurse in the hospital who had undertaken paediatric competencies, which was not certificated. The Spire Healthcare corporate paediatric competencies were available on-line. Senior outpatient staff told us that the intention was to put all staff through, although this had not happened to date.
- For young people aged 12 and over this meant that a registered sick children's nurse may not always be present during interventional procedures. Interventional procedures were defined as minor operations or invasive examinations that may be carried out in the outpatient, physiotherapy or diagnostic imaging departments. Such procedures were subject to a risk assessment and the involvement of the child's parents where appropriate. The peripatetic paediatric nursing service was available by telephone for advice if required.
- Some of the staff working in other areas of the hospital where children were treated, such as the radiology and physiotherapy departments had undertaken specific training in relevant therapeutic paediatric interventions.
- Nursing staff in outpatients told us that if there were any concerns about the care of children they would contact the peripatetic paediatric nursing service for advice. They told us they always received a prompt response and the company offered a very good and supportive service.
- The peripatetic nursing service provided the hospital with details of their training and qualifications. These were kept on file and demonstrated that the registered children's nurses working for the company were qualified and experienced to look after and care for children and young people.
- The company also undertook supervision and appraisal of their staff and periodically asked the hospital for confirmation that their staff were operating to a satisfactory level in the form of a 360 appraisal.
- For the hospital's own staff, Spire healthcare had an appraisal system called 'Enabling Excellence' that was underpinned by the corporate Spire behaviours. The object was to ensure that the patient's experience and customer service was a top priority for all staff.
- We noted there was little opportunity for formal clinical supervision however all the staff we spoke with told us they now felt well supported. Team meetings were held on a regular basis and staff told us they felt able to contribute where necessary.
- The role of the MAC (Medical Advisory Committee) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. We spoke with the Chair of the MAC and reviewed the practicing privileges documentation. We heard how the MAC was responsible for undertaking routine reviews of each clinician's practicing privileges which included reviewing the clinicians whole practice appraisal, incidents, general activity and complaint data.
- All consultants who wished have paediatric admitting rights were required to submit details of their relevant NHS paediatric practice together with current EPLS (European Paediatric Life Support) and level two safeguarding training.
- The hospital's policy was for every consultant to have an up to date and valid appraisal at the NHS trust they worked for in order to retain practicing privileges at Spire Gatwick Park Hospital. Any issues within their trust would be communicated to the hospital by the CEO of the trust or the Medical Director.
- As part of the appraisal process for the NHS trust, each consultant completed an annual transfer of information form from Spire Gatwick Park Hospital. This detailed any conduct or capability issues, serious untoward incident or significant event investigation, any complaints or referral to GMC. For consultants who did not work within the NHS any communication was with their responsible officer at their main place of work.

# Services for children and young people

- There were few consultants working with children at the hospital who did not also work in the NHS. We were told that Spire Healthcare had arrangements in place to ensure their practice was reviewed in line with their governing body's revalidation requirements.
- Outside of the annual appraisal process, meetings took place with the local NHS trust where any issues or concerns with a consultants practice would be discussed and actions agreed.

## Multidisciplinary working

- We found throughout the hospital, the staff delegated the care, treatment and well-being of children to the peripatetic paediatric nursing service. When questioned, staff all told us that the care of children in the hospital was directed through this service.
  - We spoke with the manager of the peripatetic paediatric nursing service and he told us that he worked closely with the theatre staff, surgeons and nursing staff to promote safe care and treatment of children in the hospital. He was part of the newly formed Children's Group and was working with the children's lead and Matron to implement the paediatric action plan.
  - We saw that the newly formed Paediatric Group included representation from across the hospital from all the departments that saw and treated children for example physiotherapy, radiology and outpatients.
  - We looked at the treatment records for six children who had recently had surgery. The records contained details of all multi-disciplinary input, which included the medical, nursing and anaesthetic teams and recovery input.
  - The hospital told us that there were strong GP relationships supported by the GP education programme. The hospital told us they had a positive and proactive relationship with the local NHS trust and the nearest CCGs (Clinical Commissioning Groups). However we did not see any evidence that related to the care and treatment of children or young people.
- The hospital maintained a seven day service with an on call rota for the pharmacy, radiology and physiotherapy teams out of hours. The RMO was available on site 24 hours a day, seven days a week and was always available throughout this period on a bleep system.
  - Consultants provided 24-hour on-call (off site) cover for their patients. If they were unavailable at any time, they organised a consultant colleague with admitting rights to provide cover in their absence. However, children and young people were only accepted as day case patients therefore overnight arrangements were not generally needed.
  - Consultants we spoke with told us that families were given their contact details, as well as the hospitals, the local emergency department and the peripatetic paediatric nursing service.
  - We were told that the X-ray services ran from 08:00 to 20:00, or the end of the outpatient clinics from Monday-Friday. On Saturday, a radiographer covered outpatient clinics and theatre as required. There was an on-call service outside these hours. The scanning department ran between 09:00 to 17:00 Monday to Friday, with the MRI scan services operating between 07:30 to 21:30 Monday to Friday; and 09:00 to 17:00 Saturday, with Sunday services if required.
  - The pathology operated between 08:30 to 17:30 Monday to Friday; 09:00 to 13:00 on Saturdays, with an on-call service outside these hours.
  - The theatres operated from 08:00 to 21:00 Monday to Friday; 08:00 to 16:00 Saturday, with an on-call service outside these hours.

## Access to information

- The hospital and nursing staff had access to the medical records of all patients who paid for their own treatment or through insurance for a period of three months post operation. After this period the notes were able to be retrieved from the Spire secure storage facility within 24 hours.
- For NHS funded patients full medical records were available in outpatients for all their clinic appointments.
- However consultants held their own outpatient notes, either electronically or in hard copy for all private patients. The hospital only had access to these

## Seven-day services

# Services for children and young people

documents on request. If for any reason the records were not available, a risk assessment was carried out on the safety of proceeding without notes and the appointment may have been delayed or postponed. The terms and conditions under which consultants provided services at the hospital required them to make their outpatient notes available to the hospital on request. This meant that the outpatient medical records were only accessible to the consultant; the hospital did not have immediate access to the decisions or discussions that took place during medical consultations at the hospital.

- The hospital sent us treatment literature they told us was given to children and their parents. This information was not readily available at the hospital during the inspection. We noted that the information was mostly generic in nature and apart from the Hospital Stay sheet, not child focussed. The information leaflet about day case admissions included the contact details of the lead children's nurse and the peripatetic paediatric service manager.
- There was information about children's services on the hospital's website. This was aimed at providing information to parents regarding procedures, costs and methods of payment. The hospital was transparent in the information provided about the cost of any intervention. We noted that the information on costs included a breakdown of the charges for example, the hospital's fees, consultants fees, diagnostic and discharge costs. A contact number was supplied for further information if required. This provided parents with adequate information about the likely cost of any procedure or consultation.

## Consent

- The hospital had in place the Spire Healthcare consent policy that met current best practice guidelines issued by the Department of Health.
- The policy was readily available for staff to access and included guidelines for treating children and young people who may be unable to consent to investigations or treatment.
- Staff we spoke with in theatres, outpatients, radiotherapy and physiotherapy were aware of the policy and the correct procedures to ensure patients

gave valid consent prior to any treatment or surgical intervention. In outpatients, staff told us that children signed the consent form alongside their parents, where they were deemed competent and wished to do so.

- All hospital staff received training on the Mental Capacity Act (2005) as part of mandatory training. It could not be verified that the staff from the peripatetic paediatric nursing service had undertaken similar training as the Mental Capacity Act (2005) applies to young people aged 16 and over.
- We looked at the recording of consent for six children and young people who had recently undergone surgery in the day care ward at the hospital. We found that consent had been appropriately recorded and included details of the conversations the consultant had with patients and their parents.
- Audits of consent had not been undertaken in order to monitor that consent was always appropriately documented.

## Are services for children and young people caring?

Not sufficient evidence to rate

We were unable to make a judgement for this element of the report, as the hospital did not have any means of separating the feedback from children or their parents from the general patient feedback. Although the service was in the process of implementing age specific patient feedback questionnaires, this had not started and there was no separate data available to support whether the service offered compassionate care to children and young people.

There were no children or young people attending the hospital for surgery and only two attending as outpatients during our inspection. We could not ascertain from the generic patient feedback information if any of the comments or data related to children or young people. We found one testimonial on the hospital's website from a parent who had attended the hospital with their young child.

Throughout the hospital, staff spoke positively about the caring staff from the peripatetic paediatric nursing service. We heard how the hospital facilitated children attending

# Services for children and young people

the hospital prior to any surgical intervention. Staff from the peripatetic paediatric nursing service attended the hospital to show children around the day care ward and hospital. We were told that a room would be set up as if for a child's admission and the paediatric nurse spent time talking with the child and their parents answering questions and allaying fears.

## Compassionate care

- During our inspection there were no children attending the hospital for surgical interventions and only two children who attended as outpatients. We spoke with their parents who told us that they had no problems with the outpatient service, and had found the consultant very approachable.
- We were unable to observe any interactions between staff and children or young people.
- The hospital staff we spoke with talked positively about the care given by the peripatetic paediatric nursing service. One consultant told us that the children were always disappointed at their outpatient follow up when the paediatric nurses were not there.
- Children and young people were cared for in single en-suite rooms that ensured their privacy and dignity.
- In radiology and physiotherapy, the staff told us of the measures they took to reassure children and their parents such as allowing parents to sit with the child during x ray procedures and taking extra time to explain treatments etc.
- Spire Gatwick Park did not have any means of separating the feedback from children or their parents from the general patient feedback. Although the service was in the process of implementing age specific patient feedback questionnaires, this had not started and there was no separate data available to show the service offered compassionate care to children and young people.

## Understanding and involvement of patients and those close to them

- There was no feedback available to confirm that the children, young people and their parents felt involved in their care and decision making, or that they were well informed before they signed the consent form for surgery and other treatment.

- Although there were no child specific information leaflets available in the reception, in outpatients and on the wards we were told all children were provided with a booklet on admission regarding their stay in the hospital which was age appropriate.
- Patients' satisfaction survey questionnaires were not age specific and therefore could not be used to improve the children's service.

## Emotional support

- We were told that the peripatetic paediatric nursing service offered emotional support to children and their parents from the pre-operative assessment through to the discharge follow up phone call.
- We looked at the records of six children who had recently undergone surgery at the hospital. The records did not include information to provide assurance that patients were supported emotionally through their surgical treatments.
- As there were no children or young people receiving treatment during our inspection or information, data or audits available to provide evidence we were unable to make an assessment of the emotional support provided by the hospital.

## Are services for children and young people responsive?

Good



The hospital was in the process of reviewing its service for children and young people in order to meet the needs of the local population, the consultants who provided the services, and ensure compliance with current best practice guidelines and legislation. Children and young people were all assessed prior to admission to ensure that the hospital could meet their needs. Children were only admitted as day care inpatients when there were registered children's nurses from the peripatetic paediatric nursing service available to support children and their families.

We found that patients had timely access to assessment, diagnosis and urgent treatment. There were no delays in accessing paediatric surgical interventions, and the website provided information that parents would be able to arrange surgery at a convenient time for them.

# Services for children and young people

The hospital maintained good communication and relationships with local GPs and other healthcare providers. Parents were given copies of letters to provide to their GP, and GPs were contacted if appropriate. This ensured patients received continuity of care when discharged from the hospital.

The hospital had a complaints policy and procedure in place and there was information available for patients about how to raise concerns, however this information was not available in a child friendly format. We were told that the Spire Group had launched a child friendly feedback form four days before our inspection. This was not yet readily available in the public areas of the hospital and was too soon to assess its impact or evaluate its effectiveness. Before this, there was no child friendly complaints literature available. There had been no complaints recorded in the past year which related to the care and treatment of children and young people.

Spire Gatwick Park Hospital was a purpose built building with adequate facilities and arrangements in place to enable children or parents with disabilities equal access to the facilities. The general environment was maintained to a high standard. The facilities were modern, clean and with the exception of carpeted clinical areas, provided a safe and efficient working environment and a pleasant setting for patients to undergo investigations and treatment. We noted that children did not stay overnight in the hospital and had limited interaction with the clinical environment. However there were few child specific facilities available with minimal alterations made to make the environment appropriate for the care and treatment of children.

## Service planning and delivery to meet the needs of local people

- The hospital was in the process of reviewing its service for children and young people in order to meet the needs of the local population, the consultants who provided the services and ensure compliance with current best practice guidelines and legislation.
- Senior staff at the hospital told us how following a review of the paediatric service, children under 16 were no longer admitted for surgery or interventions which required an overnight stay.
- We saw through minutes of the MAC that the MAC and Hospital Director ensured they only offered practicing privileges at the hospital if there was an identified need,

therefore reviewed clinicians applying for practicing privileges for different procedures. However, we noted a large number of clinicians had practicing privileges to treat children, although very few maintained an active paediatric practice at the hospital.

- The clinicians we spoke with told us they worked well with local GPs, the local authorities and other healthcare professionals. Generally communication among the multidisciplinary team was effective within the limits of the service offered.

## Access and flow

- Patients had access to timely assessment, diagnosis and urgent treatment. Staff told us there were no delays in accessing paediatric intervention once the patient was identified and had accessed the hospital's booking systems.
- The hospital's website promoted patients being able to arrange surgery at a convenient time for them. In outpatients, staff told us that parents could arrange appointments which fitted in with child care arrangements or school hours where possible.
- As the surgery was elective and planned in advance when registered children's nurses would be available, there were no instances of unplanned surgical interventions.
- There was a good patient flow on the day care ward. Children were seen and admitted by the peripatetic paediatric nursing service who co-ordinated their stay in hospital from admission to discharge.
- There was no information available regarding auditing the child's pathway through admission, surgery to discharge.
- We spoke with outpatient staff who told us that should a consultant wish to perform a minor procedure on a child under 12, it would be arranged with the peripatetic paediatric nursing service to arrange a convenient date. They gave an example of a consultant who wished to undertake a minor procedure on a child's toe nail. A text was sent to the peripatetic paediatric nursing service and a date arranged. It was unknown what the paediatric 'Did not attend' rate was, although we were told in general that this was low compared to the NHS.



# Services for children and young people

- Outpatient staff told us there was very little wait between consultant appointments. Appointments were arranged for the convenience of the children and parents with younger children seen first where possible.

## Meeting people's individual needs

- Spire Gatwick Park Hospital was a purpose built building with adequate facilities and arrangements in place to enable children and parents with disabilities equal access to the facilities. For example, there were ramps in place, disabled toilet facilities and extra wide doors and corridors.
- We noted that the hospital had prioritised refurbishment of the outpatients' areas as these were starting to look a little dated and tired, however in general the environment was maintained to a high standard. The facilities were modern, clean, and with the exception of the carpeted clinical areas, provided a safe and efficient working environment and a pleasant setting. However, there were few child specific facilities available.
- We were told that children's' individual needs and requirements were assessed and documented during the pre-assessment clinic appointment. If the hospital could not meet their needs they would not be admitted.
- Staff told us that Spire Gatwick Park had arrangements in place to provide interpreter services if needed and specialist advice was available if required.
- The Spire Gatwick Park Hospital website also included information for patients on the services available at the hospital and detailed information about the individual operations, costs, risks and benefits.
- Spire Gatwick Park Hospital was noted to be compliant with the Government's requirement to eliminate mixed-sex accommodation. Children and young people admitted to the hospital only shared facilities when clinically necessary such as in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity.
- We heard how the hospital provided individual meals for children if they didn't want the meals from the children's menu. This included cultural dishes or specialist medical diets.

- There were minimal activity and play facilities at the hospital. The day case wards provided children with a soft toy and colouring books and games to entertain children on the ward. There was a small, dedicated play area in the outpatients department with games for younger children. Staff told us that children preferred their electronic games to any toys they provided.
- Parents were encouraged to stay with their child while they were on the day case ward.
- There was a motorised car for children to 'drive' to the theatre and they received a certificate congratulating them on driving well.
- Translation services were available for patients and families for who English may not have been their first language.

## Learning from complaints and concerns

- Spire Gatwick Park Hospital had a system for managing complaints that included documenting each complaint in a complaint log. Verbal complaints were also documented this way. From April 2015, all complaints were also entered onto the hospital's information management system, which was used as an adverse event reporting system. All correspondence, investigation reports, and file notes were filed by individual complaint, and held by the hospital. This included any learning outcomes and actions taken.
- All complaints were reviewed at the senior management team meeting with specific complaints being discussed within teams and departments.
- Statistics, themes and some specific clinical or medical complaints were reviewed at the Medical Advisory Committee.
- The hospital invited the relevant department manager to join any patient feedback meeting.
- In 2014, the hospital received 46 complaints of which 85% were upheld. The hospital did not separate the complaints from children and young people, so it was unknown if any of these complaints related to the care and treatment of children. These were not separately audited.

# Services for children and young people

- The hospital gave examples where complaints about the service had led to a change in practice, however there were no recorded complaints from children or their parents to necessitate any changes in practice because of a complaint.
- We were told that patients were encouraged to raise concerns with any staff members while at the hospital.
- Adult complaints leaflets were available throughout the hospital, however we did not see any complaints information in a child friendly format relating to making a complaint or telling staff when something was wrong.
- We were told that the Spire Group had launched a child friendly feedback form four days before our inspection. This was not yet readily available in public areas of the hospital and was too soon to assess its impact or evaluate its effectiveness. Before this there was no child friendly complaints literature available.
- We noted that the hospital's website gave information about how to make a complaint and raise concerns.

## Are services for children and young people well-led?

Requires improvement 

Spire Gatwick Park Hospital was supported through the governance arrangements of the corporate provider. This included the Spire Healthcare regional clinical quality committee and the corporate clinical governance board.

At the time of the inspection the care of children and young people in the hospital was under review, mapping the service against best practice guidance and assessing the viability of meeting legislative requirements. We saw the hospital had an action plan in place in order to ensure children received safe and appropriate care in the hospital.

We found that although there was a governance structure in place, hospital staff in general delegated ownership of the paediatric service to the peripatetic paediatric nursing service. There was evidence that the peripatetic paediatric nursing service managed the identified risks and escalated them accordingly to the clinical lead and Matron.

We found that although staff could describe the level of support children should receive whilst in hospital, there were inconsistencies in describing the different ages of children in literature, policies and procedures.

There was little opportunity for children to feedback directly to staff on the care and treatment they received. Although a child's feedback form was available, the feedback systems were adult orientated and did not differentiate between adults and children's service. There was no evidence that the views of children were sought or taken into consideration.

Staff told us they felt able to approach senior managers with any concerns. They said there was good leadership within hospital as a whole. They told us the managers were very approachable and they would have no hesitation in raising issues, confident that they would be listened to and action taken.

### Vision and strategy for this service

- Spire Gatwick Park Hospital as part of a large independent healthcare provider had the corporate vision and values of Spire Healthcare. These included an improved focus on the patient journey in all areas; with a senior management restructure ensuring equal focus on clinical and non-clinical areas. The hospital was supported by the Spire Healthcare regional clinical quality committee and the corporate clinical governance board.
- There was a clinical strategy document, allied to the hospital's strategic vision and the latest strategy included a section on children's services
- At the time of the inspection the care of children and young people in the hospital was under review, mapping the service against best practice guidance and assessing the viability of meeting legislative requirements.
- There was a plan in place to ensure that Spire Gatwick Park fully met the standards required to be able to continue to accept paediatric inpatients. Paediatric activity has been reduced to day cases only, and morning surgical lists only in order to maintain a limited paediatric service whilst minimising risk to patient care, while the paediatric review took place.

### Governance, risk management and quality measurement

# Services for children and young people

- The hospital management team told us that robust clinical governance was a priority across the hospital and was a key focus, supported by the internal governance framework and team meetings.
- We found that the hospital had a governance framework in place that included policies, procedures and oversight by the senior management team, the clinical governance committee, quality and risk committees and the MAC.
- There was a newly appointed children's lead, with the Matron assuming overall responsibilities for the care of children and young people in the hospital.
- The hospital had recently started a children's group to oversee paediatric practice in the hospital. The group had met once to agree terms of reference and discuss actions from the review of paediatric services.
- A large number of clinicians had practicing privileges to treat children. We were told that not all of these maintained an active children and young persons' practice at the hospital. The children's lead agreed that the register required updating.
- The Paediatric Service Compliance Action Plan documented that all Consultants had recently confirmed that they only undertook the same scope of practice that they did in the NHS. However as of four days before our inspection there was no evidence available about the volume of paediatric work they had recently undertaken. This was raised as a risk on the action plan, as this information was needed before their practicing privileges could be reviewed in line with the Practising Privileges Policy.
- The hospital had a service level agreement in place with the peripatetic paediatric nursing service. However, the agreement did not formalise the responsibilities, obligations and expectations on the different areas of childcare that the service undertook. For example, there were only four lines on the care of children overall and this did not address the different staffing requirements for children's ages, the service to outpatients, X Ray, advice leaflets, follow up or pre-assessment etc.
- We found that hospital staff in general delegated responsibility of the care and treatment of children to the peripatetic paediatric nursing service. There was evidence that the peripatetic paediatric nursing service managed the identified risks and escalated them accordingly to the clinical lead and Matron. Consultants told us they had full confidence in the skill and experience of the nurses working for the service.
- However, there had not been any auditing of the paediatric service undertaken. Without this information, it was not possible to have assurance that any form of quality measurement was being effectively undertaken.
- There was some gathering of information. For example, in the outpatients department all children were entered into a paediatric list, kept in a paediatric file. The list documented all children seen in the department. Staff were unclear why this list was kept, although it contained useful information about the children seen in the department, there was no auditing of this list or monitoring for quality assurance purposes. They told us the information was not used.
- We found that there were inconsistencies in describing the ages of children who attended the hospital. The age range definitions were confusing and we found inconsistencies in how the hospital described and treated the different age groups, particularly children in the age range from 11 to 16. Although Government guidelines state that children and young people are identified as 0-18 years, in common with other independent healthcare providers Spire Healthcare interpreted children as being 16 years and under. An example of this was the Spire Gatwick Park Hospital local policy, which described adolescents as young people up to the age of 20 (19 and 364 days).
- The Matron confirmed that children would only be admitted for day case surgery between the ages of three to 16, with 16 – 18 being classed as adults. Children were seen from birth for consultation in the outpatients department. They told us that minor procedures would not be undertaken on children under the age of 13 without the presence of a registered children's nurse from the peripatetic paediatric nursing service. Consultants told us that they would not admit a child under 16 years of age for an overnight stay.
- However the in the various documents we reviewed this was not always clear. For example, some documents stated children 12 years old and over did not require an on-site a registered children's nurse. Staff in outpatients

# Services for children and young people

told us that children aged between 13 and 16 could be treated as adults in the pre-assessment clinic, whereas all children under 13 were seen by the peripatetic paediatric nursing service.

- There was a grid from the local policy in use in outpatients and radiotherapy departments that gave staff clear guidelines as to the level of services and support children needed. However, that did not match with updated Spire paediatric policy on the level of support children required.

## Leadership of service

- Staff told us that there was good leadership in the hospital as a whole. They told us the managers were very approachable and they would have no hesitation in raising issues, confident that they would be listened to and action taken.
- The hospital had recently appointed a children's lead nurse to work one day a week to be the voice of the child, and oversee paediatric interventions in the hospital. A children's group had been set up and had met once at the time of our inspection. Although this demonstrated the particular needs of children were now being formally considered it was too soon to assess if the leadership of children's services was effective.
- Staff throughout the hospital spoke of the visibility of the Hospital Director and senior management team. They told us they felt able to approach the senior managers with any concerns.
- Although staff in the hospital deferred to the peripatetic paediatric nursing service, all the staff we spoke with were aware of the newly appointed children's lead, and felt this added value to the children's service.

## Culture within the service

- The staff we spoke with were enthusiastic about working at the hospital, and spoke positively about the team work and camaraderie. We spoke with all grades of staff across the hospital who told us they felt supported and encouraged to carry out their day to day duties. All the staff we spoke with told us they felt valued and respected. One staff member told us "It's like a family here".

- We spoke to members of the ancillary and administration teams who told us if they had concerns about a member of staff or a consultant's behaviour, they would raise it with their line manager, confident that it would be addressed.
- There were low rates of sickness for all staff groups (Less than 10%). With high levels of staff stability, for allied health professionals in particular. There were moderate levels of staff stability during 2014 (Percentage of staff who had been in post less than a year.) However, it was noted that this was an improvement on the previous year (2013).

## Public engagement

- The hospital had a patient feedback system that operated across the Spire Healthcare group. However, there was no system to separate parent/children's feedback from adult patients. There was little opportunity for children to feedback directly to staff on the care and treatment they had received. Although a child's feedback form was available, there was no evidence that the views of children had been sought or taken into consideration.
- Hospital staff and consultants we spoke with told us that the peripatetic paediatric nursing service acted as advocates for children, and ensured the voice of the child was considered. They told us that nurses contacted the patient and their parents following discharge, and fed back any concerns. We did not see this information collated or monitored, as the individual forms were kept with the patient record.
- There were no other forums identified where the hospital engaged with the public, or children and young people.
- We noted that the Spire Healthcare website provided detailed information about the paediatric interventions. The information was noted to be honest, and gave responsible advice.

## Staff engagement







- All staff we spoke with were positive about working at the hospital, and told us they enjoyed working there. They especially praised the social aspect of the hospital and told us how "It's a great place to work".

# Services for children and young people

- The Matron told us the hospital made sure they recognised and rewarded staff who made a particular contribution to life in the hospital. Nominated by their peers, staff were recognised through the 'Inspiring People Awards' and 'Employee of the Month'. The staff we spoke with valued this. They told us that although you are just "Doing your job" someone out there has taken notice and seen that you are doing it well. "It makes you feel valued and special" one member of staff told us.
- We were told that there was good communication between staff and managers and several forums where staff could raise any issues or provide feedback.
- The senior management team told us of their priorities for the future of the paediatric service at Spire Gatwick Park was to ensure the hospital offered a safe, effective and financially viable service.
- Following an audit of the service against the new Spire Healthcare paediatric policy and Association of Independent Hospital Organisations guidance, there was an action plan in place to address any outstanding issues.
- The hospital decided to curtail the paediatric service until there was assurance that the care and treatment of children met with best practice guidance and the updated policy.

## **Innovation, improvement and sustainability**

# Outpatients and diagnostic imaging

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

The Spire Gatwick Park hospital provides outpatient clinics for a wide variety of different specialties that include; orthopaedics, ear, nose and throat, gynaecology, cardiology, urology, gastroenterology, general surgery, ophthalmology, paediatrics, neurology and bariatric management. The diagnostic and imaging department carried out routine x-rays as well as more complex tests such as MRI, CT and ultrasound scans and mammograms.

There was a main waiting area for all clinics, as well as a smaller waiting area shared with the BUPA Health Assessment Service, which is run and managed by the hospital. The outpatient department included a number of consultation and treatment rooms, a physiotherapy department and gym. Pathology and pharmacy departments are on site.

In 2014 there were a total of 33,250 outpatient first attendances, of which approximately 25% were NHS referred patients. There were 29,266 follow up appointments, of which approximately 7% were NHS referred patients. Orthopaedics was the largest clinical specialty, followed by physiotherapy and cardiology. Between June 2014 and May 2015 there were 15,695 patients seen in the imaging department of which 45% were MRI patients. Patients were referred either by their GP, consultants' private practices or patients could self-refer. Local clinical commissioning groups commissioned NHS services with patients referred by their GP or NHS hospital.

The pathology service is part of Spire Pathology network of laboratories. Tests done on site include haematology,

biochemistry and blood supplies for transfusion. Some processes were shared between other local Spire laboratories, sent to specialist laboratories or outsourced to other accredited laboratories.

During our inspection we spoke with a range of staff including service and departmental managers, registered and non-registered nurses, specialist nurses, radiographers, physiotherapists, health assessors and administrative staff. We also spoke with 11 patients, consultants of various specialties and an external contractor. We visited the outpatient, imaging and pathology departments. We looked at four sets of nursing outpatient documentation. We were not able to review outpatient consultation records as these were not kept by the hospital, which is required by current regulations.

We observed care, looked at performance, and held a number of focus groups with a variety of staff.

# Outpatients and diagnostic imaging

## Summary of findings

The hospital did not maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided.

Incidents were reported and investigated, with shared learning well established. The environment was clean and there was a refurbishment programme to be implemented that included outpatients and the reception areas. Space was an issue in the outpatients department. Equipment was well maintained.

Patients received care and treatment in line with policies and national guidelines. Staff were well trained and supported with processes in place to ensure they were up-to-date with training, appraisals etc. Patients received compassionate care. There was good information provision. We found an emphasis on patient centred care.

Outpatient and diagnostic imaging clinics were available in the evenings and at weekends with appointments made for the patients' convenience. Waiting times were minimal and well managed.

There was clear and visible leadership provided by senior management and within the departments. Staff spoke highly of their managers. Good governance processes were seen to be in place in most areas but there was limited audit undertaken in outpatients.

## Are outpatients and diagnostic imaging services safe?

Requires improvement



Incident reporting, investigating and learning was well established in outpatients and imaging departments. Learning was shared across the hospital departments and discussed at staff meetings. The environment was visibly clean except for one room known to have a risk of cross-contamination. There was a refurbishment plan in place for later in the year as there was worn carpeting and some paint peeling.

Equipment was well maintained, calibrated where required and cleaned with staff clear about their role in regards to equipment. Emergency equipment was in place. Medicines were well managed within the department.

The hospital did not maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken as required by current regulations.

There were sufficient numbers of medical, nursing and diagnostic staff to deliver care safely. Patient risk was assessed and responded to. There was a major incident plan in place.

### Incidents

- Incidents were logged on the hospital electronic system, analysed, investigated and learning shared across departments in the hospital.
- Staff demonstrated a good knowledge of the reporting system and described incidents that they had reported recently. They understood how to escalate incidents.
- However, during the inspection we found one prescription form that had not been signed off on the sheet against the number. When we brought this to the attention of staff it was immediately noted, we were advised it would be investigated, addressed and discussed, however it was not considered as reportable. Therefore an opportunity for wider learning was potentially missed.

# Outpatients and diagnostic imaging

- For the period June 2014 to May 2015 there were a total of 433 reported incidents throughout the hospital. Of this number outpatients had 47, pathology 42 and imaging department 56. Together these accounted for 33% of the total number reported.
- Incident reporting and learning was evident on all examples of staff meeting minutes that we looked at. Staff described incident discussions at these meetings and were aware of incident investigations.
- One serious incident was reported between January and March 2014. The incident was identified at a multi-disciplinary meeting, a full root cause analysis was undertaken and we saw evidence of actions and changes resulting from this.
- An example of incident reporting provided in imaging was where an MRI scan was abandoned because metal was identified in the limb to be scanned. This was reported as well as advice being sought from the referring NHS trust on how to progress the patient's management and care.
- All radiology staff worked in accordance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) and guidance. There had been no reportable incidents for 2014 or for 2015 up to the date of the visit.
- Following an incident where there had been a communication failure which resulted in a patient being added on to the clinic who was not known by outpatient staff. Outpatient and administration staff discussed the incident to improve communication. This was also discussed at the outpatient staff meeting and was recorded in the minutes we looked at. The time of printing out the clinic lists was changed and only completed when the consultant arrives in the department to ensure they were working to the accurate list.
- We were provided with an example of staff contacting relatives to explain an incident had occurred. Nursing staff were aware of their duties under Duty of Candour and we saw that the Spire Healthcare booklet was being distributed to clinical and non-clinical staff.
- Consultants told us that they undertook Duty of Candour training at the NHS hospitals they worked in. However, we found limited knowledge of the current regulation. The consultants we spoke with were not aware of any incidents of harm that would need to be disclosed. They said they would always discuss any concerns, complaints or issues with the hospital management.

## Cleanliness, infection control and hygiene

- All clinical and non-clinical areas were observed to be clean and tidy. Good hand washing facilities were available and we observed good infection control practice during the visit.
- The hospital provided the 2015 infection prevention and control annual plan. This included, for example, the roles and responsibilities for maintaining a clean environment, access to laboratory support and staff training.
- There was a rolling programme of infection control audits across the hospital. There had been an audit in the outpatient department in May 2015. This highlighted several issues that were known and formed part of the refurbishment planned for the autumn. We saw examples of other audits such as hand hygiene and uniforms.
- There was a room referred to as the 'dressing clinic' that was used by nurses. We were told that this was the dressing storage room. Care and treatment carried out there included: changing dressings, removal of clips post-operatively and tests such as electrocardiograms (ECG) and 24 hour tapes. This was an identified area for the refurbishment. However, the audit noted the infection control risk as dressings stored in the room were in open wired cages next to the treatment couch. The required action was to purchase enclosed storage for installation during the refurbishment. However, the room was in use with this identified infection control risk at the inspection, and planned to continue to be used in this manner until refurbishment. No risk assessment had been carried out. In addition, we noted that there were flies in the enclosed overhead light fittings as well as dust under the cabinets and storage crates.
- Several of the consulting rooms had carpets. Spillage kits were available if required and housekeeping would be called to shampoo any area affected.
- There was a quarterly patient survey on their perception of staff hand hygiene. We saw the results for the last four quarters had good results. Monitoring and improvements in hand hygiene were regularly discussed at staff meetings.
- We saw that infection control was a standing agenda item on the bi-monthly outpatient staff meetings. There was an infection control link nurse with updates discussed and displayed in the department, together with other information such as the Ebola policy.



# Outpatients and diagnostic imaging

- We saw good supplies of personal protective equipment such as gloves and aprons in the clinical areas we visited. Hand washing facilities, soaps, gel and paper towels were all available. Hand washing notices were displayed above basins in the clinical areas and in the patients toilet.
  - Curtains were disposable with the date used highlighted.
  - Equipment and surfaces used in clinical rooms were the responsibility of the outpatient nursing staff. We saw cleaning equipment and clinical wipes. We observed green stickers placed on cleaned equipment to easily see that they were ready for use. There were check lists for the cleaning schedules duly completed.
  - Physiotherapy staff were responsible for cleaning the room they were in for the day and any equipment used. We saw the checks in place for weekly tasks duly completed. Any issues were fed back at the joint inpatient and outpatient fortnightly staff meetings. An example provided was cotton wool found in a sharps bin.
  - Sharps bins throughout were dated. There were clinical and non-clinical waste containers clearly marked and appropriately bagged.
  - Infection prevention and control was part of the annual mandatory training programme and provided by the hospital specialist infection control nurse. We saw examples of completed training. In addition, suppliers of cleaning materials also provided training.
  - General cleaning for the outpatient department, diagnostic imaging and physiotherapy rooms and gym had been outsourced to a commercial company under contract. We saw the contract in place that included, for example, cleaning schedules and Control of Substances Hazardous to Health (COSHH) risk assessments.
  - No healthcare associated infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C.diff) or Methicillin Sensitive Staphylococcus Aureus (MSSA) were attributed to the outpatients or imaging departments over the last 12 months.
  - All the patients we spoke with said that the hospital was clean.
- known to the hospital and were to be included in the planned refurbishment later this year. This was also reflected in the hospital presentation at the inspection visit.
- Space was another known issue. This meant that the 'dressing clinic' was run from the dressing storage room. There was a couch and a curtain that could be drawn for privacy. We were told that this will not be used for patients following the refurbishment. Currently the sink and taps are not compliant with a clinical area.
  - The audiology room was not used every day and was used for equipment storage at the visit. We were told that the equipment was moved to another available consulting room when the audiology room was required for clinics.
  - There was a recent contract in place for maintenance of all equipment across Spire Healthcare and there had been no issues identified to date.
  - Patients commented on how relaxing the lighting was in the main waiting area and that they appreciated it.
  - A weekly health and safety check was undertaken that included outpatients, imaging department and physiotherapy department.
  - We saw that the physiotherapy gym was an airy and pleasant environment although fairly small. Staff told us that, in their view, they were not always able to complete a patient's rehabilitation programme due to lack of some equipment, for example a treadmill, in the current available space.
  - The imaging department had a list of equipment that detailed: type, manufacturer, asset number and date of installation.
  - There was suction/oxygen available in the MRI preparation area and in the recovery area.
  - Service documentation was seen. For example, the mammogram was serviced in June 2014 with no actions required; the general room was checked in December 2014 with actions documented and subsequently signed off as completed. Annual physics testing were done.
  - We saw that in the event of a power failure there was emergency lighting in place and the hospital had a backup generator.
  - The hospital provided the Pathology Department certificate of accreditation by Clinical Pathology Accreditation (CPA) dated May 2014.

## Environment and equipment

- Some areas in the outpatient department were a little worn, for example carpets were well used and some walls had chips in the paint and marks. These were

# Outpatients and diagnostic imaging

- The Sterile Services Department was accredited by Société Générale de Surveillance (SGS) under ISO 13485. The audit report in February 2015 concluded continuation of the service with re-audit planned in one year.
- A portable appliance testing policy was in place and the samples we looked at were all in date. We also saw a new piece of equipment that had been checked as ready to install with the service date for the following year recorded.
- We spoke with an external contractor who was on site repairing ophthalmology equipment. They had received a call out and told us that they responded as soon as possible or at least within 48 hours. They were positive about the contact and relationship with the hospital. Consultants told us that the hospital was supportive in respect of new equipment for patient care.
- There was no bariatric chair in outpatients although there was one available on the ward. The maximum weight for treatment was in line with the CT maximum of 200kg.
- Calibration of equipment that needed it was done annually.
- The emergency equipment and resuscitation trolley that would be accessed by outpatient staff was on the inpatient ward on the ground floor. Should it be required, a porter was responsible for bringing it to the department. This had not been needed in recent years. The outpatient sister was part of the crash team so always responded to any calls on the wards. There was oxygen available in the department.

## Medicines

- Up-to-date medicines policies and procedures were available to staff on the hospital electronic system. Staff were aware of medicine management procedures.
- We saw that medicines were stored in locked cupboards in the imaging department and in the minor operations room in outpatients. There were daily fridge temperature checks in place with a clear escalation plan should the temperature be raised. We saw that oxygen cylinders were checked.
- No controlled drugs were kept in the outpatient department.
- Prescription pads were kept in a lockable filing cabinet in the small office area on the outpatient corridor. The cabinet was unlocked during clinics but locked at the

end. There were pads and signing sheets for each consulting room. These were taken in when the room was prepared and returned once the clinics were finished for the day. We were told that the signing sheets should be checked against the prescription pad number both in and out of the clinics so that any queries could be looked into at the time. On the Monday of the unannounced visit we were shown an example of a pad and signing sheet for one of the consulting rooms. We saw that the prescription pad had one prescription missing that was not signed off on the signing sheet. We brought this to the attention of the outpatient sister who immediately made a note on the sheet and stated that this had last been used at a Saturday clinic. They told us it would be followed up and investigated.

## Records

- We were told that the consultants were responsible for and kept their own outpatient medical records of patient consultations. This meant that the hospital did not maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided. If a patient was to be admitted for an elective procedure the consultant would provide the hospital with a copy of the clinical letter that had been sent to the patient's GP.
- We were provided with an extract from the Spire Consultant's Handbook: Record keeping, section 7.7e stated, "A Consultant must make their outpatient records readily available in the hospital for use by other healthcare professionals when requested. Consultants holding electronic patient records are advised that they are required to register and maintain registration with the Information Commissioner's Office". The Hospital Director informed us that this was not monitored by the hospital, nor was it a requirement of maintaining practicing privileges.
- Outpatient records were maintained for all patients seen by the nurses in clinic for treatment such as wound dressings or clip removal. These records were kept on site for three months. Following this period they were stored externally in a secure storage facility and could be retrieved within 24 hours. We reviewed four examples of the nursing records which were completed to a good standard.

# Outpatients and diagnostic imaging

- We were told that it was very rare that a do not attempt resuscitation (DNR) form would be completed but, if it was, it would be stored with the hospital record.
- All NHS patients had full medical records available in outpatients for their clinic appointments. The records were returned to the NHS hospital afterwards.
- Records were held securely in the medical records library. When the clinic was open, patient records were in lockable cupboards but they were not locked during the clinics.
- Staff could not remember any recent occurrence of patient records not being available for clinic. In such an event this would be discussed with the relevant consultant prior to the start of the clinic. Patient records were held electronically in the imaging department.

## Safeguarding

- The adult safeguarding lead was the hospital director. Adult and Children Safeguarding training was part of the hospital's mandatory training programme. Policies and procedures were available to staff.
- Staff in the radiology department demonstrated good knowledge of the safeguarding procedures and their role. We saw that all pathology staff had completed the on-line training. 100% of nursing staff in outpatients had completed the mandatory on-line Adult Safeguarding Training.
- We saw certificates for Level 2 and Level 3 training completed for adults and for children. We were told that face-to-face training at Level 3 was sourced externally from the local Safeguarding Board for key staff.
- Consultants told us they undertook safeguarding training at the NHS hospitals they worked in.

## Mandatory training

- Staff received corporate and departmental induction before they worked unsupervised. We spoke with a newly appointed nurse who had worked regularly in the department when on the bank. They described the corporate induction that included Moving and Handling and Fire Safety. They undertook the required e-learning and received a welcome pack from outpatients. They shadowed their mentor as supernumerary and we saw the completed staff record.
- All new staff undertook diagnostic imaging induction. The check list ensured that they had read and understood the policies and procedures, local rules, examination protocols, had a personal monitor and

- were trained in using the equipment. We saw examples of completed induction checklists and a newly appointed radiographer told us they felt very supported with their learning.
- Radiology staff told us that their mandatory training was tailored to radiographer work roles. They said they had good access to training now that they were fully staffed.
- Training targets were set by calendar year with the aim to have all completed by the end of June each year. Information provided by the hospital from January to May 2015 demonstrated that all outpatient staff had completed, for example, Fire Safety, Health and Safety, Equality and Diversity and Compassion in Practice. 94% had completed Children's Safeguarding and 88% completion of Manual Handling. All outstanding training was monitored by the outpatient sister and discussed at one-to-one and staff meetings.
- Consultants either undertook the training at the NHS hospitals they worked in or accessed the Spire training programme.
- All mandatory training was e-learning with the exception of the practical Manual Handling and Basic Life Support training.

## Assessing and responding to patient risk

- Any concerns regarding a patient's wellbeing, including emotional, such as high anxiety levels, were discussed with outpatient staff. This meant that when the patient attended, staff could support them.
- Where a patient with, for example, complex medical conditions was felt to be inappropriate for treatment at this hospital, the consultant would explain to the patient and have discussions with them and their referring GP.
- There was a resuscitation policy and we saw evidence of staff training. There was a crash call system in place and, whilst this had not been required in outpatients for a considerable time, the sister was part of the team and responded to all crash calls elsewhere in the hospital. Crash call buttons were in clinical areas in outpatients.
- The hospital had appointed a suitably qualified Radiology Protection Advisor and Radiology Protection Supervisor.
- We saw that there were protocols in place for all procedures to minimise radiation doses. Local rules were visible in all x-ray rooms as well as being attached to the mobile x-ray unit. The principles of radiation protection were in place.

# Outpatients and diagnostic imaging

- Policies and protocols were on the hospital intranet. We looked at a range including; protection of pregnant patients, MRI quality standards and breast imaging services.
- Radiation risk assessments were in place, together with the Spire Healthcare general risk assessment for the imaging department. These included moving and handling and power failure.
- Controlled area signs and information were visible and working, and informed patients where radiation exposure took place.
- Information about pregnancy and radiation was displayed on walls with patients directed to speak to the receptionist in the first instance. Latex and other allergy information was also displayed.
- Physiotherapy patients were risk assessed before using equipment.
- We were given an example where the bariatric specialist nurse had trained another nurse to cover any periods of absence that avoided cancelling clinics.
- There were low rates of sickness (below 10%) for all staff groups working in outpatient departments.
- Physiotherapists told us that they generally had sufficient staff. However, busy times on the wards impacted on the work of other departments and required flexibility of approach to timings by allied health professionals.
- Recent recruitment in the imaging department has allowed the operating hours to be extended from 08:00 to 20:00, to 07:00 to 22:00, Monday to Friday.

## **Nursing, imaging and physiotherapy staffing**

- There was continuous and on going recruitment of nursing staff, senior executives told us that this was a challenge for the hospital as a whole.
- The outpatient department had a good supply of bank staff who regularly worked in the department. This meant that they were well staffed, did not need to use agency staff and the bank staff knew the department well and felt part of the team. We spoke with one registered nurse who had recently been recruited from the bank into a permanent post.
- Staffing for clinics was planned for two registered and three non-registered nurses, based on clinic hours with approximately one nurse hour per consultant hour. Staffing was therefore planned in line with the clinics running each day and reviewed nearer the time. The exact nursing hours were filled in following clinics and these had to match up with the nurses' time sheets on a monthly basis. The outpatient sister monitored the process and was responsible for monthly checks. We saw the electronic planner that confirmed this process and showed that at time of inspection, staffing levels met planned levels.
- There were ten permanent and twelve bank staff who worked in the outpatient department. The ratio of permanent and bank staff was managed to ensure there were more permanent staff on each shift. At the unannounced visit there was one bank non-registered nurse in the morning and one bank registered nurse in the afternoon with all other staff were permanent.

## **Medical staffing**

- Medical staff were mainly employed in a substantive post in NHS organisations. They were granted practicing privileges in order to practice at Spire Gatwick Park.
- Every consultant had to have an up-to-date and valid appraisal at the NHS organisation they worked for in order to retain the practicing privileges.
- Consultants in a purely private practice were required to evidence alternative appraisals.
- Consultants had an agreed programme of clinics with the hospital. If a consultant was unable to attend a clinic then the patient appointments would be rearranged. We were told this was rare. Patients only saw the consultant they had been referred to.

## **Major incident awareness and training**

- The hospital had a major incident business continuity plan in place. This included clear roles and procedures such as employee notification and alternative service provision for pathology and imaging. Staff we spoke with demonstrated awareness of the plan, however it had not been tested with staff.
- Radiographers described the hospital's MRI evacuation process should a patient require the emergency team. We saw evidence of the training provided that included attendees, descriptions of the various roles and how the patient would be removed from the scanning room and the room secured before allowing the emergency team through the outer security door.

**Are outpatients and diagnostic imaging services effective?**

# Outpatients and diagnostic imaging

Not sufficient evidence to rate

Patients received care and treatment in line with policies and national guidelines. There was limited clinical auditing or monitoring outcomes of care in relation to outpatient procedures.

Staff and consultants had the skills and knowledge to obtain implied, verbal and written consent for patients with capacity to consent. No audit of consent forms or the consent process had been carried out.

## Evidence-based care and treatment

- Policies and procedures, both corporate and local, were available to all staff electronically.
- We were told that all new NICE guidelines and other national guidance were reviewed centrally within the Spire Healthcare governance group. Changes made to corporate policies were communicated to each hospital. New information was included in the Spire Healthcare monthly safety bulletin. We saw an example of the bulletin and staff demonstrated awareness of these information updates.
- We found evidence of consultants working to NICE guidelines such as the diagnosis and management epilepsy.
- The British Thoracic Society guidelines for asthma and Resuscitation Council guidelines were in place.
- Physiotherapists told us that they worked together with consultant protocols and research findings. There was a consultant and physiotherapist buddy system in place that they said worked well. Updates for protocols would be supported by two journals and discussed with the consultants. If staff moved off the protocol this was recorded in the patient record.
- We saw the policy offering mammogram screening to women over 40 years of age in line with the European and North American Breast Screening Programme. We saw that NICE guidelines were followed for women with a family history of breast cancer.

## Pain relief

- Local anaesthesia was used for minor procedures in the outpatients department. Staff told us that patients were advised on pain management following the procedure.

- Patients were assessed for pain relief and analgesics were available for pain management should they be required by patients.

## Patient outcome

- Consultants undertook clinical audits as part of their revalidation process but we did not find evidence of audits in relation to outpatients, or that they had been presented at relevant committees such as the clinical governance group.
- We were told that orthopaedic surgeons participated in the national joint registry. As a consequence of the results and feedback a prosthesis was changed.
- Physiotherapists undertook regular note audits that looked at the original goals set for patients, the reviewing of goals, and the outcomes for patients.
- For patients undergoing a CT scan, we saw that there was an on-going dosimetry audit for patient size, weight, dose and whether contrast was given. This was also recorded on the post examination document on the electronic system.
- Patient waiting times were monitored on an on-going basis. First appointment times were monitored by the bookings teams, with any clinic delays were monitored by outpatient nursing staff.

## Competent staff

- All staff confirmed they had regular one-to-one meetings with their line managers.
- The appraisal process set objectives and was reviewed twice a year. There was a 67% completion rate of appraisal for registered nurses; 100% for non-registered nurses and a 79% rate for allied health care professionals (combined inpatient and outpatient).
- We saw an example of a staff record that included discussion of the corporate objectives, specific competencies and regular one-to-one meetings with their line manager. We were told that there was very good communication within the outpatient department and staff felt able to discuss anything as and when needed.
- Staff we spoke with had completed their mandatory training and felt supported with clinical and developmental training. One member of staff was working with the ophthalmology department of an NHS hospital to enhance their skills, knowledge and experience.

# Outpatients and diagnostic imaging

- Consultants described the appraisal/re-validation process with the hospital as “excellent”. Full disclosure and barring checks were carried out as well as occupational health clearance. We were told that if anything needed updating the hospital reminded them. We saw evidence of mandatory training that had been completed. The hospital could require additional training to be done and could withdraw practicing privileges if any required training was not completed.
- A consultant who recently received practicing privileges was orientated and introduced to staff and other areas. They told us they felt confident and very positive about their, “smooth” start at the hospital.
- There was 100% rate of validation of professional registration for nurses working in the outpatient department; 100% rate of validation of biomedical scientists.
- We found a process in place where there were concerns regarding staff performance. Initially there was a discussion which included support, for example with training. If there was no improvement a personal improvement plan would be developed setting time periods and very specific goals. This would be monitored by regular meetings with their manager, however, this had not been required for some considerable time.
- An example of training completed by MRI radiographers provided was an Intraorbital foreign body interpreting course. This was followed by double reporting with a radiologist before being deemed competent to move to single reporting.
- Booking and reception staff completed a bespoke training and competency assessment that included the electronic system, answering the telephone and managing cash and payments.
- We saw evidence that health assessors for the wellness clinic were up-to-date with competency assessments and appraisal. These were recorded on an electronic system and sent to the corporate quality management team. If required, action plans would be put in place to achieve competencies.
- We saw examples of the monthly pathology and radiology staff meetings and bi-monthly outpatient staff meetings. These all included, for example, discussions on training requirements and new information. In pathology there were consultant presentations for staff

continuous professional development (CPD). This meant that staff were provided with information in a timely manner as well as a forum for discussion and learning.

- There was a programme for increasing radiographers’ skills such as being trained in cardiac scanning.

## Multidisciplinary working

- Multi-disciplinary working was evident in all areas that we visited and we observed good communication between the various teams and departments.
- There were processes in place to inform wards when patients were to have imaging tests and the wards provided confirmation. During busy times on the ward outpatients would also be informed and, where possible, they would help to ensure patients had their tests on time to ensure that patient flow was maintained.
- All staff we spoke with said that multi-disciplinary working between the various clinicians and departments was good. Staff gave examples of good team working; physiotherapists supported nursing staff with patient pain control, nurses supported radiographers, for example during lung biopsies, and radiographers working in theatre with consultants.
- We were told that all cancer cases were discussed with the multi-disciplinary teams (MDT) at NHS Trusts wherever the consultants worked. A referral form was faxed to the administration team. It was at one of these MDT meetings that an error was identified and resolved.

## Seven-day services

- The MRI scanning service was provided from 07:30 to 21:30 Monday to Friday, 09:00 to 17:00 on Saturdays with Sunday services as required. There was an on-call service outside these hours.
- Outpatient clinics ran from 08:00 to 21:00 Monday to Friday and 08:00 to 15:00 on Saturdays.
- Pathology provided services from 08:30 to 17:30 Monday to Friday and 09:00 to 13:00 on Saturdays. There was an on-call service outside these hours.

## Access to information

- Consultants brought their own outpatient records to and from clinics. Inpatient records were requested two days prior to the clinic appointment.

# Outpatients and diagnostic imaging

- X-rays were available immediately on the hospital digital system. Any images required and requested from NHS hospitals could be uploaded on to the system.
- Clinic lists were printed off the system so everyone was aware of the patients attending for each clinic. One consultant we spoke with told us that they were always informed in advance of how many patients they would be seeing in clinic.
- The hospital was part of the image exchange programme (IEP). Films were sent to a local NHS Trust, accepted by their system and reported on. A 'blue light' meant the films were sent and reported on immediately.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy in place together with relevant consent forms.
- The consultant undertaking the procedure discussed risks and options with the patient and obtained written consent prior to the procedure. We looked at five sets of records and saw written consent completed on the day of admission in each case.
- Staff and consultants were aware of the Mental Capacity Act 2005 (MCA) but had not carried out any MCA assessments. We were told that people with learning disabilities were accompanied by their parents/carer and proposed procedures discussed with them all. We were told it was rare that patients who lacked capacity to consent to the specific procedure were seen at this hospital. There was no audit or monitoring of consent forms or the consent process carried out.
- Consultants we spoke with stated they always requested permission from self-funding patients before sending a letter to their GP.

## Are outpatients and diagnostic imaging services caring?

Good



Patients received compassionate care in an environment that afforded them privacy and dignity. Staff were passionate about providing good patient care and there was good information provision. Patients were supported throughout their care and treatment and all patients spoke highly of their care and treatment regardless of how they were referred or funded.

## Compassionate care

- All patients checked in at the main reception area opposite the main entrance to the hospital. We observed that reception staff were polite and attentive with patients. We saw that they listened carefully and observed patient confidentiality by not repeating personal information and speaking quietly. The computer screens were not visible to patients.
- The hospital electronic system ensured that once patients had checked in at the main reception desk, staff in the various departments could see that they had arrived. Patients were then greeted by name and escorted to the correct area.
- Patients we spoke with told us that the consultants and staff were very kind and helpful. Patients said that they did not feel rushed, although reception was sometimes very busy. Staff were aware that patients were anxious and treated them in a kind and caring manner.
- We observed consultants introducing themselves to patients. A patient told us that the radiographer in the imaging department had greeted them and then introduced themselves.
- Patients told us that their privacy and dignity was maintained. One patient said that the consultant, "made sure I was comfortable to undress and be examined by her."
- There was a chaperone policy in place, and we saw notices advising patients that they could request a chaperone displayed in the department.
- The hospital had consistently high response rates for Friends and Family Tests for all patients with consistently high scores for NHS patients.

## Understanding and involvement of patients and those close to them

- Patients were directed to their appointments with clear, easily understood directions. We observed that all staff were vigilant and if anyone looked uncertain would approach to help them, regardless of their role in the hospital.
- Patients could call a treatment enquiry line at the hospital where staff provided information on the range of treatments and costs. They worked closely with specialist nurses and consultants.
- Patients could self-refer to clinics. Information was provided about options for treatment, together with

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costs, in order for patients to make informed choices. We saw notices that reminded patients to check that, for example, all x-rays were included in the consultation fee.

- There were leaflet racks in the outpatient waiting areas with information on a range of conditions, symptom management and support organisations. Examples included various cancer treatments, stroke, memory loss, depression and information on orthopaedic conditions. The wellness clinic waiting room had information on such topics as testicular cancer, alcohol consumption, reducing salt intake and breast awareness.
- Consultants told us that they brought their specialty information leaflets to their clinics as well as providing patients with electronic information.
- Patients said that they were involved in their treatment plans and asked how they would like to progress with care and treatment. They were encouraged to ask questions. Patients felt well informed regarding costs and were clear whether their insurance plan would cover all costs.
- One patient described how every aspect of their planned procedure was discussed so that they knew what to expect. All their questions were answered and additional information provided that they had not thought about.
- One patient told us that their consultant discussed how their condition might affect their health in other areas and helped with advice on how they could live more healthily.
- One consultant we spoke with told us that they did not routinely send a copy of the GP letter to the patient unless it was requested. However a patient told us that they always received a copy of the GP letter.

## Emotional support

- One patient told us that the consultant was supportive in dealing with their “life changing” circumstances, and gave them as much time as they needed.
- Another patient described discussions around coping following their procedure.
- Specialist nurses were always present to support patients, particularly for cancer diagnoses. They could also access specialist nurses at a neighbouring NHS trust and could refer on to them where appropriate. We were told there was access to a priest and counsellors.

- One consultant we spoke with said that, if they had concerns about a patient’s emotional wellbeing, they would refer them back to their GP for support.

## Are outpatients and diagnostic imaging services responsive?

Good



Outpatient clinics were provided in day time, evenings and at weekends with patients able to access appointments at their convenience. Waiting times were minimal for both private and NHS referred patients.

Patients’ individual needs were met and staff responded immediately to any concerns raised. Space was an issue in the outpatient and imaging departments. Some of these were included in the proposed refurbishment plans.

## Service planning and delivery to meet the needs of local people

- A number of areas required investment to ensure a positive patient experience and staff working environment. Funding had been approved for a refurbishment programme planned for the autumn that included outpatients and the reception area. Staff we spoke with had been consulted with and were aware of what was proposed.
- Waiting areas were comfortable with hot drinks and water available for patients and their relatives or carers.
- There was sufficient free parking at the hospital.
- At busy times clinics were also run in consulting rooms alongside the wellness clinics. Patients were clearly directed to the appropriate waiting area. We were told that staff would be able to make a room available for discussions with patients if required in addition to the clinic rooms, even when busy.
- The imaging department lacked space at busy times to enable confidential discussions with patients.
- Storage was an issue in the outpatient department with staff moving equipment around depending on what clinic was running.
- Evening and weekend clinics were available.
- Patients were able to self-refer to some clinics, for example the nurse led bariatric clinic. The first appointment with the specialist nurse was free and



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included a full assessment and discussion of the various options available. The clinics were available on different days on alternate weeks and there was a Saturday clinic every month.

- Dedicated booking teams provided appointments to suit private patients wherever possible. There was also an information service which patients could call. Dedicated booking teams booked NHS patients and also offered information and assistance.
- All patients reported to a central reception area and were booked in on the electronic system, therefore staff in all outpatient and imaging areas were informed of each patient's arrival.
- The hospital had a BUPA approved bowel cancer centre, breast cancer centre and MRI unit.

## Access and flow

- Patients told us that appointments were easy to make. Both private and NHS referred patients all said that appointments were promptly made at their convenience. Patients who self-referred themselves, also told us that making appointments was easy and suited to them.
- We were provided with evidence that demonstrated referral to treatment times were being met for NHS patients. One patient told us that they had only waited a week for their first appointment in the orthopaedic clinic.
- There was a policy in place for managing patients who did not attend. Private patients were telephoned and rebooked. For NHS patients the paperwork was returned to the referring NHS trust informing them that the patient had failed to attend. We were told that this was "never a problem" in radiology and rare in outpatients generally.
- For some procedures such as gastric band surgery, regular follow ups were very important. Where patients did not attend these, we were told that they were telephoned and encouraged to attend. The follow up appointments were included in the total cost of the procedure. There was also a four weekly support group available.
- We found that referral to treatment times were being met for NHS patients referred to the hospital, both for outpatients and radiology appointments. Patients we spoke with said they did not wait long to be seen once

they had arrived in the waiting area. We saw that to maintain patient flow, if a patient had not arrived staff checked if the next patient had checked in and would take them through.

- We observed that if waiting times exceeded the appointed time by five minutes nursing staff advised them of the delay and the reasons were explained.
- There was good wheelchair access for patients with poor mobility. We were told that it was very rare that clinics were cancelled. We were told of an example where, during a nurse led clinic, they became very concerned about a patient. An ambulance was called and the patient was accompanied by a nurse to the hospital. Administration staff telephoned patients with later appointments and rebooked them as soon as possible. However, one patient was already on the way so the consultant surgeon saw the patient in place of the specialist nurse which meant the appointment was not cancelled.
- The hospital had a contract to provide radiology services with an external contractor. A request form was faxed, together with an Ebola questionnaire that was checked before the patient arrived. The x-ray was reported on by a radiologist and could be reported remotely if required and the films printed. Out of hours, the contractor called directly to the hospital reception who then called the out of hours radiographer. There was 24 hour cover, seven days a week.
- Patients referred for treatment under the NHS could access transport in line with NHS procedures. Private patients did not get assistance with transport but where required staff would book taxis. There was a car park on site.
- MRI and CT reporting times were one week or less. Ultrasound results were given on the day. Urgent reports were telephoned through on the day. The images were uploaded electronically as well as being burnt onto a disc with copies provided for the referrer and the patient.
- Spire Pathology network of laboratories processed pathology tests. Some tests were done in house, such as haematology. Histology tests were prepared on site and sent to the Spire laboratory at Chatham for processing and returned for reporting.
- For tests not processed within the network we saw there were contracts in place with other NHS and private laboratory services. All services were monitored for accreditation and quality.

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- Reporting times were three days for urgent and five days for general reports.

## Meeting people's individual needs

- There was a breast one-stop clinic where patients saw the consultant, underwent relevant tests such as mammogram and biopsy and saw the consultant again. We were told that biopsy results were received within a week. Where bad news was to be delivered, patients saw the consultant again, together with the specialist breast nurse.
- Self-referred patients to the wellness clinics were seen by a health assessor and a doctor. They underwent many tests that included blood and urine, weight and height, ECG and cholesterol levels. There was evidence of client centred care where there was an interview to discuss and agree goals for improvement. We spoke with a client who described the process as easy and efficient.
- We were told of an example where a radiographer noted a serious pathology on a patient's x-ray. As it was out of hours the radiographer drove the x-ray to the NHS trust which resulted in the patient being transported by ambulance to the appropriate tertiary centre for prompt treatment.
- Physiotherapist team meetings included complex patient discussions. They had good access to consultants when they were on site for discussions on individual patients.
- There was no specific protocol for people with learning disabilities, dementia type illnesses or other developmental difficulties. However, staff said that their treatment and care planning included extra staffing if required.
- The hospital had access to language and translation services. These were displayed, with contact numbers in the outpatient department.

## Learning from complaints and concerns

- We were provided with evidence that for the period May 2014 to June 2015 there had been two formal complaints in respect of outpatients and two in respect of the imaging department. These were investigated, responded to and discussed at the respective staff meetings.
- There was a complaints policy in place. Information on how to make a complaint was displayed and patients invited to speak to staff if they had any concerns.

- Staff were aware of the policy and would speak with patients to try and resolve issues immediately where possible.
- Issues from informal discussions with patients were taken to staff meetings as discussed, as were patient comments on surveys.
- Complaints were reviewed by the senior management team and any themes discussed at the clinical governance meetings.

## Are outpatients and diagnostic imaging services well-led?

Good



Staff were aware of and engaged in the mission, vision and values for the hospital and the service they worked in. They described strong leadership in their areas with senior management who were visible and accessible for all staff. There was an open culture evident.

There were limited processes for patient input. However, staff communicated well with patients, providing information and responding promptly to any queries. The imaging department evidenced good governance processes.

## Vision and strategy for this service

- We saw vision and mission statements displayed in the departments. Staff demonstrated a good knowledge of the vision and strategy for the hospital and the various departments.
- Staff we spoke with were positive and engaged in, "delivering the highest quality patient care" as well as the values, for example "caring is our passion."
- The appraisal system was underpinned by the Spire mission and values ensuring that the patient experience/customer service was a top priority for all staff.
- The corporate induction programme ensured that new staff were aware of the Spire Mission and Spire Values.

## Governance, risk management and quality measurement

- Outpatients and imaging services were represented at executive level.

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- We saw evidence of health and safety risk assessments in place, acted upon and signed off. However, the identified area of risk in the 'dressing room' had not had a formal risk assessment undertaken. The infection control audit identified the risks but there was not a formal plan for managing the risks until the refurbishment programme started.
- The hospital clinical governance action plan included improvements required in reporting and investigating incidents times with actions and targets in place. This was the only item that also related to outpatients and diagnostic imaging.
- A radiologist dose survey was completed for fluoroscopy in 2014. The results showed that no personal monitoring was required as dose levels were low. There was a cannulation audit underway during the inspection.
- The radiology protection supervisor worked with theatres on sentinel lymph node procedures. These are routinely audited, as are the lasers used in the procedure. No issues had been identified.
- Personal badges were monitored every three months with no incidents identified to date.
- Pathology undertook regular audits that included joint learning from the Spire Pathology network audits. We saw that cancer pathology reports were logged and sent to the Cancer Register on a monthly basis.

## Leadership of service

- Staff were aware of leadership changes in structure at the senior management level. They were positive about the changes and several had taken up the opportunities provided for meeting the hospital director and recently appointed matron.
- Staff spoke positively of the managers in the outpatient and imaging departments. Managers were visible and approachable. Staff described them as supportive and always available to help.
- The outpatient manager worked hard to recruit registered and non-registered nursing staff to the department. We saw that sufficient numbers of bank staff were maintained that ensured appropriate staff numbers for the clinics on each early and late shift. Evidence was provided on how this was managed on a daily basis.
- The imaging manager left the hospital in February 2015. On-going recruitment was underway with an acting manager appointed in the interim.

## Culture within the service

- All staff we spoke with described an open and friendly culture within the organisation. They were very proud of the teamwork, both within and across departments. Staff liked working at the hospital. There was an emphasis on patient centred care and we saw examples of this in practice.
- They told us that senior management were visible and accessible. We were told of the open door policy. We heard examples where staff had been able to access a senior manager and that they were welcomed and listened to. One staff member told us that they had been sent flowers following a surgical procedure.
- We were told that a staff party had been arranged and that this had been well received.
- Consultants we spoke with described a good service provided by the hospital with good communication and working relationships in place.

## Public engagement

- There was an outpatient survey in use that included questions on the overall service received as an outpatient, the quality of care from the outpatient nursing staff and whether they were likely to recommend the hospital to friends and family. There was a free text space for anything done well or anything that could have improved the experience. Results were discussed at team meetings. We were not provided with aggregated results from the completed forms.
- The individual forms we looked at and all patients we spoke with were positive about the care and treatment provided. We observed staff communicating well with patients, providing information and addressing any queries raised.
- Some consultants gave patients a card detailing a web address and inviting them to comment on their care. This supported the consultant's re-validation but there was no evidence that this was shared with the hospital.
- Patients were asked for their perception of staff hand hygiene on a quarterly basis. The hospital was working on ways to increase the response rate.
- Patients attending the wellness clinic were all invited to complete a customer satisfaction survey. We saw the report displayed in the department for June 2014 to May 2015 which demonstrated trends over time. There were

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good results for health assessors at 97% and doctors at 77% for extremely or very satisfied. There was a breakdown of comments made so that any negative comments could be identified and worked on.

## Staff engagement

- The hospital director held brief daily meetings for all staff known as '10@10' that staff told us were useful. The senior management team took their meals in the restaurant. Staff told us they were encouraged to join them, or senior managers would ask if they could sit at their table. The recently appointed matron held 'open table' sessions in the restaurant in order to meet staff and introduce herself. There was a 'Friday fry up' for all staff which was very popular.
- The hospital wide 2014 staff survey identified areas for action and improvement. Staff in outpatients, imaging and physiotherapy said that there had been improvements and that they felt listened to.

- Reward and recognition of staff contribution is supported through the 'Inspiring People Awards' and 'Employee of the Month'.
- All staff and consultants we spoke with said they had been involved in the plans for refurbishment and were given the opportunity to input into the plans.

## Innovation, improvement and sustainability

- A bronchoscopy service had been implemented with support from the Medical Advisory Committee and senior management with the governance processes.
- MRI staff were involved in discussions around enhanced roles due to an increase of referrals into the department.
- All staff we spoke with felt involved in the proposed refurbishment programme. However, it was felt by some staff we spoke with that there were further areas in need of upgrading.
- Service improvements and business cases in respect of pathology were managed by the Spire Pathology network.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

The hospital must take action to:

- Ensure that medicines are stored at temperatures that maintain them in optimum condition.
- Review its arrangements for the retention of out-patient records at the hospital to ensure that a complete record for each patient attending the hospital as outpatients is maintained.

### Action the hospital **SHOULD** take to improve

The hospital should take action to:

- Ensure all staff have access to the electronic incident reporting system and know how to use it.
- Ensure all staff are up to date with mandatory training, including Basic Life Support.
- Carry out an appropriate risk assessment for the cleaning of carpets, and ensure that replacement plans comply with Department of Health HTM Health Building Note 00-09: 'Infection control in the built environment'.

- Review the arrangements for maintaining records in an easily usable condition.
- Ensure consultants holding electronic patient records are registered with the Information Commissioner's Office.
- Review its arrangements for pre-operative starving of patients to meet current guidance.
- Review the arrangements for the provision of 'as needed' pain relief for day case patients.
- Ensure that all elements of the World Health Organisation Surgical Safety Checklist are consistently completed and that compliance is audited.
- Consider how it can differentiate the feedback from children and young people from that of other patients.
- Consider how it measures and monitors the outcomes of treatment for children and young people
- Identify the skills staff require to effectively care for children and young people.
- Review its policies, procedures and literature to ensure that the definition of children is consistent.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance  The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.  The provider did not have complete outpatient records for all patients.  Regulation 17 (2) (c)