Spire Bushey Hospital

Quality Report

Spire Bushey Hospital
Heathbourne Road
Bushey
Hertfordshire
WD23 1RD
Tel: 020 8901 5526
Website: www.**spire**healthcare.com/**bushey**

Date of inspection visit: 26 and 27 July 2016, 4 August 2016, 12 September 2016, 13 December 2016
Date of publication: 09/01/2018

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection on 26 and 27 July, 12 September 2016 and 13 December 2016, with an unannounced inspection on 4 August 2016.

Our key findings were as follows:

We rated the hospital as good overall.

Safe was rated as requires improvement in surgery and outpatients and good in medical care. Effective, caring, responsive and well-led, were rated as good overall.

The termination of pregnancy service was inspected but not rated.

Are services safe at this hospital?

- Not all staff who had responsibility for potentially assessing, planning, intervening and evaluating children's care were trained to level three in children's safeguarding, but the hospital had an action plan to improve compliance.
- There were no registered nurses (child branch) available when children attended the hospital.
- Not all HSA1 forms had a reason for termination documented, in line with legislation.
- Not all patient records had evidence that a HSA4 form had been completed and sent to the Department of Health chief medical officer within 14 days to comply with the Abortion Act 1967.
- Staff were encouraged to report incidents and were aware of the duty of candour regulation. There was evidence of learning from incidents and complaints and effective processes were in place to reduce risk.
- Medical notes for nurse's clinics in outpatients were not always available for staff who were treating patients in the department.
- Staffing levels ensured the needs of patients were met. There was little use of bank and agency staff.
- There was access to appropriate equipment to provide safe care and treatment.
- The environment was visibly clean and there were systems in place to maintain the safety of equipment used across clinical areas. The hospital used the; 'I am clean' stickers to indicate that equipment had been cleaned.
- Systems were in place for the prescribing, storage and administration medications.
- Staffing levels were appropriate to the needs of the clinical areas and flexed according to the demands of the service, ensuring flexibility to meet patient demands.
- There were clear escalation processes in place, which included escalating to the resident medical officer (RMO) and the patient's consultant.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns.

Are services effective at this hospital?

- Care and treatment was delivered in line with evidence based-guidance.
- Policies were accessible, current and reflected professional guidelines. The hospital monitored adherence to policies with the use of local audits.
- Screening for sexually transmitted diseases did not happen within the termination of pregnancy service. There were no processes in place for patient referral to obtain screening. This does not comply with national guidance.
- We found that audits carried out in the termination of pregnancy service were not detailed and did not consider all relevant checks of patient records for compliance with standards.
- We did not see evidence of conversations regarding contraception being conducted with patients who had attended for termination of pregnancy, or whether long acting reversible methods were discussed/offered.
- Some patient outcomes were audited and the hospital participated in the Private Hospital Information Network.
- Pain was well-managed and pain management was audited.
- Patients' nutritional status was assessed.

Summary of findings

- An induction programme was provided to all new staff.
- There was a process in place for checking professional registration.
- The Medical Advisory Committee (MAC) ensured consultants were competent to practice and practising privileges were reviewed annually.
- Consultants were on call for 24 hours a day and seven days a week for their inpatients and day case patients. The hospital employed RMOs who were on site 24 hours a day providing medical cover for patients and clinical support to staff.
- Most of the time staff were able to access all necessary information to provide effective care.
- Staff were aware of their role with to regards to the Mental Capacity Act and Deprivation of Liberty Safeguards and had received training.
- Mental capacity assessments which had been completed for patients with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders were not always recorded in patients' records in line with hospital policy.
- Multi-disciplinary teams worked well together to provide effective care. Multi-disciplinary team working included hospital staff, local acute trusts, clinical commissioning groups and general practitioners.
- Staff had received an up to date appraisal and individual training needs had been identified. Staff had the right qualifications, skills, knowledge and experience to do their job.

Are services caring at this hospital?

- Patients were treated with dignity and respect. Their preferences were taken into account with treatment planning and they were given the time and information required to make informed decisions about their care.
- Feedback from patients and those close to them was positive about the way staff cared for them and the treatment they had received.
- The hospital wide Friends and Family survey, which included both NHS and private patients scored consistently above 97%.
- Staff recognised the need to provide patients and their families with emotional support and the hospital had a list of multi-faith contact details should patients require these.
- The hospital had a 'Pink Petals' peer support group which provided patients with a number of opportunities to access links within communities and support and information for individuals.
- Staff told us that if they had to deliver distressing news to a patient or their loved ones this would happen in a single use room on a ward or in a consulting room to allow privacy.
- The chemotherapy unit had received the Macmillan Quality Environment Mark (MQEM) which was an assessment of services provided for cancer support. Part of the assessment related to having a caring and supportive environment where people can talk in confidence and privacy.

Are services responsive at this hospital?

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- Appointments were scheduled according to the patient's condition.
- Appropriate facilities were provided to meet the needs of patients requiring wheelchair access and a hearing loop was in place. Telephone interpreters were available to support patients if necessary.
- Patients could access the service at times to suit them.
- The services had protocols and procedures in place to manage patients with complex needs, including those living with a learning disability and dementia.
- Staff had awareness and had attended training in caring for patients living with dementia.
- Information on complaints or how to raise a concern was available for patients.
- Complaints and concerns were always taken seriously and responded to in a timely manner. There was evidence of actions taken to address issues raised in complaints and staff were informed of changes required in response to complaints.

Summary of findings

- Patients received and had access to appropriate written information about their condition and treatment.
- There were toys and books available in the waiting areas specifically for children when they attended outpatients, physiotherapy or diagnostics appointments. These had been renewed during the inspection as we found some were dirty and damaged.

Are services well led at this hospital?

- There was no clear governance process in place to manage the termination of pregnancy services. The audits were unreliable and there was some non–compliance with the Abortion Act 1967.
- The hospital had a vision and a set of values. The hospital also had a clear corporate governance structure and a clinical governance committee that met quarterly to discuss a range of hospital issues.
- There were defined routes for cascading information to hospital staff.
- The hospital had a robust risk register.
- Senior managers at the hospital were visible, supportive and approachable.
- Staff were generally proud to work at the hospital and said they felt supported and valued.
- Clinical leads had a shared purpose and motivated staff to deliver services and succeed.

We saw an area of outstanding practice including:

- The formulation of the 'Pink Petals' support group was inspired by the needs of the local community and provided an accessible platform for all patients to gain information and support to help them manage their conditions.

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

Importantly, the provider must:

- The hospital must ensure that HSA1 and HSA4 forms are completed in line with the Abortion Act 1967 for all patients.
- Meet the requirements for staffing levels for children's services in accordance with the Royal College of Nursing standards for clinical professionals and service managers, 'Defining Staffing Levels for Children and Young People's Services', (2013) .
- Ensure there is access to a registered nurse (child branch) available to advise on the management and care and treatment of children and young people.
- Ensure staff that have responsibility for assessing, planning, intervening and evaluating children's care, must be trained to level three in safeguarding children.

In addition the provider should:

- Ensure effective governance processes are in place and that termination of pregnancy services audits reports to a committee to review results and action plans.
- The hospital should ensure that all audits relating to the termination of pregnancy service accurately reflect findings in patient records.
- The hospital should ensure that it is documented within patient notes following a termination of pregnancy whether consent to share information with their GP has been given or declined.
- The hospital should consider installing clinical hand basins in patient bedrooms when refurbishing the department in line with latest infection control guidelines.
- Consider the floor covering in consultation rooms and in patient bedrooms which were non-compliant with infection control guidelines.
- Ensure that MCA capacity assessments are always recorded in line with organisational policy and guidance.
- Ensure medical notes are always available for staff who are treating patients in the outpatients department.
- Ensure consultants do not bring mobile equipment to use in clinics without being able to evidence how it is cleaned and maintained.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	We rated the service as good for safe, effectiveness, caring, responsive and well led. Staff recognised the importance of raising concerns and recording incidents to encourage learning and improve patient care. We saw that systems and processes were in place to keep people safe from harm and abuse and where areas for improvement were identified, this was acted upon. The endoscopy facilities and chemotherapy unit were visibly clean and well organised. Care and treatment was delivered in line with evidence based guidance. Information about the outcomes of patients' care and treatment was collected and monitored to identify areas for improvement and share best practice. There was a programme of local and national audits conducted to improve care. The endoscopy facilities had started working towards gaining national Joint Advisory Group in Gastroenterology (JAG) accreditation. Patients spoke positively about the care they had received. Mental capacity assessments which were completed for patients with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders were not always recorded in patients' records in line with hospital policy. Patients were offered support to manage their treatment and conditions. There was a clear vison and strategy for medical services which all staff were aware of and felt involved in. Staff were constantly striving to improve performance and find new and innovative ways of working.

Summary of findings

Staff caring for young people did not have the appropriate level of safeguarding training.
There was no registered nurse (child branch) managing the care of young people admitted to the hospital. In addition, the hospital did not have access to registered nurses (child branch) to care for children and young people.

Surgery

Good

We rated the service as requires improvement for safe and good for effectiveness, caring and responsive and well led. This led to a good rating overall.
Patients' areas were tidy and visibly clean and staff followed the hospital infection control policies.
Patients were assessed and treated in line with professional guidance.
There were effective arrangements in place to monitor and manage pain. Patient nutrition and hydration needs were met.
Patients were treated with dignity and respect. Patients complemented staff on the care they received; they were given appropriate information about their care and treatment.
There was effective and flexible booking in systems that considered patients' needs.
Complaints were acknowledged, investigated and responded to in a timely manner and information was shared with staff.
The hospital had a clear governance structure. Information was cascaded to all staff. The service reviewed and acted on feedback about the quality of care received. There was strong leadership and staff felt valued.
Staff caring for young people did not have the appropriate level of safeguarding training.
There was no registered nurse (child branch) managing the care of young

Summary of findings

people admitted to the hospital. The hospital did not have access to registered nurses (child branch) to care for children and young people.

Outpatients and diagnostic imaging

Good

We rated the service as requires improvement for safe, and good for caring and responsive and well led. Effectiveness was inspected but not rated.
Staff identified and addressed safety concerns. Staff were clear with regards to the process to report incidents and were fully aware of the Duty of Candour regulation.
There was good evidence of learning from incidents.
There were good infection control procedures in place and the areas we visited were visibly clean.
Staffing levels were appropriate for the service provision with minimal vacancies.
Staff delivered patients' care and treatment following local and national guidance for best practice.
Staff obtained patient consent before care and treatment was given.
The hospital management team planned and delivered services in a way that met the needs of the local population. The importance of flexibility, choice and continuity of patient care was reflected in the services. Patients could access the right care at the right time.
The imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice.
Multi-disciplinary teams worked well together to provide effective care.
Referral to treatment times for NHS patients, were in line with the national average and patients could make appointments easily and quickly when required.
Patients were positive about the way staff treated them in all outpatient and diagnostic areas.

Summary of findings

Information on how to raise a concern or complaint was available for patients. The hospital complaints lead took complaints and concerns seriously and responded to them in a timely manner.
Staff had knowledge regarding the vision for the hospital. There was good staff satisfaction. Staff felt supported and valued. There was a strong culture of team working across the areas we visited.
Staff caring for young people did not have the appropriate level of safeguarding training.
There was no registered nurse (child branch) managing the care of young people attending outpatients. The hospital did not have access to registered nurses (child branch) to care for children and young people.
Clinical hand basins were not provided in consultation rooms when the hospital was built. This did not comply with current Health and Building Notice (HBN) 009 (2013).
The flooring in the consultation rooms were not compliant with HBN (2013) 00-10 part A.
Medical notes were not always available for staff who were treating patients in the department.

Termination of pregnancy

Not sufficient evidence to rate

The service was inspected but not rated.
Staff caring for young people did not have the appropriate level of safeguarding training.
There was no registered nurse (child branch) managing the care of young people admitted to the hospital. The hospital did not have access to registered nurses (child branch) to care for children and young people.
There was no evidence that the termination of pregnancy service was discussed or reviewed at any committee meeting.

Summary of findings

Not all HSA1 forms had a reason for termination documented in line with legislation.
Not all patient records had evidence that a HSA4 form had been completed and sent to the chief medical officer within 14 days to comply with the Abortion Act 1967.
Records did not always contain consistent information to demonstrate all aspects of patients care or medicines received.
There was no screening for sexually transmitted diseases in place. There were no processes in place for patient referral to obtain screening. This does not comply with national guidance.
Some records contained errors that had been crossed out but there were no initials to state who had rectified this error or crossed the previous content out.
Audits did not always accurately reflect the evidence we saw in patient records, this was non-compliant with Department of Health Required Standard Operating Procedures (RSOP) and was not always identified or addressed.
Action plans did not always address areas of non-compliance following audits.
Patients were protected from abuse and avoidable harm, as staff knew how to recognise untoward incidents and safeguarding concerns, and report them appropriately. There were arrangements in place to share and action any identified learning points following incidents.
Robust procedures were in place for managing medicines used in terminations.
All staff within the service and pharmacy team were aware of legislation surrounding medicines used in terminations.
Patients underwent thorough assessments prior to any treatment being delivered, with any potential risks documented and explained to patients.
Procedures were in place to ensure effectiveness of both medical and surgical terminations; the service had a 0% failure rate.

Summary of findings

Staff understood the need to show care and compassion towards patients who had decided to undergo a termination, and were aware of the emotional impact this may have on patients.
Services were easily and readily accessible to patients, with clinics available at various times throughout the week, including one weekend day.
Clinical audit plans were in place within the service that were compliant with RSOP.
The corporate risk registered identified the appropriate risks relating to the service.
There was an inclusive and team-working culture throughout the service, with a drive for effective patient care.

Summary of findings

Contents

Good

Spire Bushey Hospital

Services we looked at

Medical care; Surgery; Outpatients & diagnostic imaging; Termination of pregnancy;

Summary of this inspection

Background to Spire Bushey Hospital

Spire Bushey Hospital is a purpose built private hospital which was opened in 1982. Since then there have been a number of developments and a significant growth in volumes of patients treated year on year. In 2007 a private equity company called Cinven bought the company from BUPA Hospitals Ltd, and Spire Healthcare was established. Spire Healthcare became a public limited company when it floated on the London Stock Exchange in July 2014.

The hospital is located close to the M25, and M1 and provides access to a wide geographical area including; Watford, Hemel Hempstead, St Albans and Harrow.

The hospital has 58 inpatient beds, over two wards including four extended recovery beds.

There are five theatres, three with laminar flow which included an endoscopy suite and a laparoscopic theatre.

There are 20 consulting rooms. Diagnostic imaging facilities include a 128 slice dual source CT scanner, a newly replaced MRI scanner, digital mammography, ultrasound and x-ray. The physiotherapy department has eight treatment rooms, a hydrotherapy pool and a gymnasium.

The hospital undertakes a range of surgical procedures, to patients aged 16 years and over. The hospital suspended its inpatient and day case surgical service for children under the age of 16 years in January 2016 following a review of paediatric services. They provide outpatient consultations to patients aged from two years and over.

There is an off-site Elstree Cancer Centre (ECC), two miles from the hospital, which is based in a separate unit. This opened in 2010, Spire Bushey's day-case chemotherapy services were provided there together with the out-patient telephone appointment team.

There were administration and management staff on site.

The hospital is managed by Spire Healthcare and is part of a network of over 38 hospitals. The hospital provides care for private patients who are either covered by their insurance companies or are self-funding. Patients funded by the NHS, mostly through the NHS referral system can also be treated at Spire Bushey Hospital.

Our inspection team

Our inspection team was led by:

Inspection Lead: Julie Fraser Inspector, Care Quality Commission

The team of 11 included CQC inspectors and a variety of specialists: theatre nurse, consultant surgeon, infection control nurse specialist, and an oncology nurse specialist.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visits on 26, 27 July and 13 December 2016, an unannounced inspection on 4 August 2016. We made an additional announced visit on 12 September 2016 to review additional medical notes for TOP services. We spoke with a range of staff in the hospital, including nurses, consultants and support staff. During our inspection we reviewed services provided by Spire Bushey Hospital in the ward, operating theatre, outpatients and imaging departments and the Elstree Cancer Centre.

During our inspection we spoke with 22 patients, 68 staff, including consultants, who are not directly employed by the hospital and six family members/carers from all areas

Summary of this inspection

of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Information about Spire Bushey Hospital

The hospital has 58 inpatient rooms in two main wards, including four extended recovery beds, all with ensuite facilities. There are five theatres, three with laminar flow which includes an endoscopy suite and a laparoscopic theatre.

There are 19 consulting rooms. Diagnostic imaging facilities include a 128 slice dual source CT scanner, a newly replaced 1.5t MRI scanner, digital mammography, ultrasound and x-ray. The physiotherapy department has eight treatment rooms, a hydrotherapy pool and a gymnasium.

Spire Bushey Hospital has an in-house accredited theatre sterile services department.

Spire Bushey Hospital provides outpatient and inpatient service for various specialties to both private and NHS patients. Outpatient services are provided from the age of two years and upwards. The hospital previously carried out surgical procedures on children aged two years and upwards, but changed its registration in January 2016 to only admit young people aged 16-18 years and adults for surgical procedures.

The services include, but are not limited to, orthopaedics, gynaecology, general surgery, urology, ophthalmology and termination of pregnancy. There were 11,398 inpatient and day case surgical procedures carried out from April 2015 to March 2016. Of these patients 2,442 stayed one or more nights, the rest were day cases and 98 were children and young people aged between 2-18 years. There were 13 medical terminations of pregnancy and 12 surgical terminations of pregnancy were carried out from April 2015 to March 2016.

From April 2015 to March 2016, 87,022 people were seen in outpatients, 7,177 were children and young people aged between 2-18 years.

The hospital is accredited by all the major private medical insurers. From April 2015 to March 2016 around 8% of patients having day or in patient treatment were funded by the NHS, the remaining patients were self-funding or paid for by their insurance companies.

There are 371 doctors that have practising privileges and their individual activity is monitored.

All patients were admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day, seven days a week by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists who are employed by the hospital.

The hospital Accountable Officer for Controlled Drugs (CDs) is the matron.

The hospital has a local contract with a variety of local NHS trusts for blood transfusion services, genetics services, and used Spire Healthcare pathology services in a variety of locations within the United Kingdom.

Spire Bushey Hospital has been inspected twice by the Care Quality Commission, once in March 2013 and again in February 2014, with eight of the core standards being assessed during these inspections. All standards assessed were found to be compliant. The termination of pregnancy service was reviewed in March 2012 and all standards were met.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe? Start here...	Requires improvement 
Are services effective? Start here...	Good 
Are services caring? Start here...	Good 
Are services responsive? Start here...	Good 
Are services well-led? Start here...	Good 

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Termination of pregnancy	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

1. We will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.
2. We are doing further work on the aggregation tool for IH. If you have not followed the principles, please highlight the agreed reason determined at NQAG.

Good

Medical care

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

Information about the service

Spire Bushey medical services consist of a day-case chemotherapy treatment for patient aged 18 years and over and endoscopy services for patients aged 16 years and over.

The endoscopy facility is located at the main hospital site within the theatres complex and carries out a variety of procedures as day cases including colonoscopy (an internal investigation of the bowel) and hysteroscopy (an internal investigation of the uterus). The facilities include six day case beds on Gade Ward.

The chemotherapy unit is a part of the Elstree Cancer Care Centre and located at shared facilities two miles away from the main hospital site. The unit is open Monday to Friday 8am – 8pm delivering treatment agreed by the patient's consultant oncologist. Treatment provided at the chemotherapy unit is delivered by a team of specialist oncology nurses and overseen by a consultant. The unit consists of six patient treatment pods, one consulting room and a treatment room.

All attendances at the chemotherapy unit were patients aged 18 years and over who were receiving treatment through private medical insurance or self-funded. Endoscopic procedures were available for NHS patients (18 years and over), privately funded and self-pay patients aged 16 years and over. From April 2015 to March 2016 there were 1,992 attendances at the chemotherapy unit,1,121 endoscopic procedures were carried out on patients aged over 18 years and 10 endoscopic procedures were carried out on patients aged 16 and 17 years old.

We carried out an announced inspection on 26 and 27 July 2016 and an unannounced visit on 4 August 2016. During our inspection we visited the chemotherapy unit and endoscopy facilities. We spoke with 14 members of staff including the lead chemotherapy nurse, theatre manager, administrative and support staff, pharmacists and specialist care nurses. We received information from patients who used the service and viewed 10 sets of patient records.

Good

Medical care

Summary of findings

Overall, we rated the medical services at Spire Bushey as good for safe, effective, caring, responsiveness and well-led, because:

- Performance data showed a good track record on safety, patients were told when things went wrong and there were systems in place to ensure that patients received the correct treatment.
- Staff recognised the importance of raising concerns and recording incidents to encourage learning and improve patient care.
- We saw that systems and processes were in place to keep people safe from harm and abuse and where areas for improvement were identified, this was acted upon.
- The endoscopy facilities and chemotherapy unit were visibly clean and well organised.
- Care and treatment was delivered in line with evidence based guidance.
- Information about the outcomes of patients' care and treatment was collected and monitored to identify areas for improvement and share best practice. There was a programme of local and national audits conducted to improve care.
- The endoscopy facilities had started working towards national Joint Advisory Group in Gastroenterology (JAG) accreditation.
- Patients spoke positively about the care they had received.
- Patients were offered support to manage their treatment and conditions.
- There was a clear vison and strategy for medical services which all staff were aware of and felt involved in.
- Staff were constantly striving to improve performance and find new and innovative ways of working.
- Staff who were responsible for assessing young people's care in medical services, did not all have the correct level of safeguarding training.
- The hospital did not employ or have access to a registered nurse (child branch) when children or young people attended the hospital. This did not comply with national guidance.

Are medical care services safe?

Good

We rated the medical services as good for safe because:

- Performance data showed a good track record in safety.
- The service used an electronic system to record all incidents.
- Clinical areas were generally clean and well-organised. Medical records were maintained accurately and securely.
- There were safe systems for the storage and handling of medicines.
- Infection control procedures were followed and the service conducted regular audits.
- The service had a system in place to recognise and respond to changes in patients' health.
- There was evidence that patients were told when things went wrong and offered an apology.
- Mandatory training was up to date.
- The chemotherapy unit had been assessed by the Macmillan Cancer support charity in November 2015 and was awarded the Macmillan Quality Environment Mark (MQEM).

However, we also found:

- The service did not follow all of the Department of Health (DH) guidance for facilities for inpatients and clinical areas.
- Staff employed by the hospital, who were responsible for assessing young people's care in medical services, did not all have the correct level of safeguarding training.
- The hospital did not employ or have access to a registered nurse (child branch) when children attended the hospital. This did not comply with national guidance.

Incidents

- Staff understood their responsibilities to raise concerns and record incidents and near misses using the hospital's electronic reporting system. All staff that we spoke to were able to describe the process of reporting incidents.

Good

Medical care

- From April 2015 to March 2016 there were 333 incidents reported across the hospital for all services, 217 of the incidents were attributed to surgery and medicine. Eight of the incidents related to the chemotherapy unit and included incidents such as spilt anti-cancer treatment.
- Incidents were recorded as clinical and non-clinical and graded in severity from no or low harm to severe harm or death.
- We saw evidence that all incidents were robustly investigated and there were opportunities for learning this was discussed with staff and changes made when necessary. For example, nursing staff on the inpatient wards were able to tell us about the improvements to the process for assessing the risk of patients falling due to an incident and there were notices in patients' rooms encouraging them to call for assistance.
- A clinical governance and risk manager was in place to oversee all incidents within the hospital, alongside the head of clinical and non-clinical services. Incidents were discussed at senior management meetings, clinical governance meetings and there were monthly adverse incident meetings. If necessary, an incident would also be discussed at speciality meetings including medicines management committees. Following these meetings feedback would then be disseminated to staff within the service.
- There had been no 'never events' reported for this hospital from April 2015 to March 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff were able to discuss the principles of duty of candour and being open and honest. We saw evidence that patients were offered an apology and reasonable support when things went wrong.
- Incidents which were discussed regularly at medical advisory committee (MAC) meetings, clinical governance and departmental meetings included reviews of incidents that had resulted in expected or unexpected death to identify trends.
- National patient safety alerts were discussed at clinical governance meetings and we saw evidence that alerts were dealt with appropriately; staff were informed through daily briefings and team meetings.

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

- The medical services had systems in place to monitor the number of falls, pressure ulcers, catheter related infections and blood clots (venous thromboembolism, VTE) that occurred for inpatients in line with national guidelines.
- Monthly audits were conducted on the wards to check the effectiveness of controls put in place to minimise the risk of patients falling or acquiring pressure ulcers. This included comprehensive risk assessments and training to ensure compliance to organisational policies.
- From April 2015 to March 2016, the hospital recorded eight instances of VTE. We saw that there were VTE screening processes in place and the hospital had carried out audits which showed that from April 2015 to March 2016 there was 100% compliance to VTE screening. There had been 14 inpatient falls from April 2015 to March 2016. The hospital introduced a number of ways to help prevent falls, this included staff education in completing risk assessments and encouraging patients to call if they needed assistance to move.

Cleanliness, infection control and hygiene

- The day case unit and chemotherapy unit were visibly clean and tidy. We saw that cleaning schedules were in place and housekeeping staff had signed regularly throughout the day to indicate when the area had been cleaned. There were also 'I am clean' stickers on equipment marked with the date they were cleaned.
- There were reliable systems in place to prevent and protect people from a healthcare associated infection.
- There was an infection prevention and control committee which held regular meetings that were attended by infection leads from all departments. We saw that the committee monitored the infection control systems in place and made improvements when required.

- Quality indicators for infection control were displayed on the hospital's clinical scorecard which was on the organisation's internal website. Hospitals within the organisation were able to view all scorecards and compare their results.
- Infection control audits were conducted on a regular basis and included adherence to hand hygiene protocols. We saw that there were posters relating to hand-washing techniques in the wards and chemotherapy unit. Hand hygiene audits for staff were conducted by hospital employees and patients attending the hospital. All staff adhered to the arms bare below the elbow policy.
- From April 2015 to March 2016 hand sanitiser was used 19 times per occupied room per day and the hospital's target was 18. From April 2016 to June 2016, 86% of patients who took part in the audit said that they had seen information relating to handwashing techniques and 82% of patients reported that staff always sanitised their hands before attending to their dressings or wounds, 2% said sometimes and 8% were unsure.
- The chemotherapy unit infection and prevention control lead conducted infection control audits which were in addition to those in the hospital infection control plan. Staff told us that they did this because patients receiving chemotherapy were susceptible to infections as their immune system was compromised by cancer treatment drugs. These included audits relating to aseptic techniques used when inserting catheter devices for delivering systemic anti-cancer therapy (SACT). We saw that in March and April 2016, staff in the chemotherapy unit achieved 93% compliance to infection control protocols when managing catheter devices. Actions from the audit included reminding staff to use specific alcohol wipes at the site of insertion.
- Staff working in endoscopy were able to describe the precautions taken when seeing patients with communicable diseases, this included arranging the theatre list to see the patient at the end of list when possible and following infection control procedures. Staff also told us that they would liaise with the infection control lead and consultant microbiologist for advice.
- The Department of Health's (DH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. We saw that the processes adapted at Spire Bushey were in line with DH recommendations. There was a robust process in place which ensured that the start of endoscopic equipment decontamination process started immediately at the bedside. The endoscopes were then transported directly to a dedicated decontamination area adjacent to the theatre. The equipment was then tested for integrity and underwent a further manual clean with specialised single use brushes and equipment before being placed in an endoscopic washer-disinfector. Clean endoscopes were placed in sterile trays and transported through a sterile area to a separate clean area which had a drying unit and then placed in an ultraviolet cupboard and appropriately stored for up to 72 hours.
- From April 2015 to March 2016 there were no reported incidents of Clostridium.Difficile (C Difficile), MRSA or Methicillin-susceptible Staphylococcus Aureus (MSSA).
- Staff had access to appropriate personal protective equipment such as disposable aprons and gloves.

Environment and equipment

- The service had systems in place to ensure that equipment was maintained and staff knew how to use it; this included training by manufacturers on specialist equipment.
- The hospital followed most of the DH guidance for facilities for inpatients and clinical areas, for example, in regards to space. The hospital was in the process of refurbishing their inpatient rooms as some of the facilities did not follow DH guidance. The hospital had identified that the carpeted rooms did not meet with Health Building Notice (HBN) 00-10 Part A and had started replacing the carpet with vinyl flooring; this was due to be completed by the end of 2016 and was on the hospital's risk register. We saw that areas that were still carpeted underwent a routine monthly deep clean and there was a record of when additional cleaning had been undertaken due to domestic or clinical spillages.
- The endoscopy decontamination area was compact and staff told us that there were plans to increase the size. There was one sink in the endoscopy decontamination area and this was not in line with DH guidelines, however, there was a separate 'clean' and 'dirty' area to minimise the risk of cross infection. This was on the hospital risk register and we saw an action plan to increase the capacity.
- There were systems and arrangements in place to manage waste which included processes for managing cytotoxic (cytotoxic drugs are used for cancer

treatments to help prevent growth of cancer cells) spillages. We saw that they had appropriate 'spillage packs' for cytotoxic drugs in the chemotherapy unit. Staff in the chemotherapy unit and pharmacy were able to describe the process in the event of a spillage and the hospital had a comprehensive policy on the safe management of cytotoxic substances.

- We saw that clinical waste was appropriately disposed of and sharps bins were used and stored appropriately.
- The resuscitation trolleys on the wards and in the chemotherapy unit were checked and maintained on a daily and weekly basis and staff told us they would highlight equipment and drugs that were nearing expiry date. However, we noted that some of the equipment that should have been stored in sterile packaging was not; staff told us that this was so that they would have easy access in the event of an emergency. This was not in line with best practice for infection and prevention control and the hospital responded by reviewing all of the resuscitation trolleys and ensuring that equipment was stored correctly; we saw this on our unannounced inspection. Staff told us that they had received training in how to use the resuscitation equipment.
- In the chemotherapy unit we saw evidence that staff had received training by manufacturers to use specialist equipment such as syringe drivers (these were used to help reduce symptoms such as pain or sickness by delivering a steady flow of injected medication under the skin). The senior nurses in charge told us that they regularly arranged for medical device representatives to attend the unit and deliver bespoke training; we saw records that showed that staff had attended these training sessions.
- Equipment was stored appropriately and we witnessed staff contacting the in house engineers department to remove defective equipment.
- Maintenance of equipment was completed by in house engineers and manufacturers of specialised equipment. The hospital had policies which defined which equipment would need to be serviced and repaired in house or off site. We saw that there was a clear schedule in place for the maintenance and servicing of all equipment.
- The chemotherapy unit had been assessed by the Macmillan Cancer support charity in November 2015 and was awarded the Macmillan Quality Environment Mark (MQEM). The MQEM award was an assessment of services provided for patients living with cancer, which is based on an assessment of the environment ensuring it is welcoming and accessible, that patients are treated with dignity and respect and are given choices in their care and treatment. Accreditation standards were reassessed three yearly to ensure continued compliance.
- The hospital completed the Patient-Led Assessments of the Care Environment (PLACE) in 2016 and received 99% for 'condition, appearance and maintenance'.

Medicines

- Pharmacy services were available at the main hospital site Monday to Friday 8am to 5pm and 8.30am to 12.30pm on Saturdays, there was a 24 hour on call service available seven days a week. The hospital had recently opened a dedicated oncology pharmacy at the main site to improve safety and efficiency; there were plans to relocate the oncology pharmacy closer to the chemotherapy unit.
- There were arrangements in place for safely managing medicines, including chemotherapy. This included systems for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- Nursing staff were aware of the hospital's policies on medicines management and the administration of controlled drugs was in line with Nursing and Midwifery Council (NMC) guidelines.
- The hospital conducted regular medicine audits and we saw that action plans had been devised to improve compliance to protocols in specific areas. For example, an audit conducted in November 2015 showed that staff were not always completing documentation in line with the hospital's policy when medicines were taken from the storage area. An action plan had been developed and included appropriate guidance and mandatory requirements being displayed on the front of drugs cupboards and ensuring that staff were aware of the policy and process through online training and daily briefings.
- The hospital used medication records to document medications prescribed and administered. We reviewed six sets of medical records and found that these had been completed appropriately and whether the patient had any allergies was clearly indicated in the appropriate area of the records.

Good

Medical care

- Medicines reconciliation was completed by designated nurse practitioners and pharmacy staff. This was a process of identifying medicines that patients were prescribed before admission and reviewing any newly prescribed drugs to prevent any interactions.
- There were no controlled drugs kept at the chemotherapy unit. Chemotherapy treatments were prepared by an external provider and delivered to the dedicated oncology pharmacy at the main hospital site and transported to the chemotherapy unit within 24 hours. We saw that the hospital had processes in place to track the transfer and receipt of all chemotherapy treatments. Upon receipt of the treatments staff at the unit secured the medicines in a refrigerator.
- The hospital did not use unlicensed medications but did have access to medications that were not usually available on the NHS, for example, specific anti-sickness medications used in the chemotherapy unit.
- Patients who received medicines to take home were given clear instructions on how to take them and given the opportunity to discuss possible side effects.
- We saw that the fridge temperatures were regularly checked and we witnessed two members of staff checking a patient's medication against the patient's medical record and notes as per the organisation's policy.
- In theatres where endoscopic procedures were carried out controlled drugs were kept in each theatre's locked cupboards. Access to the theatres was via a fingerprint entry system and the keys for the controlled drugs were held by one member of theatre staff whilst theatres were open. The keys were stored on the ward in a locked cupboard when theatres were closed, the sister or senior nurse in charge would hold the keys for the locked cupboard. There were processes in place to track and identify who had the keys and we saw that medicines management was discussed regularly at departmental meetings.
- The hospital had a robust policy, process and guidelines for managing the administration of prophylactic and therapeutic antibiotics. This included regular monitoring and review as a part of the overall medicines audits to ensure that prescribers were following protocols.
- We saw that the hospital had a sedation policy which was based on American Society of Anaesthesiologists (ASA) and British Society of Gastroenterology (BSG) guidelines; staff in theatres were able to articulate the process including emergency situations.

Records

- Patients' individual care records were managed and stored appropriately. The hospital had a comprehensive policy which described how records should be completed and stored. There was clear guidance on how information should be recorded and which areas of the records had to be filled in, for example, hospital numbers and discharge details.
- There were clear systems in place to ensure that medical records generated by consultants holding practising privileges (the term used for health care professionals such as consultants who practised in private hospitals) were safely integrated into the hospital's records for the patients. The process for this was clearly defined in the hospital's records management policy, which those with practising privileges were required to adhere to.
- Records within medical services were paper based and stored in locked areas at the main hospital site and the chemotherapy unit.
- During our inspection we reviewed 10 sets of patient's records and found that the admission notes had been written in line with General Medical Council (GMC) guidance. The reasons for admission were clearly documented and decisions relating to care pathways documented. Records for patients receiving chemotherapy treatment were detailed and contained clear information about individual patient medication regimes and treatment plans.
- The endoscopy service care pathway included a modified version of the World Health Organisation's (WHO) five steps to safer surgery checklist.
- Notes made by nursing staff were clear, legible and described the care and treatment given to patients in line with NMC guidelines.

Safeguarding

- There were systems and processes in place to keep patients safeguarded from abuse.
- The hospital had a safeguarding policy for adults and children and we saw that flow charts were displayed in

departments, this included information about recognising women or children at risk of female genital mutilation in line with national guidelines. The flowcharts and policies also included the details of the hospital's safeguarding leads and external organisations.

- All hospital staff were required to complete safeguarding level one for adults and children as part of their mandatory training. At the time of our inspection 69% of nursing staff had completed level two safeguarding for children and 72% had completed safeguarding level two for adults. In theatres, where the endoscopic procedures were performed, 93% of staff had received safeguarding level two for children and 95% had received safeguarding level two for adults. We saw that the hospital had a comprehensive plan to improve the levels of training and this had been discussed in clinical governance meetings. Clinical staff and consultants had training planned for the future for children's safeguarding level three. The aim was to ensure that all clinical staff would complete children's safeguarding level three training. The matron had completed children's safeguarding level three and could offer advice to staff as required. The matron and OPD Manager, who was also the hospital Safeguarding Lead, was planning to complete children's safeguarding level four.
- Nursing staff were able to describe their responsibilities and actions if they had concerns that a patient was vulnerable and at risk of abuse.
- The hospital did not employ or have access to a registered nurse (child branch) when children attended the hospital.
- There were no patients treated at the chemotherapy unit who were aged under 18 and the nursing staff had received adult safeguarding training as part of their mandatory training.
- Staff who were caring for young people aged between 16-18 years were not trained to level three in safeguarding. Although we saw no evidence of a failure to safeguard children, we were not assured that all staff who had contact with young people had received the appropriate level of safeguarding training. The provider should ensure that a process is in place to ensure clinical staff working with young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a young person and parenting capacity where there are safeguarding/child protection concerns has received training to the appropriate level of competency as outlined in the Intercollegiate guidance Safeguarding Children.
- The hospital had three managers who acted as the leads for adult and children's safeguarding and had been trained to safeguarding level three for children. This included the theatre manager for the endoscopy services; however, no other staff in theatres had received this level of training.
- We raised the lack of children's safeguarding level three training with the hospital and we received details of their action plan to address this. We also saw that this had been discussed at the hospital's annual clinical governance meeting in 2015 and plans had been made to increase the level of safeguarding training for all staff.

Mandatory training

- Mandatory training at the hospital was delivered through self-directed online learning and face to face training. The hospital's target for mandatory training completion was 95%.
- Training included modules relating to health and safety, infection prevention and control, information governance, safeguarding for adults and children, medicines management and manual handling.
- From April 2015 to March 2016, compliance with mandatory training was 91% and we saw that this had been discussed at departmental meetings to improve the figure to meet organisational targets. Senior managers discussed different ways to deliver training including more access to online courses and an emphasis on encouraging staff to complete self-directed learning.
- We saw that records of staff who had completed their mandatory training were held by senior nursing staff in charge of departments.

Assessing and responding to patient risk

- The service conducted comprehensive risk assessments for patients using the service and developed risk management plans in line with national guidance.
- The hospital had a clear admissions policy which set out guidelines for safe admission of medical patients. Every patient who attended the endoscopy facilities and chemotherapy unit was required to undertake a pre-admission risk assessment. There were four

different levels of risk assessment undertaken prior to admission which began at the booking stage with a medical questionnaire. There was also a nurse led telephone and face to face assessment. The policy also defined which level of risk assessment was automatically required for specific patient groups; for example, patients who had pacemakers (an internal or external electronic device used to regulate heart rates) fitted would automatically receive a face to face assessment and if necessary a pre-admission assessment was made by a consultant anaesthetist.

- Admissions were not accepted unless the patient was under the care of an appropriate consultant who had practising privileges at the hospital. The hospital did not accept emergency or unplanned admissions until an appropriate consultant had liaised with the referrer and agreed to be present at the patient's admission.
- Medical services within the Elstree Cancer Centre did not provide 24-hour cover. Out of hours, provision was through the inpatient ward area and the resident medical officer. Patients undergoing chemotherapy who became acutely unwell were admitted to the main inpatient area for treatment.
- The hospital used the National Early Warning Score (NEWS) for all patients in line with the National Institute for Health and Care Excellence (NICE) guidelines relating to recognising and responding to the deteriorating patient. This was a colour coded system staff used to record routine physiological observations such as blood pressure, temperature and heart rate, with clear procedures for escalation if a patient's condition deteriorated. Nursing staff that we spoke with were able to describe the process and explained who they would contact in an emergency, we saw evidence that these checks were made and recorded appropriately.
- The hospital had a clear critical transfer policy for patients who deteriorated and needed a higher level of care than that provided by the hospital. There was a service level agreement with a local acute NHS trust to transfer patients by ambulance if required. All staff we spoke with in the endoscopy service and chemotherapy unit were able to describe the process and their actions. Staff told us that this was rare and if this happened it would be recorded as an incident. From April 2015 to March 2016, we saw that there had been no recorded incidents of patients being transferred as an emergency whilst receiving medical care.
- Patients receiving chemotherapy treatments were advised of the risk of neutropenic sepsis (patients receiving anti-cancer treatments are susceptible to neutropenic sepsis due to a temporary reduced white blood cell count during treatment) and given information to allow them to recognise any signs or symptoms of sepsis after treatment. Staff had access to an algorithm based on NICE guidelines in regards to treatment of neutropenic sepsis, this included timeframes for antibiotic administration.
- The chemotherapy unit provided a 24 hour telephone advice service which was always staffed by the hospital's oncology nurses. We saw the telephone triage tool that was used which was based on UK Oncology Nursing Society (UKONS) recognised guidance designed to promote safer decision making. Patients were advised to contact the 24 hour line for any queries and concerns. In addition, some staff at the main hospital site had received training and guidance on how to use the triage tool. Staff told us that this meant that in an emergency if a patient was unable to get through to the 24 hour line they would still be able to receive an appropriate assessment. Staff could not provide us with any specific examples of when a patient had not been able to get through to the 24 hour line.
- We saw that the hospital had a robust extravasation policy. Extravasation is a term used when medicines that are being administered intravenously (such as chemotherapy) unintentionally leak into the surrounding tissue and cause damage. Staff were able to describe the process for treatment and the importance of recognising the early symptoms. The service had an agreement with a local acute NHS trust to transfer patients who needed treatment as a result of extravasation.
- The service used a Spire Healthcare modified version of the World Health Organisation (WHO) five steps to safer surgery checklist. Staff conducting procedures were required to confirm the patient's name, age, procedure site and consent before starting treatment and record that this had been done on the checklist. We saw that in an audit conducted in March 2016 staff had recorded details on completion of the checklist in line with the hospital's policy 95% of the time. We saw that recommendations from the audit were to ensure that all staff recorded actions and this was discussed at departmental meetings and a reminder sent to all staff

Good

Medical care

Nursing staffing

- During the inspection we observed in the endoscopy facilities and chemotherapy unit that there was a good skill mix and appropriate level of nursing staff to meet patients' needs.
- The hospital used an acuity tool to plan and review staffing levels and skill mix which was based on national guidelines for staffing on wards in independent hospitals. Senior staff told us that they planned based on the acuity levels of patients and the amount of 'care hours' each patient required. We saw that senior staff used historical data to calculate how many hours of care a patient needed and planned the rotas accordingly. Senior staff told us that on the wards this generally equated to one registered nurse (RGN) and two health care assistants (HCA) for every five patients but this could be adjusted or increased to meet the acuity of the patients. The clinical ward manager or matron and ward sisters were supernumerary and on each shift; they acted in a supervisory position and provided a point of escalation.
- There was no baseline acuity tool for nursing staffing in chemotherapy. The chemotherapy unit was staffed with a chemotherapy sister, four senior oncology nurses, eight oncology nurses and three HCAs. Senior staff planned to have a minimum of four nurses and two HCAs on duty per day and at least one senior member of staff to act in a supernumerary position; with six chemotherapy rooms this meant that there was always a member of staff to look after a patient. We saw that this number was adjusted downwards to meet the demands of the service.
- Staffing for the endoscopy unit was made up of RGNs, HCAs and Operating Departmental Practitioners (ODP) who worked on the day case ward and in theatres. There were dedicated theatre staff with specific competencies who assisted consultants with endoscopic procedures.
- There were no vacancies in the endoscopy service or chemotherapy unit at the time of our inspection.
- Clinical nurse specialists worked within the medical services; specifically breast care nurses and cancer nurse specialists. The hospital employed one palliative care nurse and two breast care specialist nurses.
- There was minimal use of bank and agency staff. The hospital's target was 3% use of bank and agency staff, from April 2015 to March 2016 the hospital average bank and agency use was less than 1% and in theatres they had used no agency staff. We saw that bank or agency staff would receive a comprehensive induction which included a competency checklist.
- We observed effective handovers between nursing staff on the wards at the start of their shifts. The majority of patients that attended the endoscopy facilities and chemotherapy unit were admitted as day cases, we observed appropriate handovers between theatre staff and nursing staff in the recovery area which included all vital information necessary for continuity of care.

Medical staffing

- The hospital's medical advisory committee (MAC) was responsible for granting consultants practising privileges at the hospital. The MAC carried out appropriate checks for medical staff in regards to their scope of practice and eligibility to practice.
- Consultants with practising privileges at Spire Bushey were required to be contactable at all times, when they had a medical patient at the hospital, and visit them daily. They were also required to be able to arrive at the unit within a specified timeframe of 45 minutes if there was an emergency. Nursing staff told us that they were able to call and speak with the consultants at any time for advice.
- The hospital had four resident medical officers (RMOs) who provided emergency consultant cover and medical advice 24 hours a day, seven days a week. The RMOs generally worked a week on duty and a week off duty and stayed within the hospital at all times. Rotas were arranged so that there was one RMO available at all times in line with national guidance.
- Consultants with practising privileges were required to make their own arrangements for appropriate equivalent cover for annual leave. This was with another consultant with practising privileges at the hospital and cover arrangements were logged on an electronic register.
- Nursing staff told us that they received effective handovers from medical staff when patients were admitted to the hospital and after consultants had visited their in-patients. The RMOs conducted handovers at the change of their shifts with the new RMO on duty detailing any areas of concern and highlighting any patients that may have higher acuity needs and require extra monitoring.

Good

Medical care

Major incident awareness and training

- The hospital had a business continuity plan which described what staff should do in the event of loss of facilities due to events such as severe weather or loss of power. Each department was provided with action cards that described the process in the event of an evacuation due to a major incident affecting service. Staff were able to tell us where the plan was located on the intranet and where paper copies and action cards were located and they were familiar with the evacuation procedures.
- The Elstree Cancer Care Centre had a separate business continuity plan due to the nature of the treatment being delivered. Staff were able to direct us to the plan and we saw that they had attended specific training sessions and conducted evacuation exercises.
- We saw evidence of regular fire alarm testing at both sites.

Are medical care services effective?

Good

We rated the service as good for effectiveness because:

- Care and treatment was delivered in line with evidence based guidance.
- There was a programme of local and national audits conducted to improve care.
- The endoscopy service had started working towards national Joint Advisory Group in Gastroenterology (JAG) accreditation.
- Staff were proactively encouraged to develop new skills.
- All nursing staff had received an up to date appraisal and identified individual training needs.
- The service had robust systems in place to ensure that medical staff with practising privileges had received regular appraisals and had completed revalidation in line with General Medical Council (GMC) requirements.
- The service worked well with internal and external teams to plan and deliver care and treatment.

However, we also found:

- Mental capacity assessments which were completed for patients with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders were not always recorded in patients' records in line with hospital policy.

Evidence-based care and treatment

- We saw evidence that patients' needs were assessed and treatment delivered in line with legislation, standards and evidence-based guidance. For example, the endoscopy service followed National Institute and Health Care Excellence (NICE) professional guidance for endoscopic procedures for patients aged 16 and over.
- The hospital had a comprehensive clinical audit programme which included local and national audits. For example, the chemotherapy unit were participating in a national organisational neutropenic sepsis audit which looked at compliance to NICE guidelines for risk assessing, recognising and treating neutropenic sepsis; this was ongoing at the time of our inspection so results were not available. We did see that policies and processes relating to cancer care were based on NICE and UK Oncology Nursing Society (UKONS) guidelines.
- Local audits were undertaken to monitor and review compliance to protocols and national guidance. For example, monthly audits were conducted for patients assessed as being at risk of venous thromboembolism (VTE) being offered VTE prophylaxis in line with NICE guidelines.
- The hospital used a modified version of the World Health Organisations (WHO) five steps to safer surgery checklist which included a team brief and a team debrief in the checklist.

Pain relief

- Patients we spoke with told us that their pain had been well managed.
- The service met the core standards for pain management services (Faculty of Pain Medicine, 2015). We saw in medical records that patients with acute pain had an individualised analgesic plan appropriate to their condition. Pain was assessed during observations and recorded on NEWS charts; we saw that this was audited regularly to ensure that this standard was being met. From April 2015 to March 2016 we saw that audits showed that all patients had their pain scores documented in their medical records in line with the hospital's policy.
- Syringe drivers were used in the chemotherapy unit which delivered a slow steady flow of pain relief. We saw that all staff had received specific training in the use of these.

- The palliative care nurse specialist was able to speak with patients about symptom control and arrange for assistance in the community for patients who needed help with pain control on discharge.

Nutrition and hydration

- Patients nutritional and hydration needs were assessed by a nurse upon admission. Nursing staff were required to confirm that patients had completed the 'fasting' required for certain procedures.
- Patients who were having endoscopic procedures were given information prior to admission that detailed the types of food they could have and when to stop eating solid foods. They were also given information regarding fluid intake to ensure that they did not become dehydrated.
- The catering and housekeeping department provided food and drink for patients after procedures where patients were encouraged to eat before leaving the unit, for example, after undergoing a colonoscopy (an internal endoscopic investigation of the bowel).
- Patients who attended the chemotherapy unit were able to request food and drink which was delivered to the chemotherapy unit for patients' appointment times. Staff also had access to a kitchen area where they could prepare hot and cold drinks for patients.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored to identify areas for improvement and share best practice.
- The endoscopy service was working towards Joint Advisory Group Gastroenterology Society (JAG) accreditation and had an action plan to meet the standards. The action plan was based on the results of audits which were based on JAG quality and safety in endoscopy global rating scale (GRS) (British Society of Gastroenterology Quality and safety indicators for endoscopy, 2009). The GRS audit was divided into four areas which were clinical quality, patient experience, workforce and training. A comprehensive GRS audit of the endoscopy service had been conducted in September 2015 and it showed that the service had an overall compliance of 92%. Areas for improvement were highlighted in the action plan and included strengthening the processes in place to deliver bespoke endoscopy training and formalised feedback to individual staff members.
- There had been an annual external review of the decontamination services in 2015 and accreditation had been received from an organisation which measured quality management systems.
- Each hospital within the organisation used a clinical scorecard which displayed quarterly results from monthly local audits in a number of areas including infection control, accurate record keeping, medicines storage and completion of risk assessments. The clinical scorecards were available on the organisation's intranet which meant that services were able to compare their performance to similar services within the Spire group.
- The chemotherapy unit conducted regular audits relating to peripheral and centrally inserted central lines (a long thin catheter inserted into the veins) used to deliver chemotherapy treatment. For example, in March 2016 the unit scored 93% for compliance to aseptic techniques and insertion techniques. The unit had developed an action plan which included reminding staff of the correct alcohol solution to disinfect the insertion site.

Competent staff

- All staff had the right qualifications, skills, knowledge and experience to do their jobs. At the start of their employment with the hospital, staff were given a comprehensive induction and received on-going training, opportunities for development and competency checks.
- Oncology nurses attended annual training sessions by an external provider to maintain and check their competencies and knowledge. We saw records that showed that these were up to date.
- Training for staff in endoscopy was based on British Society of Gastroenterology (BSG) guidelines and we saw that this was audited and reviewed on an annual basis to ensure that staff received on-going appropriate training.
- All nursing staff were required to undertake basic life support (BLS) as part of mandatory training. Safer staffing guidelines recommend that at least one member of staff on duty should have advanced life support (ALS) training. There were 15 staff at the hospital trained in ALS, four of whom worked at the chemotherapy unit. We saw that rotas were planned to ensure that at least one staff member per shift had ALS training.

- In theatres, one member of staff had undergone the European Paediatric Life Support (EPLS) training. If a young person, aged 16-17 was having an endoscopic procedures the theatre manager ensured that the EPLS trained member of staff was on duty. The resident medical officer also had EPLS and was on duty 24 hours a day.
- Revalidation is the process that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. We saw that the medical services had been holding workshops to assist staff with understanding revalidation requirements and training sessions in specific areas which could be used for revalidation purposes; for example, an oncology study day for all staff which included training about managing and screening for neutropenic sepsis.
- All registered nurses that worked in the wards and theatres had valid nursing and midwifery registration or were registered with the Health and Care Professions Council. This confirmed that nurses and other practitioners, such as operating department practitioners were trained and eligible to practise within the UK. There was an effective process in place to ensure these were updated.
- The hospital director was responsible for ensuring that all medical staff with practising privileges had the correct skills, competencies, experience and qualifications to carry out the care and treatment provided. The MAC assisted with this process by providing professional advice. This included comprehensive background checks including Disclosure and Barring Service (DBS) checks and ensuring that medical staff were registered to practice in the area of practice. All medical staff were given a 'consultants' handbook' which clearly laid out the requirements of maintaining their practising privileges at Spire Bushey. Practising privileges were reviewed every two years by the MAC and hospital director to ensure that consultants were practising within their scope and meeting the hospitals and statutory requirements.
- From January 2015 to January 2016 all nursing staff including health care assistants and operating departmental practitioners and 96% of support staff received an annual appraisal. Staff told us that this was an opportunity for them to highlight their individual training needs and identify areas for improvement.
- Medical staff with practising privileges were required to provide evidence of appropriate appraisals in line with the General Medical Council (GMC) guidelines; this was checked by the MAC and the hospital had a comprehensive policy which described the consultants' responsibilities. Consultants who did not provide appropriate evidence had their practising privileges temporarily suspended until the evidence was produced.
- The pharmacy manager and two other pharmacists had completed specific training to dispense medications related to oncology and at the time of our inspection another member of the pharmacy team was undergoing the training.

Multidisciplinary working (in relation to this core service)

- We saw that staff, teams and services worked effectively together to deliver effective patient care.
- Weekly multi-disciplinary team (MDT) meetings were held for breast cancer care and were attended by oncology nurses, breast care specialists, consultants and GPs; we saw evidence of this in patients' medical records; these MDT meetings were well established. The hospital also held MDT meetings for patients with urology and bowel cancer, staff told us that they were developing agreements with local NHS trusts to improve MDT meetings for patients in these groups. This was highlighted as an area for improvement on the hospital's risk register and we saw that MDT meetings for urology had developed since April 2016.
- There were good working relationships between all the teams and we saw that staff in medical services liaised with outpatients and surgery to assess and plan care and treatment for patients.
- We saw that the palliative nurse specialist worked closely with staff in the cancer care centre and on the wards to provide support and advice in planning end of life care; this included providing important links to community services and support networks.
- The breast care specialist nurse liaised with external organisations to provide support and advice for patients.
- Nursing staff told us that they had developed good working relationships with consultants and that they felt confident to contact them whenever it was necessary.

- We saw that the service had good working relationships with local NHS acute trusts for transferring patients in line with agreed pathways.
- We saw that discharge plans included information sent to the patient's GP and referral to other community services such as local hospices for ongoing care.
- The Elstree Cancer Care Centre was a partnership between Spire Bushey hospital and another healthcare provider. Spire Bushey provided oncology consultation and chemotherapy treatments and the provider they worked with was responsible for delivering radiotherapy treatments. We observed effective working relationships at the centre and seamless interaction between the services.

Seven-day services

- The chemotherapy unit and endoscopy facility provided services Monday to Friday 8am to 8pm. Staff told us that they sometimes adjusted the times to meet demands, for example, staff in the chemotherapy unit told us that on occasion they would deliver treatment on the weekends during bank holiday periods to ensure patients received their treatment in a timely manner.
- The hospital had a resident medical officer (RMO) who was contactable 24 hours a day, seven days a week.

Consultants responsible for patients were required to be contactable at all times when their patients were at the hospital.

- The chemotherapy unit provided a 24 hour telephone service to provide patients with advice and guidance at all times.
- Patients could phone the ward staff for advice at any times, and they could contact the consultant if required.
- There was an on call emergency theatre team that could carry out an emergency endoscopic procedure if required.

Access to information

- There were systems and processes in place to ensure that information needed to deliver effective care and treatment was available in a timely manner.
- All staff had access to the hospital's intranet where all policies and processes relating to care and treatment were located. Staff told us that this was easy to navigate and access to information formed a part of their corporate induction.
- Consultants with practising privileges were required to ensure that records that they held for their patients were available to staff. If consultant's held the patient's records they were required to provide a copy or summary that was contained within the hospital's patient records; we saw evidence of this in the records that we looked at during our inspection.
- When patients moved between services or teams relevant information was shared appropriately and in line with the hospital's policies. For example, we saw that patients who had been transferred from NHS facilities had a copy or summary of the care received before they were transferred and a letter detailing why they had been transferred.
- The service had arrangements in place to ensure that test results for patients were available in a timely manner; this included co-ordination and planning of appointments and care. Staff in endoscopy told us that the average time for endoscopy results was one to two days and that results were available when patients returned for consultation one week to ten days after their procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- MCA 2005 and DoLS training formed a part of mandatory training for staff.
- Staff were aware of the process of assessing mental capacity to consent to treatment but some were unable to tell us or show us where they would find the assessment tool to record their decisions.
- The hospital had a comprehensive consent policy which was up to date and regularly reviewed to ensure compliance with legislations.
- We looked at the medical records of six patients who had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders; we found that most of these were completed correctly and in line with legislation. In two instances where the patient was assessed as lacking capacity to consent to DNACPR, we found that the decision had been correctly discussed with the patients relative or next of kin and consent sought from them. However, we found no evidence that an assessment of capacity had taken place. We highlighted this to senior

managers who told us that consultants were required to record details of the capacity assessments in the medical records in line with the hospital's policy and this would be addressed in a briefing to all staff.

Are medical care services caring?

Good

We rated the service as good for caring because:

- Patients told us that they were treated with kindness, respect and compassion.
- We saw staff taking the time to interact with patients and those accompanying them.
- The service conducted their own surveys to receive feedback from those using the service.
- The hospital wide friends and family survey, which included both NHS and private, scored consistently high with the number of patients that would recommend the hospital.
- Patients spoke positively about the care they had received.
- Patients were offered support to manage their treatment and conditions.

Compassionate care

- Patients and those close to them were treated with compassion, kindness, dignity and respect including when receiving personal care.
- We observed staff taking the time to interact with patients in a respectful and considerate manner.
- Patients were given the opportunity to be accompanied by a friend or relative for consultations and there were chaperones available in all areas.
- Nursing staff showed a holistic understanding of the personal, cultural, social, religious and physical needs of patients and those close to them.
- The hospital wide friends and family survey, which included both NHS and private patients scored above 97% for the number of patients who would recommend the hospital from April 2015 to March 2016. The response rates were on average 34% for the same time period, which is in line with the England national average.
- Patients spoke positively about the caring and respectful manner of all staff.

Understanding and involvement of patients and those close to

- We saw staff in the chemotherapy unit greeting patients by their first name and patients calling nursing staff by their first names upon arrival.
- In testimonials from patients about their treatment at the cancer centre and the main hospital site we saw that many referred to the breast care specialist nurse and the support from nursing staff at the chemotherapy unit in a positive manner.
- We saw staff taking the time to explain information to patients in an appropriate manner and making sure patients new how to contact the units if they needed more information.
- Nursing staff told us that conversations about the costs of treatment were handled in a sensitive manner and was discussed as a part of the pre-admission assessment and also again on admission.
- The palliative care nurse spent time with all patients who had decided to stop having anti-cancer treatments and gave them information about the services and support that was available to them in the community such as hospices and end of life care planning.
- We saw that patients and their loved ones had been involved in the decision-making process and this was reflected in patients' medical records.
- Young people undergoing endoscopic procedures could have their parents accompany them to outside of the theatre and then wait for them until they returned from the recovery area.

Emotional support

- Nursing staff showed an awareness of the impact that a patient's care, treatment or condition could have on their well-being and those close to them.
- Staff in the chemotherapy unit had undergone specific training in regards to compassionate care and providing support for patients with life changing conditions.
- Patients were given information about relevant counselling services and peer support groups.
- Clinical nurse specialists with specific knowledge in breast, palliative and cancer care spent time with patients and their loved ones to help them manage their conditions and provide care and treatment.

Good

Medical care

- The 'Pink Petals' peer support group was for patients with breast cancer and those that had previously had cancer. The group provided patients with a number of opportunities to access links within communities and support and information for individuals.
- Staff told us that if they had to deliver distressing news to a patient or their loved ones this would happen in a single use room on a ward or in a consulting room to allow privacy.
- The chemotherapy unit had received the Macmillan Quality Environment Mark (MQEM) which was an assessment of services provided for cancer support. A part of the assessment related to having a caring and supportive environment where people could talk in confidence and privacy.

Are medical care services responsive?

Good

We rated the medical services as good because:

- Services were planned to meet the needs of the local population.
- At times of high demand the medical services modified hours of service delivery to meet the needs of patients.
- Staff had an awareness of the needs of patients with complex needs and had received dementia awareness training.
- Staff showed good understanding of equality and diversity.
- The hospital had a robust admissions and discharge policy which allowed flexibility for patients to choose times that suited them.
- Patients received detailed information about their care and treatment.
- The hospital was learning from complaints and had reviewed their complaints procedure.

Service planning and delivery to meet the needs of local people

- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example we saw that GPs and community care providers were involved in planning care for patients receiving chemotherapy and the hospital liaised with local NHS trusts to establish appropriate pathways of care.
- We saw that the needs of the population were discussed at organisational level and shared through annual quality accounts defining the role of the organisation in delivering healthcare in all communities.
- Staff were proud of the fact that they strived to deliver care in a manner that met the patients' medical and social needs; this included arrangements to have relatives or carers stay with patients at the hospital or nearby suitable accommodation.
- At times of high demand the medical services modified hours of service delivery to meet the needs of patients. Staff told us that this was managed in a manner which meant that they were not working more than their contracted hours.
- Part of the strategy for Spire Bushey involved redesigning and expanding the capacity for medical services to meet increasing healthcare demands. We saw that the service had plans to redesign the endoscopy facilities to provide greater space in the decontamination area and to relocate the oncology pharmacy to a new site in 2017. The plans were on-going at the time of our inspection, funding had been secured and risk assessments were still being conducted to ensure that the plans for redesign were safe for staff and patients.

Access and flow

- The hospital had a robust admissions and discharge policy. It set out the time frame for admissions from referrers and the process for requests for emergency admissions. All admissions had to be agreed and accepted by a consultant and a booking form had to be received.
- Consultants with practising privileges were required to give a minimum of seven days' notice for planned patients' admissions and this was highlighted in their consultant's handbook. For emergency admissions, consultants were required to complete the booking form and be present at the hospital to accept the patient when they arrived.
- The scope of practice policy at the hospital set out the guidelines for procedures and treatments that could be

carried out within medical services. Consultants who were referring patients were required to ensure that the procedure or treatment booked for their patients was within the scope of practice.

- Patients were able to access care and treatment at a time to suit them in line with the hospitals terms and conditions of admission. All patients were offered flexibility of appointments and the hospital reported referral to treatment times (RTT) for NHS-funded patients in line with national guidance. From June 2015 to March 2016 the hospital met the 92% target for all non-admitted and admitted patients to receive an initial consultation or treatment within 18 weeks of referral.
- There was no waiting list for endoscopic procedures and staff told us that all endoscopic procedures were carried out within two weeks of referral unless the patient requested a time longer than two weeks.
- The hospital had a system in place to manage cancellations of procedures or treatment for non-clinical reasons, for example lack of staff. The hospital told us that from July 2015 to June 2016 there had been 15 cancellations of treatment across all services for non-clinical reasons and all patients had been offered alternative appointments within 28 days. Cancellations were discussed at clinical governance meetings to identify trends and areas for improvement.
- Patients who attended the chemotherapy unit had already received their initial consultation and staff told us that appointments for treatment were planned and discussed with patients.
- There were arrangements and processes in place for patients to receive emergency care and advice outside of medical services' normal working hours.
- GPs received written discharge summaries either electronically through a centralised system or by post.

Meeting people's individual needs

- Services were planned to meet the needs of different people and those with complex needs. For example, we saw that staff in medical services had attended dementia awareness training and had access to the hospital's dementia lead nurse for advice.
- Staff we spoke with were aware of the diverse population they served and were aware of the needs of people with varying cultural, ethnic and religious requirements. Staff were able to describe the principles of 'protected characteristics' as defined by the Equalities Act 2010.
- The hospital's policy stated that discharge planning should begin at the pre-admission assessment stage specifically for home care packages and periods of convalescence. We saw evidence of this in patients' medical notes.
- Discharges for inpatients were planned to take place between 10am and 10pm. Patients who wished to be discharged outside of hours received a risk assessment in terms of care needs and were required to complete a form that stated that they were happy to leave at the time.
- The palliative care nurse played an integral part in discharge planning for patients who had received cancer treatments. We saw that patients were provided with comprehensive information packs of services and support groups; this included information relating to financial support.
- The breast care nurse specialist had formed a breast cancer support group called 'Pink Petals', this had been formed in 2012. We saw that patients were able to access information regarding cosmetic and alternative therapies through this group. For example, the breast care nurse specialist arranged for a presentation on different types of shampoos that were suitable for patients receiving cancer treatments and would not cause irritation for patients who had received 'scalp-cooling' therapy whilst receiving treatment.
- Weekly MDT meetings were conducted for patients with complex medical needs and we saw that this included other healthcare providers such as GPs.
- Staff told us that if a patient attended medical services who had learning disabilities they would be aware of this prior to admission and seek advice if the patient did not have a carer attending with them; staff had not received specific training in caring for patients with learning disabilities.
- The hospital had access to a telephone language translation services for patients when required.
- There were hearing loops throughout the hospital to assist patients with auditory impairments.
- There was access for wheelchair users and lifts at both sites for patients with mobility problems.
- Nursing staff told us that specific patient communication needs would be assessed prior to admission and highlighted in the patient's medical records which complied with Accessible Information standards (NHS England 2015).

- Visiting times on the wards were from 9am to 9pm, seven days a week, however, friends and family could liaise with staff to arrange different visiting times if required; this was highlighted in patient information leaflets.

Learning from complaints and concerns

- Spire Healthcare Limited's corporate complaints policy directed the management of complaints and time scales for responses. This was in line with industry standards. All complaints were reviewed by the clinical governance committees and medical advisory committee (MAC) and actions as a result of the complaint shared with individual departments via team meetings.
- Patients were given written information on how to make complaints and leaflets were on display throughout the hospital. This information was also displayed on the hospital's public website under 'patient information'.
- From April 2015 to March 2016 the hospital received 126 complaints. We saw that themes of complaints were discussed at clinical governance meetings and areas for improvement and learning were highlighted. Generally, themes of complaints related to billing information, miscommunications between providers and care and treatment. We saw that patients were offered apologies and compensation when billing errors occurred and staff had been reminded of the importance of information governance and maintaining patients' records when information between providers was not effectively communicated.
- The hospital target was to respond to 75% of all complaints within 20 days of receipt, in line with their organisational policy. We saw that between April 2015 and March 2016 they responded to 66% of complaints within 20 days. The organisation undertook an external review of their complaints process in September 2015 and developed an action plan to improve their performance in this area. The hospital's quality report for April 2016 to June 2016 showed that they had exceeded their target and had closed 85% of complaints within 20 days. Staff told us that they planned to set up a patient's forum and complaints committee to help manage and learn from complaints.
- Staff told us that they received a number of compliments and the complaints were also important because it helped them to understand if they were meeting patients' needs.

Are medical care services well-led?

Good

We rated the medical services as good for being well-led because:

- There was a clear vision and strategy for medical services which staff at all levels were aware of.
- There was a culture of openness and transparency and staff felt confident to raise concerns.
- There was a robust governance system in place to support the delivery of the strategy and provide assurances to relevant stakeholders;
- Leaders were visible and approachable and encouraged a culture of transparency and openness.
- Staff were encouraged to explore and develop new ways of working.
- There were good examples of public and staff engagement.

Leadership and culture of service

- The hospital was led by the hospital director and matron; each department had a nominated head who was a clear leader, such as a chemotherapy sister, theatre manager and ward manager.
- There was clear evidence of a strong leadership culture in medical services. The chemotherapy sister had been a part of the unit since it started and had played an integral part in the implementation and further developments. The theatre manager and clinical ward managers were responsible for leading and developing staff and services for patients receiving endoscopic procedures.
- Nursing staff at both sites told us that there leaders were visible and approachable and felt that they were able to express any concerns to them and they would be listened to.
- Staff at Elstree Cancer Centre told us that since the hospitals director had been in post they had felt less isolated as prior to that they did not see the hospital director very often and they were now included in the senior management team meetings.

- We saw that leaders of the service encouraged supportive relationships among staff through developing 'buddy' and mentoring systems for learning and peer support.
- There was a strong culture of openness and transparency and staff at all levels spoke of identifying areas for improvement to improve the patient experience.
- Staff at all levels and in clinical and non-clinical positions told us that they felt valued as part of the team and felt that their contribution mattered.
- All staff that we spoke to were proud and passionate about the care they delivered and the support that they offered patients and each other.

Vision and strategy for this this core service

- Staff that we spoke to at all levels were aware of the hospital's strategy to 'Be outstanding in all things, be the number one choice for all patients, value and invest in our staff, promoting a culture of mutual respect and teamwork, provide a high quality and efficient patient experience , work with GPs and consultants to deliver clinical excellence'.
- The strategic plan for medical services included the redesign and expansion of both the endoscopy facilities and chemotherapy unit.
- Staff that we spoke to were aware of the plans for growth and were positive about the changes improving patient care and felt that they were a part of it.
- Staff in medical services were aware of the organisations values and felt that caring for patients through doing the right thing and ensuring patient safety was at the centre of all they did; we heard this from staff at all levels.
- Progress against the strategy was monitored and reviewed with updates disseminated via departmental meetings and team briefings.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework in place to support the delivery of the strategy and good quality care. The hospital clinical governance committee reported to the Spire Healthcare Limited board.
- The clinical governance committee met quarterly. This committee had an overview of governance risk and quality issues for all departments. Senior department leads attended. Information discussed included safety alerts, learning from incidents, policy updates and audits.
- Staff understood their roles and what they were accountable for, for example; the infection control leads for departments were responsible for attending infection and prevention control meetings and reporting on concerns and compliance to protocol.
- The Medical Advisory Committee (MAC) consisted of the hospital director, chairperson, matron and head of clinical and non-clinical services, theatre manager, clinical governance and risk manager and consultants from all specialities. The role and responsibilities of the MAC were clearly set out in the hospital's policies; this included their role in granting and reviewing practising privileges and quality assurance.
- Governance frameworks and management systems were regularly reviewed by the clinical governance committee, MAC and senior management team. Improvements and changes to systems were made when required; we saw evidence of this in minutes from meetings.
- All consultants applying for practising privileges were required to provide evidence of appropriate and adequate indemnity insurance. The consultants' handbook set out what the hospital's minimum consultant medical malpractice indemnity requirements were.
- The hospital had processes in place to ensure that medical professionals granted practising privileges maintained an accurate personal record and appraisal record in line with General Medical Council (GMC) requirements of registration. This process was managed by the hospital director with input from the MAC when required.
- The hospital had a central risk register which all departments fed into. Each department also had their own separate risk assessment registers
- Leaders in endoscopy told us that the main risks were the size of the endoscopy decontamination area, current capacity of theatres and the potential risk of not meeting the standards required for JAG accreditation due to the design of the building. We saw that there were action plans to address each of these risks and they were on the hospital wide risk register.
- The hospital used a safer surgery checklist which was a modified version of the World Health Organisation

(WHO) five steps to safer surgery checklist designed for local use for invasive procedures. We saw evidence that this practice was regularly audited and education delivered when required in line with national standards. The organisation had arranged for two representatives from each Spire hospital to attend external training days in regards to National Safety Standards for Invasive Procedures (NatSSIPs, NHS England) in order for them to share learning with their colleagues. The theatre manager was involved in updating the organisation's policy related to performing invasive procedures based on NatSSIPs and was extremely positive about the impact these opportunities would have on ensuring safe patient care.

Public and staff engagement

- Patients and those close to them were given the opportunity to provide feedback through patient survey questionnaires given to them on admission. From July 2015 to March 2016 97% of all patients said they would be 'extremely likely' to recommend the hospital to friends and family.
- The hospital's public website invited patients to provide feedback through an online form and displayed testimonials from other patients who had provided feedback.
- The hospital conducted annual staff surveys in line with organisational policies. The top five results from Spire Bushey 2015 staff survey included 97% of staff reporting that they believed that the work that they did made a positive difference to the hospital and 95% of staff reporting that their manager trusted them to make the right decisions at work. An action plan had been developed to address the five lowest scoring results which included 49% of staff reporting that other departments did not understand the impact their actions had on other teams and 32% of staff felt that there were not sufficient numbers of staff to meet the demands of the service. We saw that the action plan involved developing opportunities for all departments to attend regular meetings.
- The breast care nurse specialist had set up a support and information group for patients called 'Pink Petals'. The group had been running since 2012 and membership had steadily increased over the years. Members of the group attended events arranged and co-ordinated by the breast care specialist nurse at Spire Bushey. These included closed social events such as fashion shows and events that offered opportunities for learning and sharing information. Membership was open to all patients (past and present) who had attended the breast care services and cancer care centre. We saw that patients made very positive comments about the support they had received through membership to the group. The group had presented the breast care nurse specialist with a book filled with comments and letters of thanks at a special presentation in 2015.
- We spoke with the breast care nurse specialist and they told us that they had received encouragement and support in setting up 'Pink Petals' from their colleagues and the senior managers and that there were plans to share the concept within the Spire Healthcare group.
- All staff that we spoke to recognised the value of raising concerns and taking appropriate action if required.
- Managers in medical services had an 'open door' policy and we saw that staff were encouraged to discuss ideas for innovation and improvement.

Innovation, improvement and sustainability

- Leaders and staff in medical services were continuously looking for opportunities to improve practice and develop ways of working to improve the quality of care. Staff at all levels attended national training sessions and events to discover new treatments and development opportunities for staff. The endoscopy service was working towards achieving Joint Advisory Group accreditation.
- The 'Pink Petals' peer support group set up and managed by a member of staff was an integral part of care and treatment for a number of patients. We saw that patients found this to be a valuable forum to exchange views, support each other and receive important information about their care which addressed both physical and social needs.

Good

Surgery

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

Information about the service

Spire Bushey Hospital provides surgical services for various specialties to both private and NHS patients. The hospital cares for adults and young people over 16 years of age.

There are two inpatient wards, Lea ward is on the ground floor and has 34 single ensuite rooms, Gade ward is on the first floor and has 24 single ensuite rooms, and 12 day case pods with reclining chairs.

Pre-assessments are carried out within the day care unit where patients are seen in preparation for their admission to hospital.

There are five theatres, three with laminar flow and a laparoscopic theatre with associated anaesthetic rooms and a recovery area. Sterile services are provided on site and are CE accredited.

From April 2015 to March 2016, there were 11,398 surgical episodes, mainly for elective surgery. Of these 8% were NHS funded and 92% were self-funded or patients with private medical insurance. There were 88 children aged between three and 18 years that attended for surgical procedures. The hospital had previously offered surgical services to children aged between three and 18 years, but changed this in January 2016 to offer surgical services to young people aged 16 years and over.

The hospital offers a range of surgical procedures, including; orthopaedic, ear nose and throat, general surgery, cosmetic, gynaecology and urology procedures.

All patients are admitted and treated under the direct care of a consultant surgeon and medical care was supported by resident medical officer (RMO).

We carried out an inspection of the hospital and visited the ward, main theatre, recovery and pre-assessment clinic. We spoke with 38 members of staff. We observed care and treatment and reviewed six patient records. Prior to the inspection, we reviewed performance information about the hospital. We talked to five patients and acknowledged the views expressed by patients on Care Quality Commission comment cards.

We carried out an announced inspection on 26 and 27 July 2016 and an unannounced visit on 4 August 2016 and an announced visit on 13 December 2016.

Good

Surgery

Summary of findings

We rated the surgical services as requires improvement for safe and good for effective, caring, responsive and well-led. This meant that surgery was good overall.

- Staff were encouraged to report incidents. They were dealt with appropriately and themes and outcomes were communicated to staff.
- Action was taken to ensure patients were protected from abuse. However, staff caring for yong people, were not trained to the right level in safeguarding.
- There was no access to a registered nurse (child branch) when young people attended the hospital.
- The environment was visibly clean and staff followed the hospital policy on infection control.
- There was appropriate equipment to provide safe care and treatment.
- Patients were assessed, treated and cared for in line with professional guidance, such as the five steps to safer surgery checklists.
- Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and pain. Multidisciplinary working was effective.
- Nursing, medical and other healthcare professionals were caring and patients were positive about their care.
- Patients told us they were treated with dignity and respect.
- Patients were given appropriate written information on what to expect from their care and treatment.
- There was appropriate discharge planning.
- Information about the hospital complaints procedure was available for patients and their relatives. Complaints were acknowledged, investigated and responded to in a timely manner.
- The hospital had a clear governance structure.
- Information was cascaded to all staff.
- There was strong leadership and staff felt supported and valued.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- There was no access to a registered nurse (child branch) when young people attended the hospital.
- Staff caring for young people aged 16-18 years of age were not always trained to level three in children's safeguarding.
- Some floor covering in patients' bedrooms was not compliant with infection control guidance. There was a refurbishment programme in place.
- The medication fridge on Gade ward was unlocked and staff could not find the key.

However we found that:

- Staff told us they were encouraged to report any incidents, and serious incidents were discussed at team meetings and ward handovers. Staff were confident in reporting incidents and were aware of the importance of the duty of candour regulation.
- There was access to appropriate equipment to provide safe care and treatment.
- We observed the five steps to safer surgery checklists were being completed appropriately.
- There were procedures in place for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care.
- Nursing handovers were well structured within the surgical wards.
- The environment was visibly clean. Equipment was generally cleaned after use with an: 'I'm Clean' sticker placed on to it.
- Staff had the appropriate training to be able recognise and respond to deteriorating patients.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally.
- The systems, processes and practices that were essential to keep people safe were consistently identified, put into practice and communicated to staff.

- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents; this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic system.
- From April 2015 to March 2016 there were 333 incidents reported across the hospital for all services, 217 of the incidents were attributed to surgery and medicine. Eight of the incidents related to the chemotherapy unit and included incidents such as spilt anti-cancer treatment.
- From April 2015 to March 2016, 12 serious incidents reported and nine deaths in the same time period. As the hospital offers palliative care, these deaths were expected.
- All these incidents had been investigated and there was evidence of actions taken. For example, to prevent patient falls we saw a poster in each patient bedroom with; 'Call don't Fall' to encourage patient to call staff when mobilising.
- All serious incidents were analysed at clinical governance meetings to ensure that lessons were learnt. This information was disseminated to staff via head of department meetings.
- In addition, a monthly bulletin was sent from Spire's head office outlining incidents that had taken place in other hospitals. There was a system of red, amber, green rating (RAG) with regards to rating of incidents. Learning was shared both locally and throughout the organisation, to enable procedures to be put into place so that similar incidents did not reoccur.
- There had been no never events reported in the last 12 months within surgery. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event (Serious Incident Framework, NHS England March 2015).
- From November 2014, all providers were required to comply with the Duty of Candour Regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were fully aware of the duty of candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident. We saw examples of where duty of candour had been applied with regards to incidents and complaints.

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

- The safety thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data is collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter urinary tract infections and falls.
- The hospital audited and monitored avoidable harms caused to patients. From January 2016 to March 2016 there were eight falls, no pressure ulcers and no catheter infections reported. This information was displayed on the wards.

Cleanliness, infection control and hygiene

- The hospital had policies and procedures in place to manage infection prevention and control. Staff accessed policies via the hospital intranet and were able to demonstrate how these policies were easily available.
- The wards and theatres were visibly clean and tidy.
- There was awareness amongst staff about infection prevention and control and we observed staff washing their hands and using hand gel between treating patients. We observed all staff using alcohol hand gel when entering and exiting wards and theatres.
- We observed staff complying with 'arms bare below the elbow' policy. However, we observed a small number of staff were wearing nail polish and necklaces, which does not comply with infection control guidance. We raised this with the senior managers at the time of our inspection who said they would address this immediately.
- There is a dedicated infection control lead who holds a master's degree in infection prevention and control. The lead conducts one to one meetings with the infection prevention and control links staff throughout the hospital to share learning. The lead also attends ward rounds to offer support and advice.
- We saw a robust audit programme ensures staff compliance in delivering high standards of Infection prevention and control.

- Hand hygiene audits from April 2015 to December 2015 across all surgical wards and theatres showed 95% - 100% overall compliance.
- Personal protective equipment, such as gloves and aprons were used appropriately and were available in sufficient quantities.
- We observed a lack of clinical handwashing facilities in ward areas. Clinical hand basins were provided in utility areas, but not in patient rooms. This meant that at the point of care, staff were washing their hands in patients' private bathrooms. Although the sinks in patient bathrooms had wrist operated taps, best practice would be to have dedicated clinical sinks within ensuite rooms. Department of Health Guidelines 2013 HBN009 state that: 'Ensuite single bed rooms should have a general wash-hand basin for personal hygiene in the ensuite facility in addition to the clinical wash-basin in the patient's room'. This had not been taken into consideration when some of the bedrooms had been refurbished in 2016. This was raised with the senior managers at the time of our inspection who told us this was on the risk register and they had escalated this to Spire Healthcare.
- Not all the flooring in patient rooms were compliant with Department of Health (DH) 2013 HBN0010 part A. Patient rooms had been refurbished prior to the 2013 guidance, which meant that they were not compliant with current Health and Building Note regulations 2013. Patient rooms were having carpets replaced with hard wood flooring as part of the hospital's refurbishment programme. At the time of the inspection 85% of patient bedrooms had hard flooring in place.
- Some bedrooms had laminate flooring, but other bedrooms and the day case pods had carpets. Carpets were cleaned on a regular basis. This was raised with the senior managers at the time of our inspection, and we saw this was on the hospital risk register and they had escalated this to Spire Healthcare.
- Equipment was cleaned after use with an; 'I'm clean' sticker placed on it.
- The hospital's Patient Led Assessments of the Care Environment (PLACE) for 2016 was 100% in cleanliness.
- There had been eight surgical site infections reported for April 2015 to March 2016. The patients involved had mainly undergone orthopaedic procedures and breast and gynaecology surgery. These rates were lower than other similar services. All infections were investigated and no trends had been identified, for example with particular surgeons, operations, theatres, or scrub teams.
- There had been no incidents of MRSA or Clostridium difficile from April 2015 to March 2016.

Environment and equipment

- There was sufficient equipment, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Resuscitation equipment, for use in an emergency in the operating theatres and ward areas, were regularly checked and documented as complete and ready for use. The trolleys were secured with tags, which were removed monthly to check the entire contents to ensure their integrity and that they were within date. However on the ward we found the resuscitation trolley had sterile equipment, which had been opened. This meant it was no longer sterile. The paediatric resuscitation trolley was in a locked room, which was not easily accessible. We raised this with the hospital managers and during our unannounced inspection on 4 August 2016 we found all sterile equipment was in sealed packaging and the paediatric resuscitation trolley was in the main corridor and accessible.
- Staff within the recovery unit said they had all the emergency equipment they required at hand. We observed sufficient equipment available during our visit.
- There were systems to maintain and service equipment as required. Equipment had been tested appropriately to ensure that it was safe to use.
- The hospital had a contract with an external provider that completed most of the equipment maintenance. Faulty equipment was reported and recorded. When equipment was urgently needed, the maintenance company were contracted to replace it within 24hours to enable normal service to continue.
- The Patient Led Assessment of the Care Environment (PLACE) audit 2016 for the hospital's condition, appearance and environment was 98%.

Medicines

- There was an onsite pharmacy department which opened between 8am and 5pm Monday to Friday and

8am to 12 midday on Saturdays. There was a procedure in place for the senior nurse and the resident medical office (RMO) to gain entrance to pharmacy if medicines were needed urgently. Each had a separate key.

- The hospital pharmacist visited the clinical areas daily to check agreed stock levels and to ensure there was appropriate stock rotation. The pharmacist reviewed prescription charts to help guide ward staff in the safe prescribing and administration of medicines.
- Medicines were stored in a secure temperature controlled room that had suitable storage and preparation facilities for all types of medicines such as controlled drugs and antibiotics. We saw records of the daily checks of ambient temperatures in the medicines storage room had been routinely completed.
- Medicines that required refrigeration were kept at the correct temperature. We saw records of the daily checklists of ambient fridge temperatures. The checklists indicated what the acceptable temperature range should be to remind staff at what level a possible problem should be reported. Staff were aware of what action to take if the fridge temperature was outside safe parameters.
- On Gade ward, the medication fridge was unlocked and staff were unable to find the key. Therefore we were not reassured of the safety of medication at all times. This was raised with the hospital senior management team during our inspection.
- Medicine cupboards were left unlocked in theatres, whilst theatres were in use to allow easy access. A risk assessment had been undertaken. The controlled drug cupboards were locked at all times.
- Controlled drugs were stored in a locked unit and the keys held separately from the main drug keys. We reviewed the controlled drug cupboards which were tidy and did not hold any other medicines in these cupboards.
- In theatres we found some medication had been prepared in advance and labelled, and left unattended. We raised this with the theatre manager who addressed this immediately and discussed this practice with medical staff to ensure this did not happen again. On our unannounced inspection, we found that this practice appeared to have stopped.
- We did not observe the administration of medication during our inspection. However, we checked six medicine charts which were all completed appropriately.
- Nursing staff were aware and were able to seek guidance from the hospital's medicines policy and British National Formulary (BNF), which was the latest edition. The BNF is a pharmaceutical reference book and contains advice on prescribing and pharmacology.

Records

- The hospital used a paper based records system for recording patients' care and treatment.
- Patients' records were stored in a trolley behind the nurse's station but this was unlocked, therefore we were not reassured about the safety and confidentiality of patient records at all times.
- We reviewed six sets of patient records. Information was easy to access and the records contained information on the patient's journey through the hospital including pre assessment, investigations, results and treatment provided. However we found that three out of the six sets of notes had no evidence that nursing staff had reviewed the pre-operative assessment form as this had not been signed. We raised this with the hospital managers at the time of our inspection who said they would review the notes and investigate.
- We reviewed four sets of children and young people notes and found that two did not have risk assessment completed. This was raised with the matron during the inspection. However we found consent forms had been completed adequately and there was clear discharge information.
- During the unannounced inspection we reviewed a further 10 sets of notes of notes for children and young people and found that all risk assessments had been completed.
- Daily care records such as fluid balance records and care plans were stored in folders at the patient bedside. We looked at samples of records which were fully completed, legible with entries timed, dated and signed.
- Theatre records were completed and included the five steps to safer surgery checklist. We saw good staff engagement with the process and the forms were completed fully and appropriately.
- The final order of the theatre list was decided on the day of surgery; this was communicated to theatre staff and telephoned to the ward. However the lists were not reprinted which could have allowed for mistakes to be made and is not in line with best practice. This was raised at the time of our inspection and on the

unannounced inspection we found that updated theatre lists were been printed on cream paper to indicate a change of the list and distributed to all clinical areas.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff.
- Staff received training and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- Nursing staff on the ward had a compliance rate of 84% for adult safeguarding level two, and 69% for children safeguarding level two. Clinical staff and consultants had training planned for the future for children's safeguarding level three. The aim was to ensure that all clinical staff would complete children's safeguarding level three training. The matron had completed children's safeguarding level three and could offer advice to staff as required.
- The matron and OPD Manager, who was also the hospital safeguarding lead, were planning to complete children's safeguarding level four
- The nursing and medical staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- There was no access to a registered nurse (child branch) when young people attended the hospital. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014).
- Not all staff who were caring for young people aged 16-18 years were trained to level three in children's safeguarding. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2104) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level three safeguarding. The hospital was working towards ensuring all staff had appropriate training. Although we saw no evidence of a failure to safeguard children, we were not assured that all staff who had contact with children or young people had received the appropriate level of safeguarding training. The provider should ensure that a process is in place to ensure clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns has received training to the appropriate level of competency as outlined in the Intercollegiate guidance Safeguarding Children.
- The young people were under the direct care of a consultant, who had completed safeguarding level three training, the consultant was not present for the duration of the young person's stay.
- The hospital had a policy relating to safeguarding around female genital mutilation (FGM) and posters were displayed advising staff what to do if FGM was suspected.

Mandatory training

- Staff received mandatory training to enable them to provide safe care. Mandatory training included for example infection control, fire, moving and handling and health and safety. Some training was delivered via face to face sessions and others were available via the e-learning on line.
- There was an induction programme for all new staff and staff that had attended felt that the programme met their needs.
- Mandatory training was a rolling programme and we saw that 95% of theatre and ward staff had completed the training.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained. For example patients undergoing elective surgery attend a preoperative assessment clinic and the hospital used the five steps to safer surgery checklist, in line with national guidelines.
- The hospital used a Spire Healthcare modified version of the World Health Organisations (WHO) five steps to safer surgery checklist which included a team brief and a team debrief in the checklist.
- We observed the five steps to safer surgery checklist was being used. We observed checks as they were being carried out, both in the ward and operating theatre. The practice appeared embedded throughout the hospital.

Good

Surgery

- Patients for elective surgery attended a preoperative assessment clinic where all required tests were undertaken. For example, MRSA screening and any blood tests. If required, patients were reviewed by an anaesthetist and had a dedicated appointment.
- Risk assessments were undertaken in areas such as venous thromboembolism, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate the risks identified.
- The national early warning score (NEWS) was used to identify deteriorating patients in accordance with NICE clinical guidance CG50. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored according to pre-determined parameters. There were clear directions for actions to take when a patient's score increased. There were appropriate triggers in place to escalate care, which members of staff were aware of. We reviewed six sets of patient notes and found that scores were added up correctly and escalation was carried out appropriately. This meant that patients who were deteriorating or at risk of deteriorating were recognised and treated appropriately.
- There was a formal arrangement for patients to be transferred to the local NHS hospital if the patient required critical care level two or above. These are critically ill patients, who require either organ support or closer monitoring.
- There was access to a minimum of two units of O Rhesus negative emergency blood. The hospital had a 'massive blood loss' protocol and all staff we spoke to were aware of where the emergency blood was stored and how to obtain it. Further blood for transfusion was obtained through the local NHS trust blood bank and the staff could access these details.
- The practising privileges agreement required surgeons to be contactable at all times when they had patients in the hospital. They needed to be able to attend the hospital within 45 minutes. They had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover in the event that they were not available, for example when they were on holiday. Staff told us that they were made aware when consultants were on holiday and who would be covering for them; this was written in the patients notes.

Nursing staffing

- The hospital used a staffing tool, dependency reviews, NICE guidelines and professional judgement to assess and plan staffing requirements to determine appropriate staffing levels. From this, the required number of nurses and healthcare assistants were calculated for each shift.
- During our inspection, we saw that planned numbers of nursing staff had been met.
- The hospital used a team of bank staff to cover any unfilled shifts in the ward and theatres to ensure they were able to provide safe care.
- Data provided by the hospital demonstrated that Theatres had not used any agency staff in the previous 12 months, which is within our reporting period. The theatre manager told us that agency staff had not been used for 15 years within theatres. There were low numbers of agency staff that had been used on the wards.
- We saw that staff rotas were planned six weeks in advance.
- During our inspection there was one nursing vacancy within theatres and 3 nursing vacancies on the wards.
- Revalidation is the process that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. We saw processes in place to assist nurses to maintain their registration, such as study days and NMC registration would be checked monthly to ensure staff kept these up to date.
- We observed that nursing handovers within the surgical ward were well structured and gave clear concise information on each patient. The handovers occurred in the clinical treatment room for all staff and patient privacy, dignity and confidentiality were maintained. Appropriate information was shared such as medication, pain management, discharge planning and treatment plans.

Surgical staffing

- Patient care was consultant led. The hospital practising privileges agreement required the consultant to visit and review the patient daily and more frequently if necessary. Staff we spoke with confirmed that consultants did review patients when requested to do so.

Good

Surgery

- There was a registered medical officer (RMO) in attendance in the hospital 24 hours a day, seven days a week. The RMO provided medical support to wards and theatres and was easily accessible via the hospital bleep system. The RMO generally worked one week on duty at a time and stayed within the hospital so they were available 24 hours a day.
- There was not a dedicated anaesthetist on call system. Local policy was for staff to call the anaesthetist who was present during the operation, and if they were unavailable, an alternative anaesthetist would be recorded in the patients' notes. Staff confirmed this was the process they would follow. We raised this with the senior managers at the time of the inspection. During our unannounced inspection we found a standard operating procedure was being implemented to ensure anaesthetist were on call and accessible. A risk assessment was in progress and all anaesthetist had been sent a letter to confirm arrangements.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the hospital.
- Staff were aware of the hospital policy. A contact list for out of hours staff for emergencies was available. The hospital had a contingency plan for responding to events that could disrupt the service such as lack of water supply, breakdown of IT or telephone systems. There was a member of the senior management team on call who would be contacted if necessary.

Are surgery services effective?

Good

We rated effective as good because:

- Policies were accessible, current and reflected professional guidelines.
- Care was provided in line with best practice guidelines.
- The hospital monitored adherence to policies by the use of local audits.
- Pain was managed well and pain management audited.
- Patients' nutritional status was assessed.
- Patient outcomes were audited and showed results in line with those nationally.
- The Medical Advisory Committee (MAC) ensured consultants were competent to practice and practising privileges were reviewed annually.
- There was evidence of good multidisciplinary working.
- Consultants were on call 24 hours a day and seven days a week for their in and day patients and visited them daily.
- There was a resident medical officer (RMO) providing medical cover for patients and clinical support to staff.
- Staff were familiar with the consent policy.
- Staff were aware of their role with regards to the Mental Capacity Act and Deprivation of Liberty and had received training.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health and social care needs (clinical needs, mental health, physical health, and nutrition and hydration needs). Patients' care and treatment was planned and delivered in line with evidence-based guidelines for example nutritional and hydration needs, falls assessment and consent.
- Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations for example, Association for Perioperative Practice (AfPP). Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the hospitals intranet.
- The hospital raised awareness of policies by have a 'policy of the month', which was audited the following month to determine staffs understanding. Staff said they found this useful and encouraged them to read the policies.
- There was participation in relevant local and national audits, including clinical audits such as surgical site infections and environmental audits.
- Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based and compliant with guidance from the National Institute of Health and Care Excellence (NICE 2010) for reducing the risk of venous thromboembolism in adults.
- We saw the hospital had systems in place to provide care in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition of and response to

acute illness in adults in hospital). For example, an early warning score was used to alert staff should a patient's condition deteriorate. The system used incorporated escalation actions that should be taken.

- We saw audits of the five steps to safer surgery were 98% compliance from January 2016 to June 2016. Observational audits had also been carried out from February 2016 to June 2016 with a compliance of 96%. Action plans included ensuring staff signed parts of the form and documenting patient pre-operative temperatures.
- There was participation in the Private Healthcare Information Network (PHIN) in accordance with the competition and markets authority. PHIN had recently (March 2016) assessed the hospital for readiness to commence submitting data in September 2016 and raised no concerns. The data sets to be submitted included patient satisfaction, adverse events and Patient Reported Outcome Measures for hips, knees, cataract, groin and hernias surgery.

Pain relief

- Patients we spoke with said that their pain was well managed during their treatment.
- Our observation of practice, review of records confirmed that pain was assessed and managed effectively.
- Patients' records showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner. Pain management for individual patients was discussed at handovers as required.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded using the Malnutrition Universal Screening Tool (MUST).
- In all six records we reviewed, we observed that fluid balance charts were completed appropriately and used to monitor patients' hydration status.
- Intravenous fluids were prescribed, administered and recorded appropriately in the patient notes reviewed.
- Patients were given fasting instructions at pre-operative assessment, which were aligned with the recommendations of the Royal College of Anaesthetists, (RCOA). Patients were offered drinks if there was delay in theatre times to maintain their hydration.

Patient outcomes

- The hospital participated in the elective surgery, Patient Reported Outcome Measures (PROMS) national audit. The hospital data in May 2016 showed that for the Oxford hip score, of the 19 patients reported 100% reported an improvement in health after their procedure. Data for Oxford knee score showed that of the 21 patients reported 90% reported an improvement in health after their procedure.
- From April 2015 to March 2016, there had been five unplanned readmissions, eight unplanned returns to theatre and 14 unplanned transfers of patients to the local NHS hospitals. Each case had been reported as an incident and investigated, but no trends had been identified. This is low numbers compared to similar providers.
- The hospital had achieved 100% in the National Joint Registry submissions from April 2015 to March 2016.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was a specific induction programme for all staff. Staff that had attended the induction programme told us this was useful. Staff would have a period of being supernumerary during their induction.
- Nursing staff felt well supported and adequately trained in their local areas.
- Registered nurses had completed intermediate life support training. Basic life support training was provided to support staff. This ensured that all staff were able to respond to a collapsed patient.
- Resident medical officers (RMO) were trained in advanced life support (ALS). The hospital had 15 staff trained to ALS level in addition to the RMO. We saw that rotas were planned to ensure that at least one staff member per shift had ALS training.
- The RMO also had European Paediatric Life Support (EPLS) as well as one member of staff in theatre. If a young person, aged 16-18 was attending theatres the theatre manager ensured that the EPLS trained member of staff was on duty.
- All staff we spoke with told us that they had received an annual appraisal and found this a positive experience. Hospital data showed that 100% of theatre staff had completed an appraisal and 76% of wards staff had completed an appraisal.

- We saw evidence that all registered nurses and professional staff that worked in the wards and theatres had valid nursing and midwifery registration or were registered with the Health and Care Professions Council. This confirmed that nurses and other practitioners, such as operating department practitioners and physiotherapists, were trained and eligible to practise within the UK. There was an effective process in place to ensure these were updated.
- The role of the Medical Advisory Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document. The hospital checked registration with the General Medical Council the consultants' registration on the relevant specialist register, Disclosure and Barring Service (DBS) check and indemnity insurance.
- There were arrangements which required the consultant to apply to undertake a new technique or procedure not undertaken previously by the practitioner at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which may have taken specialist advice such as that from the National Institute for Health and Care Excellence or the relevant Royal College. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.
- Practising privileges for consultants were reviewed annually. The review included all aspects of a consultant's performance, including an assessment of their annual appraisal, volume and scope of activity, plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. The hospital used an electronic system to check when privileges were due to expire.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment and worked collaboratively to understand and meet the range and complexity of people's needs.
- Staff described the multidisciplinary team as being supportive of each other. Health professionals told us they felt supported and that their contribution to overall patient care was valued.
- We observed good working relationship between nurse, doctors and allied professionals.
- Discharge letters were sent to the patients' GPs immediately after discharge, with details of the treatment provided, follow up care and medications provided.

Seven-day services

- Consultants were on call seven days a week for patients in their care.
- There was cover 24 hours a day by the RMO to provide clinical support to surgeons, staff and patients.
- There was not a dedicated anaesthetist on call system. Local policy was for staff to call the anaesthetist that carried out the operation, and if they were unavailable this would be documented in the patients' notes as to who to call and staff confirmed this was the process they would follow.
- There was an on call system for theatre staff, radiographers, physiotherapists and pharmacists. Staff we spoke with were aware how to access this information if they needed to call someone out of hours.
- There was a senior manager on call 24 hours a day for staff to access for support and advice.

Access to information

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the hospitals electronic system.
- Staff said they had good access to patient related information and records whenever required.
- We observed on-going care information was shared appropriately at handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy that staff were familiar with.
- The hospital had three nationally recognised consent forms in use; there was a consent form for patients who were able to give valid consent, another for patients

who were not able to give consent for their operation or procedure, for example if they lacked mental capacity, and one for young people aged between 16 and 18 years.
- Some staff were unaware that there were three different consent forms available; this was raised with the ward manager during our inspection who said that they would raise this at the staff meeting.
- Staff understood consent, decision-making requirements, and guidance.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA).
- Staff we spoke with had undergone training in MCA 2005 to ensure that they were competent to meet patients' needs and protect their rights, should a patient lack capacity. The training received included training of Deprivation of Liberty (DoLS). Staff had an understanding of when DoLS may be required.
- Training was provided as part of the hospital's mandatory training package. Information provided by the hospital indicated that 100% of ward nursing staff and 100% of theatre staff had completed all their mandatory training modules in MCA 2005 and DoLS.
- The service ensured there was a two week cooling off period for cosmetic patients, between patients being seen in outpatients and a procedure taking place. This allowed the patient time to decide whether to have a cosmetic procedure and allow them time to 'cool off'. This is in line with national guidance from the General Medical Council and British Association of Aesthetic and Plastic Surgeons.

Are surgery services caring?

Good

We rated caring as good because:

- Staff were caring and compassionate to patients' needs. Patients spoke highly of the care they had received.
- Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.
- We saw examples of staff taking measures to ensure patients' privacy and dignity were respected.
- All patients we spoke with felt informed about their care and treatment.
- Consultants visited patients' throughout the day and were available to answer any questions they had.
- Information was shared with patients and their relatives and opportunities to ask questions.
- The friends and family score were consistently between 97% and 99% of patients that would recommend the hospital.
- PLACE (Patient Led Assessment of the Care Environment) score for 2016 for dignity and respect was 83%, which was in line with the national average of 84%.

Compassionate care

- Staff took measures to ensure patients' privacy and dignity, for example, patient room doors were closed unless patients wanted them open. Patients told us that they were treated with compassion, dignity and respect during their hospital stay. The PLACE score for ensuring patients were treated with privacy and dignity was 83%, which was in line with the national average of 84%.
- Patients we spoke with told us that staff treated them with respect.
- Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- Patients told us call bells were answered promptly, that staff were kind and caring and they would be happy for their family to come to the hospital for treatment. During our inspection call bells were being answered promptly.
- We saw that nursing staff introduced themselves appropriately and knocked on the door of side rooms before entering.
- We received positive comments from the patients we spoke with about their care. Examples of their comments included "staff are caring and thoughtful", "Staff always tell you who is looking after you and are very attentive" and "nurses made me feel at home, they talk about home life and are interested in me".
- Patient feedback from comment cards included comments such as: 'staff were very welcoming, polite and helpful' and 'I felt supported and treated with dignity and respect at all times'.
- Patient satisfaction survey results for July 2016 showed 83% of all patients rated the care and attention received from nursing staff as excellent, with 14% of all patients rating it as very good.

Good

Surgery

- The friends and family survey results from July 2015 to June 2016 showed that between 97% and 99% of patients would recommend the hospital to family and friends. The response rates were similar to the England average at 34%.

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. Patients and relatives had been given the opportunity to speak with the consultant looking after them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- Consultants visited their patients throughout the day and were available to answer any questions they had. In addition, they informed patients what to expect and their plan of treatment.
- We observed the care of one patient in theatre. Staff introduced themselves to the patient and gave information on what would be happening and what to expect.
- The hospital had open visiting this meant that patients could be supported by friends and family.

Emotional support

- Staff spent time with patients and families and were able to provide emotional support.
- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- One patient who had recently suffered bereavement told us that staff were compassionate caring and spent time with them during their in-patient stay.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required.
- There was information available to staff on how to contact members of the clergy to meet patients' different spiritual needs.

Are surgery services responsive?

Good

We rated responsive as good because:

- Service planning met the needs of the local people and the community.
- The booking system for patients offered flexibility.
- The admitted referral to treatment times (RTT) for NHS patients were being met.
- Access and discharge arrangements were effective.
- All areas were accessible to patients with mobility problems.
- There was support for people with a learning disability, and reasonable adjustments were made to the service provided.
- Arrangements were in place to support patients living with dementia.
- The Medical Advisory Committee (MAC), the clinical governance committee and the patient experience and complaints committee reviewed all complaints. Actions and learning from complaints was shared with all staff.
- Written information on medical conditions, procedures, and finance was available.
- The service ensured there was a two week cooling off period between patients agreeing to undergo cosmetic surgery and the surgery being performed.

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the people it served and acted on these to plan, design and deliver services, for example disabled toilets were available, and there were wet rooms and showers that were easily accessible to accommodate wheelchairs and patients with walking aids.
- The booking system was flexible, allowing patients where possible to select times and dates for treatment to suit their family and work commitments.
- The hospital had a good relationship with the local Care Commissioning Groups (CCG) for planned procedures and a good relationship with the local trust which enabled them to work together to manage waiting lists.

- The hospital had an admissions policy which detailed the criteria for NHS patients that could be safely treated at the hospital. These criteria had been agreed with the CCG that commissioned NHS care at the hospital.
- Consultants had planned, dedicated theatre lists. This enabled patients to be booked onto these lists. In addition, staff with specific skills and competencies to meet the needs of the patients could be allocated to particular theatres, for example staff that could assist with ophthalmic surgery.
- The environment and facilities were appropriate and required levels of equipment were available.

Access and flow

- The hospital's pre admission policy and local contracts ensured that all patients were seen at the pre-operative assessment clinic. This meant that patients who had co-existing conditions were identified, so that any pre-operative work, for example blood tests, could be done. This minimised unnecessary cancellations.
- Staff began planning the patient's discharge during the preadmission process where they gained an understanding of the patient's home circumstances and daily care needs.
- The hospitals admitted referral to treatment times within 18 weeks for NHS patients were being met. RTT monitors the length of time from referral through to elective treatment; the national average was 90%. From April 2015 to March 2016 the hospital exceeded the national average and on some occasions this was 100%.

Meeting people's individual needs

- Services were planned to take into account the individual needs of patients.
- All patients completed a medical questionnaire that was reviewed by the pre assessment nurses. Some patients required a face to face appointment; other patients had a telephone assessment dependant on their individual needs.
- Patients discharge plans took account of their individual needs, circumstances, and ongoing care arrangements. For example one patient we spoke with said they had all the equipment ready at home to assist with recovery such as a toilet raise and walking aids.
- All areas were accessible to patients and relatives who had problems with mobility.
- An interpretation service was available to patients who did not speak English and staff were aware of how to access it.
- Staff we spoke with had attended dementia training and had an awareness of the needs and challenges patients living with dementia faced.
- There was an opening visiting policy at the hospital. This meant that patients could be supported by their loved ones during consultations and loved ones could ask questions about their treatment and care.
- The service ensured there was a two week cooling off period between patients agreeing to undergo cosmetic surgery and the surgery being performed. The cosmetic nurses would carry out a pre-assessment on all patient booked for cosmetic surgery and ensure the two week cooling off period was adhered to.
- Patients felt they were given appropriate written information on what to expect from their care and treatment.

Learning from complaints and concerns

- Spire Healthcare had a corporate complaints policy that directed the management of complaints and associated timescales. Complaints were handled effectively and confidentially.
- Staff were aware of how to deal with complaints, they would try to resolve the issue if they could. If they could not resolve the complaint, they told us that they would report the patient's concerns to a senior member of staff.
- There was a 'Please talk to us' leaflet that explained how a patient could make a complaint. Guidance was also available on the hospital website.
- There was a dedicated complaints lead that updated each complaint regarding its current status or outcome. This information was shared at weekly management meetings. The hospital director, the matron, Medical Advisory Committee (MAC) and clinical governance committees reviewed all complaints. We saw evidence of actions taken as a result of complaints. These were shared with individual departments via team meetings. For example complaints about lack of communication was discussed at staff meetings and the implementation of hourly intentional rounding, which ensured each patient was visited by a member of staff every hour would assist with regular communication.
- The hospital had received 126 complaints from April 2015 to March 2016 which was a slight decrease of three

from 2014/15. We saw that between April 2015 and March 2016 they responded to 66% of complaints within 20 days. The organisation undertook an external review of their complaints process in September 2015 and developed an action plan to improve their performance in this area. The hospital's quality report for April 2016 to June 2016 showed that they had exceeded their target and had closed 85% of complaints within 20 days. There was a patient forum and complaints committee in place to help manage and learn from complaints.

- The Care Quality Commission had received four complaints about the service during 2015/16. There were no trends identified and the hospital responded to the complainants promptly.
- Staff were aware of outcomes from complaints, actions taken or lessons learnt.
- Staff were able to identify changes made as a result of concerns reported. One example was complaints about the charges made for procedures. Action taken included printing the information on the registration form and on posters in the outpatient department and booking staff to explain the charges. The consultant medical secretaries had also been made aware of the charge system.

Are surgery services well-led?

Good

We rated surgical services good for well-led because:

- The hospital had a clear vision in place to deliver good quality services and care to patients.
- We saw strong leadership, commitment and support from the ward and theatre managers.
- Hospital senior managers were visible, approachable and supportive.
- There were comprehensive risk registers for the whole hospital.
- Staff told us that if incidents took place, they wanted to be open and transparent with patients about any failings.
- The culture of learning from incidents was promoted amongst staff, and they told us they were encouraged to report incidents.
- Staff could raise concerns or share ideas and feel that they were listened to.
- Staff were enthusiastic about working at the hospital and felt valued and respected.
- The hospital gained feedback from both patients and staff.

However we found

- The senior hospital management had not taken reasonable practicable action to provide a safe service for children and young people. The hospital staff did not have access to a registered nurse (child branch) and children's services were not discussed at any meetings.

Leadership/culture of service related to this core service

- The hospital was led by a senior leadership team which consisted of the hospital director, the matron/head of clinical and non-clinical services, finance and commercial manager, theatre manager and business development manager. The ward and pharmacy departments had a designated clinical head of department.
- Leadership within the surgical services reflected the visions and values of the hospital and promoted good quality care.
- We saw strong leadership, commitment and support from the hospital management team. The senior staff were responsive, accessible and available to support staff.
- Staff told us that the hospital director and matron were highly visible and very approachable, providing assistance when required, they felt able to escalate any concerns.
- Staff reported that their direct line managers were supportive and kept them informed of day to day running of the departments.
- The heads of department were positive about the services offered and the level of care provided.
- The nursing team, theatre team, physiotherapy team and administration team communicated well together and supported each other.
- Staff were enthusiastic about working at the hospital and how they were treated by them as a whole. They also felt respected and valued.

Vision and strategy for this this core service

- There was a clear Spire Healthcare vision and a set of values. Quality and safety were the top priority.

- Staff were aware of the overall hospital vision, which was, 'To be outstanding in all things, be the number one choice for all patients, value and invest in staff, provide high quality and efficient patient experience and work with GPs and consultants to deliver clinical excellence'.
- The hospital had a clear vision to expand services both on site and off site over the next five years, commencing with expanding outpatients.

Governance, risk management and quality measurement for this core service

- A governance framework was in place to monitor performance, which reported to the Spire Healthcare board. All committees had terms of reference which accurately reflected their role in the hospital, their structure and purpose.
- Clinical effectiveness and audit meetings were attended by departmental leads, matron/head of clinical and non-clinical services and the clinical governance and risk manager. These committees monitored and discussed a range of hospital issues such as safety alerts, shared learning from incidents, policy updates and reported to the clinical governance committee (CG).
- The CG committee met quarterly. The hospital subcommittees reported into the CG committee and therefore this committee had an overview of governance, risk and quality issues for all departments. Senior department leads attended these meetings and were responsible for cascading information back to their department.
- Although a lead paediatric consultant was a member of the medical advisory committee (MAC), children and young peoples' service was not a set agenda item. Children and young peoples' services were discussed at this committee when relevant. This was raised with senior managers during our inspection. During our unannounced inspection on 4 August, we were told that both the lead paediatric consultant and the lead anaesthetist would be the representative at MAC for children's services and this would be included on the agenda.
- The senior hospital management had not taken reasonable practicable action to provide a safe service for children and young people. The hospital did not have access to a registered nurse (child branch) available to advise or manage the care and treatment of children and young people. The hospital had stopped offering surgical services to children aged under 16 years of age in January 2015. During our unannounced inspection on 4 August we were told that registered nurses (child branch) had been recruited to the bank and would be on duty when children attended outpatient clinics, to assist with risk assessments and pre-operative assessments for young people aged 16-18 years and would work on the ward if required.
- The role of the MAC included supporting the hospital senior managers to ensure that all consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, DBS check and indemnity insurance were all checked by the hospital and ratified by the MAC. An email was automatically generated to remind a consultant if for example their appraisal or indemnity was overdue or expired. If consultants failed to respond to the reminder their practising privileges were suspended.
- There was a clear policy about the introduction of new techniques. Applications were reviewed with the local MAC and corporately to ensure the supporting evidence was sufficient to ensure the safety and effectiveness of the procedure.
- The hospital had completed local as well as national audits. For example, a regular audit had been completed to ensure that compliance with the VTE assessments was monitored and acted upon in line with the hospitals policy and national standards.
- Audit reports were reviewed locally at clinical governance meetings and MAC and results shared with staff through the heads of department. We saw evidence of this in the meeting minutes.
- We reviewed the hospital risk register and noted there were risks identified for each department. Each risk had control measures and an identified owner. Risks included for example inadequate control to ensure full patient records are always available, control measure included policy in place to ensure records are available and audits, inadequate storage space on both the ward and theatres control measure included a review of stock and moving equipment to ensure space is available, and lack of bariatric equipment on the ward, control

measure included bariatric patients to be closely monitored by staff, risk assessments, audit of bariatric policy and develop a business plan for additional equipment.

Public and staff engagement

- There were a number of methods of communicating with staff, such as, the newsletter 'Bushey Tales', emails and team meetings as well as information on computer screen savers and the hospital social network page.
- The hospital sought feedback from patients, both those who were funded privately or by the NHS. Monthly friends and family test results were collected. The friends and family test is a survey designed for NHS patients to gauge feedback from patients about the quality of service and whether patients would recommend the service to their friends and family. The hospital also conducted its own survey for private patients. Both sets of results were consolidated into a monthly report and were discussed at clinical governance and effectiveness meetings.
- There were various methods to engage with staff such as a communication folder in the staff restaurant, monthly tea with the senior manages and staff events such as charity music quiz and hospital parties.
- All new overseas members of staff have a buddy who helps them get settled in the local community.
- The hospital conducted annual staff surveys in line with organisational policies. The top five results from Spire Bushey 2015 staff survey included 97% of staff reporting that they believed that the work that they did made a positive difference to the hospital and 95% of staff reporting that their manager trusted them to make the right decisions at work. An action plan had been developed to address the five lowest scoring results which included 49% of staff reporting that other departments did not understand the impact their actions had on other teams and 32% of staff felt that there were not sufficient numbers of staff to meet the demands of the service. We saw that the action plan involved developing opportunities for all departments to attend regular meetings.

Innovation, improvement and sustainability

- The hospital had plans to expand all services on site and off site and had funding agreed, this included out-patient services and in patient services.

Good

Outpatients and diagnostic imaging

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

Information about the service

Spire Bushey hospital provides a range of outpatient and diagnostic imaging services for privately funded, self-paying and NHS patients including children aged two to 18 years. The out patients and diagnostic imaging service was arranged over three floors with access between the levels via lift or stairs. There was no dedicated paediatric outpatient facility however; there were three dedicated paediatric clinics weekly and the remainder of the time children under the age of 18 were seen in mixed, adult and children, clinics.

The outpatient services offered included: orthopaedics, neurospinal surgery, gynaecology, general surgery, urology, oncology, ear, nose and throat (ENT), ophthalmology, gastroenterology, interventional radiology, cardiology, respiratory medicine, nephrology, dermatology, endocrinology, audiology, clinical neurophysiology, dietetics, haematology, neurology, oral & maxillofacial, pain control, plastic surgery, podiatry, psychiatry, radiology, rheumatology. Specialist services included bariatric, sports therapy, sports medicine and speech therapy.

The outpatient department (OPD) is across three floors. The main OPD reception area is on the lower ground floor. The physiotherapy department, CT scanning and MRI scanning departments are also on the lower ground floor, each with their own smaller waiting areas, changing rooms and booking in desks.

The main OPD area is on the ground floor, with 16 consulting rooms, two treatment rooms, one minor operations room, phlebotomy room and the main waiting area along with a small booking in desk.

On the first floor, a further 3 consulting rooms are situated in the cardiac department, which also has specialised equipment to aid in the diagnosis and treatment of cardiac and respiratory disorders

The diagnostic imaging service offers computerised tomography (CT) scanning, magnetic resonance image (MRI) scanning, non-obstetric ultrasound scanning, x-ray, digital mammography and orthopantomogram (OPG). The main imaging department with X-ray, mammography and ultrasound is on the first floor.

The physiotherapy department has eight treatment rooms, a hydrotherapy pool with two changing rooms and a gymnasium.

The clinical neurophysiology department has separate equipment to aid in the diagnosis of complex neurological conditions.

Pathology services were provided offsite at Spire pathology services and also at a number of locations across the United Kingdom.

In total, there were 87,022 attendances at outpatients, including 7,177 under 18 year olds, from April 2015 to March 2016. Of the total number of attendances, 4% were NHS patients and 96% were privately funded patients.

During the inspection, we spoke with 16 members of staff including a doctor, nurse, radiologists, housekeeper, engineer, administrators and physiotherapists. We spoke with seven patients and we reviewed six patient medical records.

We visited the outpatient department reception; treatment areas and waiting rooms, the diagnostic imaging

Good

Outpatients and diagnostic imaging

department; treatment areas and waiting rooms, the physiotherapy department and the hydrotherapy pool; the treatment rooms and the waiting areas. We visited the cardiac centre, waiting area and the treatment rooms.

Summary of findings

Caring, responsive and well-led we rated as good. Safe we rated as requires improvement. This led to an overall rating of good.

We inspected outpatients and diagnostic imaging for effectiveness but it was not rated.

We found:

- Staff identified and addressed safety concerns. Staff were clear with regards to the process to report incidents and were fully aware of the Duty of Candour regulation.
- There was good evidence of learning from incidents.
- There were good infection control procedures in place and the areas we visited were visibly clean.
- Staffing levels were appropriate for the service provision with minimal vacancies.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- Staff delivered patients' care and treatment following local and national guidance for best practice.
- Staff obtained patient consent before care and treatment was given.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns.
- The hospital management team planned and delivered services in a way that met the needs of the local population. The importance of flexibility, choice and continuity of patient care was reflected in the services. Patients could access the right care at the right time.
- The imaging department planned and delivered care and treatment in line with current evidence-based guidance, standards and best practice. Staff had the right qualifications, skills, knowledge and experience to do their job.
- Staff were supported to participate in training and development.
- Multi-disciplinary teams worked well together to provide effective care.
- Referral to treatment times were in line with the national average and patients could make appointments easily and quickly when required.
- Patients were positive about the way staff treated them in all outpatient and diagnostic areas.

Good

Outpatients and diagnostic imaging

- There were toys and books in the waiting areas specifically for children when they attended outpatients, physiotherapy or diagnostics appointments.
- Information on how to raise a concern or complaint was available for patients. The hospital complaints lead took complaints and concerns seriously and responded to them in a timely manner.
- A patient forum was implemented in response to patient feedback. The forum consisted of self-funding patients that had previously used the hospital services with a representative from senior management. The forum met to discuss possible improvements and the patients' perspective on how services were provided.
- Staff had knowledge regarding the vision for the hospital. There was good staff satisfaction. Staff felt supported and valued. There was a strong culture of team working across the areas we visited.

However we also found,

- Staff who were responsible for potentially assessing, planning, intervening and evaluating children's care in outpatients, did not all have the correct level of safeguarding children training.
- The hospital did not employ or have access to a registered nurse (child branch), that was available when children attended the hospital.
- Carpets in treatment rooms and some hand wash basins were non-compliant with health building notice (HBN) regulations.
- Medical notes were not always available for staff who were treating patients in the department

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the outpatient and diagnostic imaging service as requires improvement safe because:

- The hospital did not employ or have access to a registered nurse (child branch) when children attended the hospital. This did not comply with national guidance.
- Staff caring for children young people aged between 2-18 years of age were not always trained to level 3 in safeguarding.
- One consultant brought in his own mobile ultrasound machine to use in clinics which did not comply with hospital policy. The manager was unable to evidence how this was cleaned and maintained.
- Carpets in treatment rooms and some hand wash basins were non-compliant with infection control guidance and Health Building Notifications (HBN).
- Some medical notes were not always available for staff who were treating patients in the outpatients department.

However we found,

- Staff knew how to report incidents and there was good learning from incidents.
- All the staff we saw were abiding by the arms bare below the elbows policy.
- Equipment was up to date and clean, processes were in place to ensure it was well maintained.
- Medicines and records were stored securely.
- There were safeguarding policies and procedures in place and staff were familiar with them.
- There was good evidence of learning and feedback from incidents.
- Staff maintained high levels of mandatory training. All areas had local induction programmes in place to support new staff.
- Staffing levels ensured the needs of patients were met with little use of agency staff.

Incidents

Good

Outpatients and diagnostic imaging

- All the staff we spoke with knew how to report incidents on the electronic incident reporting system and could explain what incidents they would report.
- A clinical governance and risk manager was in place to oversee all incidents within the hospital, alongside the head of clinical and non-clinical services. Incidents were discussed at senior management meetings, clinical governance meetings and there were monthly adverse incident meetings. If necessary, an incident would also be discussed at speciality meetings including medicines management committees. Following these meetings feedback would then be disseminated to staff in outpatients and radiology.
- There were 74 clinical incidents in outpatients and diagnostic imaging between April 2015 and March 2016. This was comparable with similar independent acute hospitals.
- There were 38 non-clinical incidents reported during the period April 2015 to March 2016, this was higher than other comparable independent acute hospitals.
- There were no never events reported for outpatients during the period April 2015 to March 2016. Never events are "serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event."
- We saw evidence of learning from incidents. Staff explained how the changing area, lighting and grab rails in the hydrotherapy pool had been improved as a result of an incident investigation after a patient had fallen and new checks had been introduced to the labelling of blood samples leading to a reduced number of rejected samples.
- We saw minutes of team meetings detailing incidents and their outcomes. This assured us there was good feedback and learning from incidents.
- From 1 April 2015 all independent healthcare providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- All the staff we spoke with understood the Duty of Candour but told us they had never had to apply it to a complaint or incident.
- The diagnostic imaging manager was aware of their responsibility regarding Ionising radiation (medical exposure) regulations IR(ME)R and there were policies and guidelines for the diagnostic imaging department developed in line with IR(ME)R
- The imaging department had an agreement with a radiation protection advisor (RPA) from another healthcare provider who carried out equipment checks yearly or when required to do so.

Cleanliness, infection control and hygiene

- All the areas we visited were visibly clean and free from dust.
- All the staff we saw were abiding by the arms bare below the elbows policy and we saw a doctor remove his watch, tuck in his tie and wash his hands before he touched the patient.
- There was sanitiser hand gel in dispensers throughout the OPD and posters were displayed encouraging visitors to the department to sanitise their hands.
- Personal protective equipment in the form of gloves and aprons was available and we saw staff using these correctly.
- Cleaning throughout the outpatient and diagnostic imaging department was by a team of housekeepers on a daily basis but staff wiped down equipment between patients using disinfectant wipes.
- Staff informed us that they cleaned any couches and physiotherapy equipment using antibacterial wipes after each patient.
- Staff explained the procedure for dealing with patients with communicable diseases. Patients were given the last appointment of the day to reduce contact with other patients. Staff gave the areas the patient had visited a deep clean once the patient had left the department.
- Hand hygiene audits were completed routinely every two months and we saw there was good compliance, and the usage of hand gel dispensers were audited every two months. April 2015 to December 2015 there was an overall compliance of 95% - 100%.
- The house keeping department carried out routine cleaning audits along with spot checks and domestic supplies cupboard audits.

- Mattresses were audited annually for their state of repair and any which were stained or torn were replaced immediately. The house keeping manager told us that all taps were turned on daily to flush the water as a preventative measure of legionella build up.
- Fabric curtains in the consulting rooms were steam cleaned annually and housekeeping replaced disposable ones every three months. The dates we saw on a curtain confirmed this.
- We saw some of the consulting rooms in the department were carpeted, which does not comply with health building notice (HBN) regulations. Management had identified this as an infection prevention control risk and we saw the action plan for replacement of the carpets with vinyl flooring. The refurbishment was scheduled to be completed by September 2016.
- The carpets were visibly clean but we did not review any carpet cleaning schedules.
- Clinical hand basins were not provided in consultation rooms when the hospital was built. This did not comply with current Health and Building Notice (HBN) 009 (2013). been identified and were due for replacement as part of a rolling plan of refurbishment expected to be completed by September 2016.
- The flooring in the OPD disabled toilet was not HBN compliant as it did not have a continuous return between the floor and the wall meaning effective cleaning could be difficult. This was not identified on the refurbishment plan or on the risk register.

Environment and equipment

- One consultant brought in his own mobile ultrasound machine to use during his clinics. At our initial inspection the OPD manager was unable to evidence how this was cleaned and maintained. When we revisited in December 2016 the hospital had developed a process for checking the equipment for servicing and maintenance but we were not assured about the safety of the equipment and how this was stored in-between clinics.
- The outpatient reception was tidy and uncluttered. When patients arrived staff directed them to the relevant waiting area where they entered a second reception area.
- We found signage throughout the department to be clear and easy to follow.
- There were clear warning signs in areas where ionising radiation and magnetism was used.
- The physiotherapists tested the water in the hydrotherapy pool three times a day to measure the acidity or alkalinity, chlorine levels and cleanliness of the water. We saw the completed daily checklists. The physiotherapists flushed the pool filter on a weekly basis; we saw evidence of this in completed records. An offsite company tested the water microbiology once a week. On site engineers were called if any parameters were found to be out of range. We did not see any out of range parameters.
- Staff told us that there were no difficulties in purchasing new equipment if it was required. The outpatients department had just acquired a new pulse oximeter. A pulse oximeter is a mobile piece of equipment which measures the amount of oxygen in a patient's blood by being attached to a patient's finger.
- The hospital had recently acquired a new magnetic resonance imaging (MRI) scanner able to produce detailed images of every part of the body in less than 60 minutes.
- A second, mobile MRI scanner was available on Saturdays to help keep waiting times down.
- The hospital CT scanner enabled high quality images to be obtained using lower than normal doses of radiation.
- We saw equipment throughout the department had been cleaned and "I am clean" stickers had been applied. We also saw that the equipment was clean.
- We saw that diagnostic equipment maintenance was carried out under contract with an external engineering company and the equipment manufacturer in the case of the MRI scanner. Safety testing had been carried out for all electrical equipment.
- Risk assessments of radiation equipment were performed by the radiation protection supervisor (RPS) with support from the radiation protection advisor (RPA).
- Radiographers told us about the protective gowns provided to parents or carers who were required to support patients during CT or MRI.
- Physiotherapy staff told us they closed the blinds in the hydrotherapy pool area when the pool was in use to prevent patients being visible from the car park and protect their privacy and dignity. However, from the car park, we could see directly into the hydrotherapy pool and saw a patient entering the pool with the support of a physiotherapist. We raised this during our inspection and this was rectified immediately. During the unannounced inspection on 4 August we saw the blinds

were fully drawn and we could not see directly into the hydrotherapy pool from the car park. Staff recognised this was a privacy and dignity issue and discussed plans to use mirrored glass or tinted windows to address this.

- We looked at the resuscitation trolley stored in the main OPD reception. We found it to be well stocked with equipment for adults and children. We saw the daily check list was completed thoroughly. However, some of the items in the trolley were not being stored in sterile packaging and one of the carbon dioxide (CO2) detectors was out of date. We raised these issues with the physiotherapy department manager who replaced the items immediately.
- We saw staff used a treatment room to store equipment due to lack of suitable storage space. Staff told us they moved the equipment into a room which was not being used, when the room was to be used. We saw a lack of space had been identified on the risk register.
- We saw waste was segregated with domestic waste in black bags, infectious waste in orange bags and sharps into yellow sharps bins as per hospital policy. We saw used sharps bins were being stored in an unlocked room prior to collection and disposal, this is not only a health and safety issue, but also contravenes the European Waste Directive which states that all bins waiting collection must be stored in a locked room or in a waste truck in a designated locked compound. We raised this with the outpatient manager during our inspection. We visited this room on our unannounced inspection on 4 August and found the door was locked with a key code pad and only unused sharps containers were being stored.

Medicines

- The hospital had a pharmacy on site that provided daily cover between 8am and 5pm. Nursing staff reported that the pharmacy team were available to offer support and advice to both staff and patients and dispensed outpatient prescriptions.
- The diagnostic and imaging clinical lead showed us how contrast media used in diagnostic imaging was kept in locked fridges with the keys to the fridge stored in a key safe which was accessed by a code.
- Contrast media was prescribed by radiologists. Radiographers, who had received training and had their competency assessed, were able to administer contrast media. Blood tests to ensure good kidney function were carried out before the contrast was administered.
- In outpatients, medicines were stored in a locked cupboard in the treatment room and the keys were kept with the nurse in charge. There were no controlled drugs stored in the outpatient department. We checked the medications and found them to be in date with a good system of stock rotation in operation.
- We saw daily checklists of fridge and warmer temperatures were completed.
- The hospital did not use FP10 prescription forms. Only Spire Bushey prescription sheets (private prescriptions) were used, these were recorded in a prescriptions book and all medications were dispensed by the onsite pharmacy.
- The diagnostic and imaging clinical lead told us that sedation was not offered to patients undergoing diagnostic imaging.

Records

- The hospital did not have a robust system to ensure patient notes were always available. The information provided by the hospital prior to our inspection stated that: “Not all the patients that come to the nurses dressing clinic have their notes available but patients do normally bring a copy of their discharge letter so the nurses know what to do”. Following an appointment at a nurse-led clinic, nursing staff recorded specific details of the patient’s procedure on an outpatients appointment record note taking template; these sheets of paper were later inserted in to the patient’s medical records.
- We reviewed six sets of patient medical records and found that in four of them it was recorded on the outpatient appointment record template: “Did not have consultant notes available (for reference at the time of attending an outpatient appointment)”, one had “notes available” and one did not mention if notes were available or not. We asked the administration manager about the availability of notes for patients attending the OPD but were unable to get a satisfactory answer. We raised this with the senior hospital managers who told us that a review of patient notes was underway to ensure a complete set of notes would be available when patients attended the OPD, this was also on the hospital risk register.
- Nurses could access information regarding date and type of surgery from the computer system and liaise with the ward if necessary to assess patients’ needs and dressing changes required.

- Consultants seeing patients in the department had their own notes. If patients were seen as an emergency, the consultant's secretary would fax over a copy of the last clinic notes or GP letter so that the consultant had notes available.
- Consultants were in the process of implementing an electronic records storage system for all patients' notes to improve access to patient notes.
- Consultants had access to the picture archive communication system (PACS), and this was available on computers in all consulting rooms so previous x-ray and scan images could be viewed quickly and easily.
- All pathology results were available online although many consultants used the hard copy of reports sent by the laboratory.
- The diagnostic and imaging lead described to us how patients could have their images stored on an encrypted compact disc for them to take away, if they required to share this with another hospital.
- The physiotherapy department used electronic records for patient notes and were one of the only Spire hospitals nationally to do so. This meant patient records were always available and up to date.
- The hospital kept records of breast implants used for each patient to ensure traceability should there be a product recall or issues identified with specific implants. The Breast and Cosmetic Implant registry was not yet available nationally at the time of inspection.

Safeguarding

- The hospital had safeguarding policies available on the intranet, including how to manage suspected abuse and out of hours contact details for hospital staff.
- Staff received training on safeguarding through electronic learning and had a good understanding of their responsibilities in relation to vulnerable adults and children. Data received from the hospital stated that 100% of all staff working in outpatients had received safeguarding training to level two for both adults and children.
- Staff were able to explain how to raise a safeguarding concern. Posters were displayed in the department advising staff how to respond to a safeguarding issue, including contact details of the safeguarding leads.
- Staff who were caring for children young people aged between 2-18 years were not always trained to level three in safeguarding. Although we saw no evidence of a failure to safeguard children, we were not assured that all staff who had contact with children or young people had received the appropriate level of safeguarding training. The provider should ensure that a process is in place to ensure clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns has received training to the appropriate level of competency as outlined in the Intercollegiate guidance Safeguarding Children.
- All the staff we spoke with had undertaken safeguarding training of vulnerable adults and children at level two. Although there was some confusion among the staff with regarding the level of safeguarding training they had undergone and whether it was adult or children. Six members of staff in the OPD were working towards children safeguarding level three. Clinical staff and consultants had training planned for the future for children's safeguarding level three. The aim was to ensure that all clinical staff would complete children's safeguarding level three training. The matron had completed children's safeguarding level three and could offer advice to staff as required. The matron and OPD Manager, who was also the hospital Safeguarding Lead, was planning to complete children's safeguarding level four
- The outpatient manager was the lead for both adult and children safeguarding and had undertaken children safeguarding level three training. The physiotherapy manager and the diagnostic imaging manager also had children safeguarding level three training along with five other physiotherapists.
- Three members of staff in diagnostic imaging had level three children safeguarding training. One radiologist had children's safeguarding level three training.
- On our follow up inspection we found two phlebotomists were undergoing level three children safeguarding and there was additional training planned for all staff that were caring for children and young people.
- The hospital had a policy relating to safeguarding around female genital mutilation (FGM) and posters were displayed advising staff what to do if FGM was suspected.

Good

Outpatients and diagnostic imaging

Mandatory training

- The staff we spoke with had received mandatory training by e-learning and face to face on a variety of topics including but not limited to incident reporting, safeguarding, manual handling, information governance and health and safety. All areas had local induction programmes in place to support new staff.
- Staff told us that managers were supportive of them taking time to complete their training.
- We observed the training records for OPD staff and saw they were all up to date and 100% compliance.
- In the physiotherapy department we saw 100% compliance with mandatory training.
- In MRI department we saw electronic training records for 32 staff, there was 100% compliance with mandatory training.

Assessing and responding to patient risk

- The hospital had a policies and guidelines for the diagnostic imaging department which included details on "local rules", radiation protection supervisors (RPS) and radiation protection advisors (RPA) in line with ionising radiation (medical exposure) regulations (IR(ME)R)
- The diagnostic imagining department manager was the radiation protection supervisor for the diagnostic imaging department
- The hospital had a policy on the requesting of diagnostic imaging by physiotherapists called: 'procedure and guidelines for physiotherapists requesting diagnostic MRI and plain film x-rays.'
- The imaging manager informed us that staff always asked patients if they had undergone an x- ray recently. If the previous x- ray was relevant diagnostic imaging staff could obtain it electronically to avoid the patient being over exposed to radiation.
- Women of childbearing age were asked if there was any chance of them being pregnant and procedures were delayed until there was a definitive "no" if they were unsure. We saw a radiographer confirming with a female patient that she was not pregnant before they began the procedure.
- The radiology department had clear processes in place to ensure that the right patient received the correct radiological scan. Staff used a PAUSED guidance that encouraged staff to pause and follow a checklist prior to proceeding. The PAUSED checklist includes, checking with the patient details verbally, confirming the correct site to be x-rayed/scanned, confirming the examination is on the right date and the right time, selecting the correct imaging protocol, recording the dose of exposure, ensuring images are stored correctly and informing the patient on how they can get the results.
- Staff asked patients who had had contrast administered to wait in the department for half an hour so the staff could monitor them for any potential side effects.
- Administration staff in the cardiac department told us of a number of occasions where cardiac physiologists had arranged for patients to be transferred to the local NHS hospital after assessments had shown they were unwell.
- We saw the hospital critical care transfer policy which stated that in the event of an emergency in outpatients for adults or children, 999 would be called.

Nursing staffing

- There is no national baseline acuity tool for nursing staffing in outpatients. The outpatient manager told us that four staff, two registered general nurses (RGN) and two health care assistants (HCA) was safe staffing for outpatients on a daily basis and this was based on their experience and professional judgement.
- During our inspection there were two RGNs, two HCAs and three supernumerary HCAs on shift. Staffing levels were adequate to meet the needs of patients and there was an appropriate skill mix including HCAs, registered nurses and administration staff.
- There were no unfilled shifts for the period January 2016 to March 2016.
- We reviewed the staff rota for outpatients and saw all shifts were full. The rota for staffing on day one of inspection stated two RGN and three HCA, and this was what we saw.
- The service used a mix of nurses, allied health professionals and health care assistants, all who were competent to carry out their specific roles.
- At the time of our inspection, the hospital did not employ a registered nurse (child branch) but this had been identified as a risk and the OPD manager was making plans to address this by the use of bank children's nurses to work at the time of paediatric clinics and be available to support the hospital.
- There was minimal use of bank and agency staff in OPD. The hospital used an induction process to ensure that bank and agency staff had specific competencies and understanding of local policies.

Good

Outpatients and diagnostic imaging

- The OPD used the same agency practitioner for two hours every week to work in cardiology clinics; there were no other agency nurses used. We spoke to a member of bank staff who confirmed they had attended a local induction.
- The department employed two cosmetic nurses who covered eight clinics per week. Both nurses had specific competencies to work in cosmetic services.
- There were no vacancies in OPD at the time of inspection.
- The department had recently employed three new HCAs and these would be supernumerary for a minimum of four weeks. This could be longer if they required additional training and support.
- Interviews were scheduled to recruit a registered nurse (child branch) who would be on duty for paediatric clinics and available to support staff when children attended the hospital.

Medical staffing

- Consultants and radiologists attended the outpatient department and diagnostic imaging department on set days at set times. This meant that the department managers knew in advance which consultants were attending and were able to arrange staffing appropriately.
- The four consultant cosmetic surgeons who had practicing privileges with the hospital were all registered on the general medical council (GMC) specialist register.
- Medical staff were contacted by telephone, email or via their secretaries to offer advice to staff if they were not present at the hospital.
- There was a resident medical officer (RMO) at the hospital 24 hours a day. Staff could easily contact the RMO for advice or to review a patient.

Major incident awareness and training

- We saw the Spire Healthcare Business Continuity plan which had been adapted for Spire Bushey. The plan was in date and detailed action to take in OPD and imaging in event of a major incident such as a bomb explosion, widespread fire or flood, prolonged loss of power, heating, communications or water. Staff were aware of the policy although they had not received any specific training or carried out scenarios.
- We saw a departmental action card detailing the procedure to follow in case of flooding. It was in date and detailed which staff needed to be contacted.
- Staff told us about fire alarm testing which happened on Friday mornings.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate the outpatient and diagnostic imaging service for effectiveness. We found that:

- Policies and guidelines were up to date and based on best practice and national institute for clinical excellence (NICE) guidelines.
- The outpatients and diagnostic imaging department provided a seven day service.
- Effective multi-disciplinary team (MDT) meetings took place with input from national colleagues
- New staff had a significant period of supervision.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) by the consultants.

Evidence-based care and treatment

- Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE).
- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross-referenced to national audit levels and if they were found to be high, a report to the radiation protection advisor would be made.
- The diagnostic imaging department was accredited for multi-modality prostate imaging using guidelines developed by NICE. Multimodality prostate imaging enables an accurate diagnosis of prostate cancer recurrence post initial treatment.
- The hospital complied with the NICE quality standard for breast care recommendation that a clinical nurse specialist was present during appointments.
- Patients undergoing cosmetic surgery were given a mandatory two week cooling-off period between the initial consultation and committing to the procedure, to allow them time to reflect on the information prior to making a final decision. This was in line with best practice.

Nutrition and Hydration

- Staff told us that on occasion the staff restaurant had provided out patients with a meal if required.
- We saw staff offering patients hot drinks after they had undergone procedures.

Pain relief

- There was no oral pain relief or controlled drugs kept in outpatients.
- Staff told us: "If a patient saw a consultant and it was felt that pain relief was required, the consultant would complete a private prescription and the patient would purchase pain relief from the hospital pharmacy. If a patient attended OPD and was in a lot of pain, we would consider admitting them, or we could consult the RMO for review of pain managment".
- Local anaesthetic was stored in a locked cupboard in the x-ray department.

Patient outcomes

- The physiotherapy team were trialling patient specific functional scale (PSFS). Data from every discharge was added to a master spreadsheet on a monthly basis by all physiotherapists. The purpose of the study was to determine quality of life improvements, average improvement per physiotherapy session and number of sessions per point change.
- The physiotherapy department recently carried out an audit on the small number of patients having bespoke knees fitted. The audit showed increased patient satisfaction.
- We did not see any evidence of patient outcome specific related audits being performed in outpatients and diagnostics

Competent staff

- All staff working in outpatients, diagnostic imaging and physiotherapy services had an up to date appraisal, with 100% compliance.
- The Human Resources lead reviewed the health and care professions council (HCPC) registration status for allied health professionals electronically on an annual basis.
- The hospital supported in house training and development. We spoke with three staff who had started their careers at the hospital and progressed to more senior positions.
- The hospital supported and supervised physiotherapy students to work at the weekends to gain experience. The hospital then had the option to recruit the students and support them through further formal training.
- We spoke with one physiotherapist who was being funded through a master's degree (MSc). There were four physiotherapists undertaking MSc courses in total.
- Two radiographers we spoke with, who used the MRI scanner, had received specialist MRI training in London and had undertaken intensive scanner software training provided by the company who supplied the scanner.
- Radiographers could undergo training to enable them to rotate through all areas of diagnostic imaging if they chose to do so. This enabled staff to support other areas within diagnostic imaging during periods of staff leave or sickness.
- We asked two new members of staff if they had received an induction. Both staff members told us that they had and that it had been very informative.
- The department had recently employed three new HCAs and it was planned that they would be supernumerary for a minimum of four weeks, with an option to extend this period if additional training and support was required.
- All doctors who had practising privileges were at consultant level and were registered with the General Medical Council (GMC). This meant patients could be assured that registered practitioners treated them.
- Patients who attended outpatient clinics and the diagnostic imaging department told us that they thought the staff had the right skills to treat, care and support them.

Multidisciplinary working (related to this core service)

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- The hospital held a national multidisciplinary team (MDT) meeting every Monday night purely for breast care. Breast care nurse specialists, breast care consultants, oncologists, histopathologists and radiologists regularly attended and consultants from Spire hospitals nationally joined in to discuss individual patient cases via Skype.

Good

Outpatients and diagnostic imaging

- The hospital offered a consultant led "one stop" breast care clinic Monday to Friday. Patients could undergo consultation and diagnostic tests all in one visit. Breast care nurse specialist were always in attendance at the clinics to offer support to the patients.
- A specialist physiotherapist told us they attended MDT meetings on an ad-hoc basis but there was continuous liaison with consultants and specialist respiratory nurses.
- Weekly urology MDT meetings had just been set up but were not yet fully embedded.
- There were specialist nurses at the hospital for breast care, cosmetic nurses and chemotherapy nurse. Staff and patients could access them for support and information.

Seven-day services

- Outpatient and diagnostic imaging services were available seven days a week.
- Outpatient and x-ray appointments were available from 8am until 9pm Monday to Friday, 8am to 2pm Saturdays and 9am to 1pm Sundays.
- MRI scanning was available from 8am to 8pm Monday to Friday and Saturdays from 9am to 1pm. Thursday mornings were reserved for NHS patient prostate scanning.
- CT scanning was available Tuesday, Wednesday and Friday 9am to 5pm, Mondays 9am to 6pm and Thursday 9am to 8pm. The longer days were to accommodate the requirement for the presence of cardiologists. Saturdays 8am to 1pm were reserved for contract with a local NHS trust.
- 24 hour cover for x-ray and CT scanning was provided by radiographers on an on call basis.
- Physiotherapy was available in the gymnasium and the hydrotherapy pool 7.30am to 8.30pm Monday to Thursday, 7.30am to 6pm Fridays and 8am to 1pm Saturdays. At the weekend, the hydrotherapy pool was reserved for in patient use.
- The cardiac centre did not see any medical emergencies and was available to outpatients from 8am to 9pm Monday and Tuesday, 9am to 8pm Wednesday, 8am to 6pm Thursdays, 9am to 5pm Fridays and 9am to 1pm Saturdays.
- A nurse led dressing clinic was available for wound care every day.
- When the outpatient department was closed, patients could phone the ward staff for advice.

Access to information

- The hospital had a policy for the storage and management of patient medical records which detailed storage and retention, who could access them and what to do with them when the patient was discharged.
- Information leaflets were displayed in the waiting area regarding availability of chaperones, potential additional charges, and availability of translation services, providing feedback regarding patient experience, information on insurance policies and what to do if you had been waiting more than 15 minutes for your appointment.
- Spire Healthcare policies were accessible, current and reflected professional guidelines, for example, National Institute for Health and Care Excellence (NICE). They were stored on the intranet, the policies we viewed were in date and staff showed us how they accessed them.
- Each clinic room had a computer where staff could access examination results and view x-ray images.
- Diagnostic imaging departments used the picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily.
- All diagnostic images were reported on within 48 hours and sometimes sooner. We saw one image had been waiting two days, when we raised this with the radiographer she explained the specialist radiologist would be in the clinic on that day (day three) and so it would be reviewed. Staff explained that all radiographers checked images as they were being generated and alerted the relevant radiologist if they saw anything abnormal.
- Some radiologists viewed and reported on images from home via a secure network.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed the hospital policy; 'Consent to Investigation or Treatment' and found it was comprehensive, in date and compliant with national guidance such as NICE.
- The MRI lead radiographer showed us that the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLs) training was covered as part of mandatory training

Good

Outpatients and diagnostic imaging

- The diagnostic imaging manager told us that written consent for children under 16 years to undergo procedures was obtained from someone with parental responsibility.
- The outpatient manager told us that for many patients consent to procedures was implied but as a minimum consent was obtained from the patient verbally.
- We saw a doctor explaining the risks and benefits of the procedure and obtaining written consent from a patient who was about to undergo CT scanning.
- Patients undergoing cosmetic surgery were given a mandatory two week cooling-off period between the initial consultation and consenting to the procedure, to allow them time to reflect on the information prior to making a final decision. This was in line with best practice.

Are outpatients and diagnostic imaging services caring?

Good

We rated the outpatient and diagnostic imaging service as good for caring because:

- We saw patients were treated with dignity and respect.
- Feedback from patients was consistently positive about the way staff cared for them and the treatment they had received.
- Patients told us they were well informed.
- All the patients we spoke with told us they would recommend the hospital to friends and family.
- The hospital wide friends and family survey, between April 2015 to March 2016, which included both NHS and private patients scored above 97% for the number of patients who would recommend the hospital.

Compassionate care

- We observed staff being polite and friendly towards patients.
- All the patients we spoke with were complimentary of the staff and the hospital.
- We saw staff taking the time to interact with patients in a respectful and considerate manner.
- Patients told us staff were kind, respectful and always introduced themselves.
- Staff respected patient dignity and privacy at all times. We observed all consultations took place in closed rooms and staff knocked on clinic room doors before entering.
- Patients we spoke with in diagnostic imaging and outpatients praised the staff for the compassionate care they provided.
- We saw staff covered patients with blankets to protect their dignity during procedures.
- There were posters offering patients the use of a chaperone during appointments. A HCA told us that acting as a chaperone was part of her role. We saw HCAs performing this role.
- Patients told us that staff always asked their permission before starting interventions. We saw patients undergoing procedures and staff regularly asking them if they were feeling alright.
- The hospital wide friends and family survey, which included both NHS and private patients scored above 97% for the number of patients who would recommend the hospital between April 2015 to March 2016. The response rates were on average 34% for the same time period, which is in line with the England national average. All the patients we spoke with in the outpatient and diagnostic imaging department said they would recommend the hospital to their families and friends.
- Once patients had undergone a CT or MRI scan we saw they were offered a hot drink and advised when their scan results would be available.
- Staff ensured those patients who had been given sedation had transport home or organised for a taxi for them.

Understanding and involvement of patients and those close to them

- One patient told us that if they had any questions they would telephone the department, staff would answer the call quickly and be able to help.
- We saw a doctor in CT explaining a procedure to a patient. The doctor was calm and clear and allowed the patient time for questions and repeated information if the patient asked for it and asked the patient; “Is that ok?” often.
- The consultants’ secretaries provided patients with a written quotation of the cost of their cosmetic surgery prior to admission.

Emotional support

Good

Outpatients and diagnostic imaging

- We saw a nurse offering support and kindness to the relative of a patient who was undergoing a procedure. The patient was concerned their relative was worried and upset and the nurse reassured the patient that she would look after the relative giving updates to each of them.
- Specialist nurses were available at the hospital. There was a specialist breast care nurse, cosmetic nurse and chemotherapy nurse that patients could book an appointment with for advice, support or if they felt they needed to discuss their care.

Are outpatients and diagnostic imaging services responsive?

Good

We rated the outpatient and diagnostic imaging service as good for responsive because:

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- Care and treatment was coordinated with other services.
- One-stop clinics were available for some specialities such as breast care to minimise the amount of attendances for patients.
- Outpatient and diagnostic imaging was a seven day service with evening and weekend appointments available
- The department had specific clinics for paediatrics
- There was a telephone interpretation service available for those patients who did not speak English.
- There was good evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- Clinics were held at weekends and evenings to provide flexibility for patients and keep waiting lists down.
- There were three dedicated paediatric clinics held each week.
- Some consultation rooms were used for specific specialties, with dedicated equipment, for example; ear, nose and throat (ENT); and ophthalmology. This meant consultants would be able to work in an appropriate room according to their specialty and staff could be arranged to support and deliver the service.
- Some outpatients clinics had been designed as 'one-stop' so patients could undergo tests and a consultation within the same appointment; these included specialities, such as breast care.
- There was free car parking available and there were disabled spaces close to the entrance to the department.
- If patients needed to be seen urgently the department offered a clinic room to consultants and there were two hours a day reserved in the MRI scanner to see urgent patients.

Access and flow

- The Department of Health target of 92% for referral to treatment time (RTT) was met and exceeded for April 2015 to March 2016. The hospital routinely achieved 96% to 100%. The RTT is the time period between when a referral for treatment is made and the date of the initial consultation. The Department of Health stated for NHS patients, 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral; however, this was withdrawn in June 2015.
- The department offers evening and weekend clinics to provide patients with flexible access to appointments.
- Some NHS patients were able to book their appointment via an NHS referral system, which allowed them to choose a time that was more convenient for them. Alternatively, patients could contact the outpatients booking teams directly. Staff in the booking teams also contacted patients if a referral was received from a GP or other referrer that was urgent.
- A second, mobile MRI scanner was also available on Saturdays to help manage waiting times.
- Three patients told us they had been referred by their GP, seen within 72 hours at the hospital and had no wait for their appointment on arrival at the outpatient department.
- One physiotherapist told us they were able to refer patients for x-ray and other scans to aid in diagnosis.
- Five patients told us they had not experienced any delays when they had attended for their appointment. Two patients said there had been an occasion where they had been kept waiting but that the receptionist had explained the reason for the delay to them.

- The OPD manager told us there was no national Spire Healthcare policy for dealing with patients who did not attend appointments (DNA). Since 1 June 2016 there had been 168 DNAs out of approximately 7000 appointments. Administrators contacted patients if they did not attend for their appointment. If the patient no longer needed an appointment, this was recorded. We saw an administrator telephone a patient who had not arrived for their scan. The administrator spoke politely to the patient and explained how to rebook.
- Since 1 June 2016 records were being kept of late running clinics. We saw the records and there were approximately 34 late running clinics recorded. One clinic was over 90 minutes late starting. The OPD manager told us that all the patients concerned were informed of the delay and that the information had been presented at the clinical governance meeting and an action plan had been drawn up for dealing with the consultants concerned.

The OPD manager told us of two occasions when clinics had been cancelled, one was due to a burst water main preventing access to the areas around the hospital and the other was when a consultant did not arrive for their clinic. We saw that management had responded appropriately on each occasion.

Meeting people's individual needs

- The hospital had a dementia lead who could be called upon for advice and support when seeing patients with dementia.
- There was a small area dedicated to children in the waiting room. There were age appropriate toys and books in a closed toy box and crayons and colouring books were available from the receptionist on request.
- There was a chair available in the waiting room for larger patients.
- Staff were able to move the chairs in the waiting rooms to accommodate a wheelchair although the corridors around the treatment rooms were narrow and not easily navigated in a wheelchair.
- There were disabled toilets to the side of the main waiting area.
- Lifts were available so patients did not have to use the stairs.
- Hot drinks and water were available free of charge throughout the department.
- The hospital offered access to translation services via a telephone language line for patients where English was not the first language. We saw posters in the waiting area describing how to arrange for an interpreter, the posters were in multiple languages. However, a patient recently attended the department who did not speak English and was deaf; the patient brought their own interpreter.
- The MRI scanner was able to scan disabled patients in the MRI safe wheel chair or using the MRI safe walking frame. The scanner table was able to hold patients weighing up to 250kg meaning larger patients could be scanned safely.
- The outpatient department did not have a specific procedure in place for patients with learning difficulties but told us that they would seek advice and support from the patient's parent or carer.
- One patient we spoke with had been anxious that they were too wide to be scanned; the consultant had advised the patient to contact the MRI department. The patient told us the staff in the MRI department invited them to come and "have a go" on the table to reassure themselves they would fit in the scanner.
- Patients who needed to get undressed for procedures such as CT, MRI and x-ray were shown to individual changing rooms where there were lockers for their possessions and a chair. Patients were given gowns and slippers to put on and offered robes to cover up further.
- Once patients were changed ready for their procedure they could wait in the waiting area or stay in the changing room and wait to be collected by staff if they preferred.
- Patients undergoing MRI scanning could listen to music or audio stories either via CD or the internet if they wanted to. We saw a radiographer offering a patient this choice however, the patient wanted to be left to sleep.
- One patient who attended for an MRI scan told us that the radiology staff had arranged for him to have his procedure in two sessions with a comfort break in the middle because the procedure would be too uncomfortable for him in one session.
- Staff told us of occasions when they had liaised with other departments to arrange for appointments to be on the same day for a patient who needed to attend multiple clinics.
- Patients told us they had received information prior to their appointments either by telephone call or email and sometimes both.

Good

Outpatients and diagnostic imaging

- Patients that we spoke with after their appointment said that they had received information about when they would receive their test results and if they required further diagnostics or treatment what that would consist of.
- We did not see any information leaflets which were suitable for children and young people.

Learning from complaints and concerns

- Spire Healthcare Limited's corporate complaints policy directed the management of complaints and time scales for responses. This was in line with industry standards. All complaints were reviewed by the clinical governance committees and medical advisory committee (MAC) and actions as a result of the complaint shared with individual departments via team meetings.
- The hospital complaints procedures were communicated to patients in a leaflet called 'Please Talk To Us'.
- Senior managers told us about a complaint received from a patient regarding additional charges incurred during an outpatient consultation for diagnostic tests which were performed. We saw posters displayed throughout the department explaining that diagnostic testing would incur additional charges. This evidenced learning from complaints.
- From February 2015 to March 2016 there were 12 complaints.Five complaints were upheld, two complaints related to communication of test results, one related to dressings leaking, one related to charges and one related to dignity and privacy in the MRI. Complaints were handled within 20 days in line with hospital policy. Lessons learnt from complaints were shared with all staff, such as improving communication with patients.
- All the patients we spoke with told us they had no complaints but knew how to complain if they ever needed to. One patient said they had made a complaint in the past and had been pleased with the way it had been handled and the feedback they had received.
- We saw; "You said we did," posters in the department explaining what had been improved as a result of patient feedback, including setting up a patient forum and creating notice boards throughout the hospital.
- A patient forum was implemented in response to patient feedback. The forum consisted of self-funding patients that had previously used the hospital services with a representative from senior management. The forum met to discuss possible improvements and the patients' perspective on how services were provided.
- The hospital was proud of the large number of compliments they regularly received.

Are outpatients and diagnostic imaging services well-led?

Good

We rated the outpatient and diagnostic imaging service as good for well led because:

- Staff we spoke with were aware of the hospital vision and values and the individual department strategy.
- The hospital had a clear governance structure.
- Information was cascaded from the clinical governance committee to all hospital staff via team meetings.
- The hospital had an effective risk register and staff were aware of the risks specific to outpatients and diagnostic imaging.
- Hospital senior management members were visible, approachable and supportive.
- Staff were proud to work for the hospital and felt supported and valued.
- Staff felt well informed and involved in the development of the new outpatients facility.
- There were innovative ways of communicating with staff such as newsletters and social media.

Leadership / culture of service

- The service was led by the diagnostic imaging manager, outpatients manager and physiotherapy manager who were accountable to the matron who in turn reported to the hospital director.
- Each department had a manager who was responsible for the day-to-day management and staffing levels.
- Staff told us they felt confident to raise issues and that the hospital manager and matron were very regularly seen in the department and always enquired after staff personally.

- Staff told us that the senior and local managers were very supportive and actively promoted training and career development through in-house training and more formal education such as a master's degree training.
- All the staff we spoke with told us they felt valued and were proud of the teams they worked in and of the service they provided.
- We saw that communication within the hospital was good between all staff groups at all levels.

Vision and strategy for this this core service

- All the staff we spoke with were aware of the corporate vision for Spire Healthcare, which was, 'To be recognised as a world class healthcare provider,' and: 'To bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'. Senior managers told us that the hospital aspired to become world class providers within the sector.
- Spire Bushey values were; caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on our promises and keeping it simple.
- The hospital values were displayed on pop up banners throughout OPD and staff told us they felt that everyone lived by the values.
- A clear strategy was in place for the department and staff told us how they had all been involved in developing it through input at team meetings.
- There had recently been approval to develop outpatient and diagnostic services offsite and staff told us they were kept well informed about developments and had been actively involved in making decisions regarding layout and fixtures and fittings for the new facility.

Governance, risk management and quality measurement for this core service

- Governance structures were robust and clear. The hospital clinical governance committee reported to the Spire Healthcare Limited board.
- The clinical governance committee met quarterly. This committee had an overview of governance risk and quality issues for all departments. Senior department leads attended. Information discussed included safety alerts, learning from incidents, policy updates and audits.
- Departmental team meetings took place weekly and outcomes and information was shared at departmental meetings which took place monthly. Outcomes of departmental meetings were then shared at hospital management meetings. Minutes of meetings were circulated to all staff by email and we saw evidence of these.
- Risk management was led by the dedicated risk management committee set up in 2015. The committee met quarterly to review the hospital wide risk register where they identified and tracked risks. We saw the hospital wide risk register, which was up to date and each risk had been rated according to its severity.
- Every department had their own risk assessment register which covered risk assessments completed in each department. The head of the department managed the departmental risk assessment register.
- Risks were identified through variety of sources including but not limited to: risk assessment results, annual planning, KPI's, policy, complaints, staff & patient surveys, external accreditation/assessments, incidents, audit and national recommendations.
- We reviewed the hospital risk register and saw that outpatient and diagnostic imaging department had risks and control measures identified and reviewed.
- The OPD took part in routine monthly audits including hand hygiene and patient notes audits.
- The OPD had recently carried out a three month audit of consent compliance for minor surgery and implemented a World Health Organisation (WHO) safer surgery checklist as a direct result of their findings.
- Diagnostic imaging had very recently introduced monthly image audits for the MRI scanning; there was no feedback to date. Radiographers carried out intervention audits every six months.
- Staff who were exposed to radiation wore radiation monitoring badges which were checked for dose exposure monthly.

Public and staff engagement

- There were a number of methods of communicating with staff, such as, the newsletter; 'Bushey Tales', emails and team meetings as well as information on computer screen savers and the hospital social network page.
- We saw the Bushey Tales which the staff received monthly. There were updates on incidents and complaints and compliments as well as information on

award winners, staff social activities and new starters. Staff spoke enthusiastically about the newsletter and felt it kept them informed of developments within the hospital.

- The hospital wide staff forum which met quarterly. Staff told us this helped keep them motivated and well informed of changes and news across the hospital.
- The hospital operated a, "policy of the month" scheme where one policy every month was highlighted to raise awareness and compliance with staff across the hospital. We saw the policy displayed on the notice boards in MRI and CT and staff told us how they accessed it and evidenced they had read it. An audit had taken been carried out to ask staff if they had read the policy and understood the content. We saw evidence of the audits and action plans were staff were required to re-read the policy to become familiar with the contents.
- We were told by senior management that outpatient staff had taken part in the staff satisfaction survey but due to an error made at data input stage it was not possible to identify any trends specific to OPD staff.
- Staff told us they were proud to work for Spire Bushey Hospital; they said they felt engaged and motivated.
- The hospital held an awards ceremony and staff received rewards in the form of vouchers and certificates for outstanding contribution to the service. Staff could be nominated by colleagues and patients. Staff told us that they felt this was a good way to reward staff.
- We spoke to a bank nurse who told us she felt considered and treated as equal with the permanent staff.
- A patient forum was implemented in response to patient feedback. The forum consisted of self funding patients that had previously used the hospital services with a representative from senior management. The forum met to discuss possible improvements and the patients' perspective on how services were provided.
- A patient experience and complaints committee met as part of the existing governance structure to ensure patients' experiences and complaints were used to improve quality and customer service.
- Staff and members of the public were keen to speak with us during the inspection and told us they were glad to have the opportunity to show off their "excellent department". One member of staff told us "this is a lovely place to work".

Innovation, improvement and sustainability

- The hospital had recently secured £23 million service development investment. Plans were in place to improve the outpatient department. Work was underway on an offsite facility where the outpatient department would relocate. This would allow both the outpatient and the inpatient facilities at the main hospital site to expand.
- The medical services had plans to expand capacity and were constantly striving for new ways to improve. This included applying for Joint Advisory Group in Gastroenterology (JAG) accreditation and redesigning the endoscopy unit.

Not sufficient evidence to rate

Termination of pregnancy

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

Information about the service

Termination of pregnancy (TOP) refers to the treatment provided to terminate a pregnancy, by surgical or medical methods.

Spire Bushey Hospital provides medical and surgical termination services to patients from Hertfordshire, North London and surrounding areas. Services are available on Tuesdays, Thursdays and Saturdays between 9am and 5pm.

The service is mainly provided to self-funded patients, and they are offered a range of termination of pregnancy (TOP) services including pregnancy testing, early medical abortion, early surgical abortion, abortion aftercare, contraceptive advice and contraception supply.

The service holds a licence from the Department of Health (DH) to undertake termination of pregnancy procedures within Spire Bushey Hospital. The licence is publically displayed within the outpatients department.

Medical terminations of pregnancy are carried out on patients between six and eight weeks gestation. Early surgical terminations of pregnancy are carried out on patients up to 16 weeks gestation. Terminations of pregnancies of a later gestation period are referred to another provider.

At Spire Bushey Hospital, 13 medical terminations of pregnancy and 12 surgical terminations of pregnancy were carried out between April 2015 and March 2016. Patients aged 16 and above were treated by the service; anyone below 16 years of age was referred to another provider.

There were two consultants who carried out the termination of pregnancy service, with support from the outpatient manager for medical terminations, and general surgery staff for surgical terminations. Medical secretaries and the head of clinical and non-clinical services also supported the governance of termination of pregnancy services. We spoke with five staff about the service.

The inspection was conducted using the Care Quality Commission's methodology of inspecting this type of service. We looked at the medical records of 27 patients, including some young people under the age of 18. We were unable to observe interactions with patients or procedures during our inspection due to no patients being seen on the days of our visits.

This service was not rated because there was insufficient evidence.

Not sufficient evidence to rate

Termination of pregnancy

Summary of findings

We found that:

- Staff who were responsible for potentially assessing, planning, intervening and evaluating young people's care, did not all have the correct level of children's safeguarding training.
- Termination of pregnancy services governance issues were not always effective. There was no evidence that the service was discussed or reviewed at any committee meeting.
- Not all HSA1 forms had a reason for termination documented in line with legislation.
- Not all patient records had evidence that a HSA4 form had been completed and sent to the chief medical officer.
- Records did not always contain consistent information to demonstrate all aspects of patients care or medicines received.
- Screening for sexually transmitted diseases did not happen within the service. There were no processes in place for patient referral to obtain screening. This does not comply with national guidance.
- Some records contained errors that had been crossed out but no initials to state who had rectified this error or crossed the previous content out.
- Audits did not always accurately reflect the evidence in patient records, which meant non-compliance with Department of Health Required Standard Operating Procedures (RSOP), was not always identified or addressed.
- Action plans were in place following audits; however they were not always effective or robust enough to address compliance findings.

However we found:

- Patients were protected from abuse and avoidable harm, as staff knew how to recognise untoward incidents and report them appropriately. There were arrangements in place to share and action any identified learning points following incidents.
- All staff we spoke with understood duty of candour and how this applied to their practice.
- Robust procedures were in place for managing medicines used in terminations. All staff within the service and pharmacy team were aware of legislation surrounding medicines that induced termination of pregnancy.
- Clear processes and practices were in place in relation to safeguarding, with staff having completed the necessary training in adult safeguarding.
- Patients underwent thorough assessments prior to any treatment being delivered, with any potential risks documented and explained to patients.
- National guidance was followed during treatment within the service, and all staff had a good knowledge of guidance and best practice.
- Procedures were in place to ensure effectiveness of both medical and surgical terminations; the service had a 0% failure rate.
- Staff understood the need to show care and compassion towards patients deciding to undergo a termination, and were aware of the emotional impact this may have on patients.
- Services were easily and readily accessible to patients, with clinics available at various times throughout the week, including one weekend day.
- Clinical audit plans were in place within the service that observed compliance with required operating procedures (RSOP).
- The corporate risk registered identified the appropriate risks relating to the service.
- There was an inclusive and team-working culture throughout the service, with a drive for effective patient care.

Not sufficient evidence to rate

Termination of pregnancy

Are termination of pregnancy services safe?

Not sufficient evidence to rate

We found that:

- Not all HSA1 forms had a reason for termination documented in line with legislation.
- Not all patients had evidence that a HSA4 form had been completed and sent to the chief medical officer.
- We found that records audits did not accurately reflect the patient records reviewed.
- We did not see evidence of conversations regarding contraception being conducted with patients, or whether long acting reversible methods were discussed or offered.
- Screening for sexually transmitted diseases did not happen within the service. There were no processes in place for patient referral to obtain screening.
- Staff who were responsible for potentially assessing, planning, intervening and evaluating young people care, did not all have the correct level of children's safeguarding training.
- Records did not always contain consistent information to advice on patients care or medicines received.
- Some records contained errors that had been crossed out but no initials to state who had rectified this error or crossed the previous content out.
- Consultants did not document that a patient had capacity to consent to the termination procedure, there was no prompt for this within the pre-assessment paperwork.

However we found:

- Patients were protected from abuse and avoidable harm, as staff knew how to recognise untoward incidents and report them appropriately. There were arrangements in place to share and action any identified learning points following incidents.
- All staff we spoke with understood duty of candour and how this applied to their practice.
- Infection control procedures and policies were in place to protect people, and all areas inspected were visibly clean and suitable for use.
- Processes were in place to ensure medicines were available, and were dispensed in a safe way. All staff were aware of legislation surrounding medicines that induced termination of pregnancy.
- Clear processes and practices were in place to ensure patients were kept safe from avoidable harm and abuse. Safeguarding policies were available and accessible for staff. Staff we spoke with had knowledge of these policies and were able to describe the process of reporting a safeguarding concern.
- Patients underwent thorough assessments prior to any treatment being delivered, to ensure any clinical risks were addressed and mitigated, including the development of a blood clot.

Incidents

- Patients were protected from abuse and avoidable harm, as staff knew how to recognise untoward incidents and report them appropriately. There were arrangements in place to implement any identified learning points following incidents.
- There was an electronic reporting system in place to allow staff to report incidents and receive feedback electronically.
- Staff were encouraged to report incidents and all staff we spoke with were familiar with how to do so.
- A clinical governance and risk manager was in place to oversee all incidents within the hospital, alongside the head of clinical and non-clinical services. Incidents were discussed at senior management meetings, clinical governance meetings and there were monthly adverse incident meetings. If necessary, an incident would also be discussed at speciality meetings including medicines management committees. Following these meetings feedback would then be disseminated to staff within the service.
- There had been one reported incident within the termination of pregnancy service since April 2015 which on investigation was categorised as a serious incident.
- The SI related to the dispensing of termination medication to another provider that was not registered to carry out termination of pregnancy procedures. We saw a robust root cause analysis had been completed once this had been brought to the attention of the senior management team. Although an investigation had not been commenced until five months after the initial incident had occurred due to a delay in the hospital being made aware of the error. We observe that

actions documented on the root cause analysis, including a communication book, a new procedure put in place for management of termination medicines and advice to staff, were in place to prevent the incident occurring again in the future. All pharmacy staff we spoke with were aware of the incident and lessons learnt from this had been discussed at their specialty medicines management meeting.

- There had been no reported never events relating to termination of pregnancy services 12 months prior to the inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- From 1 April 2015 all independent healthcare providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Clinical staff within the termination of pregnancy service we spoke with were fully aware of the Duty of Candour regulation and what this meant in their practice. Staff told us they had received training on Duty of Candour.

Cleanliness, infection control and hygiene

- All areas where termination services were carried out, including clinical and waiting areas, were visibly clean and tidy.
- The consultation rooms and waiting areas were cleaned daily by housekeeping staff.
- Staff complied with the hospitals infection prevention and control policies. All clinical staff were arms bare below the elbow to enable effective hand washing and reduce the risk of infection. There were hand washing facilities, supplies of alcohol gel and personal protective equipment (PPE) in consulting rooms and throughout the service. Alcohol gel dispensers were available regularly from the hospital entrance to all clinical areas, to enable patients and visitors to sanitise hands and prevent spread of infection. We saw staff carrying out appropriate hand hygiene practice when entering clinical areas.
- A number of infection control audits are completed in all areas of the hospital regularly including within outpatients and surgical areas. Hand hygiene audits from April 2015 to December 2015 across all surgical wards and theatres showed 95% - 100% overall compliance.
- Single use equipment was used and disposed of in line with manufacturer's guidance. There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in a clinical environment.
- Fabric curtains in the consulting rooms were steam cleaned annually and housekeeping replaced disposable ones every three months. The dates we saw on a curtain confirmed this.
- We saw some of the consulting rooms in the department were carpeted, which was not compliant with health building notice (HBN) regulations. The senior management team had identified this as an infection prevention control risk and we saw the action plan for replacement of the carpets with vinyl flooring, however there were no specific dates for completion of this.
- Not all of the hand basins were compliant with HBN regulation 00-09, but these had been identified and were due for replacement as part of a rolling plan of refurbishment, there were not specific dates set for completion of this.
- We saw that equipment used for numerous patients, including the ultrasound machine, had a visible green; 'I am clean' sticker on it to indicate it was clean and ready for use. Staff told us they were responsible for cleaning such equipment after each use and told us how this was carried out in line with guidance. We saw one ultrasound machine within the consulting room used and this was visibly clean and had a sticker present to show it had been cleaned the morning of our inspection.

Environment and equipment

- Resuscitation equipment was available in the outpatient department and within surgical areas should it be required by those carrying out termination of pregnancy services. These were checked and

maintained by the relevant teams from each area. We observed that laryngoscopes and suction catheters were not stored in their sterile packaging across all resuscitation trolleys; this was addressed immediately when raised with staff.
- All areas where consultations and treatments were carried out were private and did not allow patients to be seen or overheard whilst receiving termination of pregnancy services.
- Oxygen cylinders were available in the treatment room and on the resuscitation trolley. The oxygen cylinders were all in-date.
- Emergency call bells were located in treatment rooms, recovery areas and patient toilet facilities. These were checked on a weekly basis by each area.
- All equipment had been serviced and safety checked in line with the provider's policy, all disposable equipment was stored within sterile packaging in-line with manufacturers' guidance.
- The staff understood their responsibilities in relation to managing clinical waste and the disposal of pregnancy remains.

Medicines

- The hospital had a pharmacy on site that provided daily cover from 8am to 5pm Monday to Friday, and from 8am to 1pm on Saturdays. Nursing staff reported that the pharmacy team were available to offer support and advice to both staff and patients and dispensed prescriptions.
- All medicines required for termination of pregnancy services were dispensed by the hospital pharmacy, this was located next to the outpatient department (OPD) where the consultations and early medical terminations of pregnancy were carried out.
- A doctor prescribed all medicines for patients undergoing early medical termination of pregnancy, including prophylactic antibiotics to reduce the risk of post-procedure infection.
- Medicines that induced termination of pregnancy were prescribed only for patients undergoing medical termination following a face-to-face consultation with a doctor. Doctors and the pharmacy team told us the first dose must be taken on the hospital site, but the second dose of medicine could be taken home by the patient for self-administration.
- A copy of the British National Formulary (BNF) 2016 was available in both treatment rooms and pharmacy for doctors or pharmacy staff to refer to. The BNF is the national authority on the selection and use of medicines.
- There was an established system for the management of medicines to ensure they were safe to use. Medicines that had temperature storage requirements were kept refrigerated. The minimum and maximum temperatures of fridges were monitored daily to ensure that medication was stored correctly; we reviewed records of temperature recordings and found them to be up to date. There were systems in place to check for expired medicines and to rotate medicines with a shorter expiry date. Stickers were placed onto medicine boxes that were due to expire within the next six months.
- We observed appropriate security procedures in place to ensure only approved staff could access medicines and out of hours provisions were clear.
- Medication administration records were contained within all patient records we reviewed, they were clear and complete. However medicine charts that documented what a patient had been administered during surgery were not always present in all the patient records we reviewed.
- We saw that the allergy status of each patient was clearly documented on their medication administration chart and this correlated with any documented allergies in their patient record.
- Pharmacy teams carried out numerous audits in relation to administration and safety of medicines, including admissions medication chart completion, medicines reconciliation and oxygen prescribing. We observed that learning points relating to any audit outcomes or incidents were shared throughout the pharmacy team and with staff carrying out termination of pregnancy services. An example of this is through an oxygen prescribing audit, it was noted that not all medical staff were correctly completing a medicine chart when oxygen had been administered. To improve compliance with this pharmacy staff send a memo to all areas to advise on the correct process for oxygen prescribing and also discussed this during a medicines management committee.

Records

- We reviewed 27 medical records of patients that had undergone termination of pregnancy, one of these

related to a patient under the age of 18 years. Records were generally well maintained and clearly documented the consulting doctor and date the patient was seen. However, not all records were completed thoroughly. We found some had errors crossed out that had not been initialled by the clinician completing the record. We also found the information contained in patient records to be inconsistent. Some records contained a list of medicines administered during surgery; others had this page missing so we could not see if prophylactic antibiotics had been administered.

- Some records had been amended by senior managers following an audit, with treatment dates added after the termination had been carried out. The senior manager had not been involved in the clinical care of the patient.
- There were comprehensive pre-operative health screening questionnaires and assessment pathways. However, the format these were presented on did not make it clear what actions had been completed. Each box had a list of actions, and one large area at the side for staff to sign when complete, there were no lines or boxes to be able to link each signature to an action. We observed that staff drew a line through all questions to suggest all actions then signed the bottom of the page; this did not make it clear whether actions had all been completed, or none had been completed. It was also not clear which staff grade was completing this area of the patient's record.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for termination and sign a HSA1 form to indicate their agreement. In the 27 medical records we checked, all HSA1 forms contained two consultant signatures. Three HSA1 forms did not document a reason for the termination. We raised this with the senior managers during the inspection who reviewed the records and provided us with the HSA4 form that had a reason documented for all patients. A copy of the HSA1 form was filed in the patient's medical record, which is considered best practice by the Department of Health 'Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy' (Abortion) required standard operating procedures (RSOP).
- Documentation audits of HSA1 forms were carried out every three months. The hospital reported a 100% compliance rate for the period January 2016 to June 2016. However, the records identified as not having a reason stated for termination had been marked in the audit as having a reason documented. This meant the audits were not being completed accurately and therefore learning was not identified in relation to the completion of records and no actions had been taken to address non-compliance with the completion of HSA1 forms.
- The Department of Health requires every provider undertaking termination of pregnancy to submit details of the pregnancy and demographical data using an HSA4 form, recording demographic and other data for every termination of pregnancy performed within 14 days. We found that three sets of patient notes did not contain evidence that a HSA4 form had been completed and sent to the Department of Health. This information was audited by the hospital and we saw evidence that 78% of HSA4 forms had been completed and sent to the Department of Health between January 2016 and June 2016. This is not compliant with the Abortion Act which states that the Chief Medical Officer must be sent the HSA4 within 14 days of the termination of pregnancy taking place. We raised this with the senior management team during our inspection. During our unannounced inspection we observed that service had implemented an online process where HSA4 forms could be tracked."
- All patients had a venous thromboembolism (VTE) assessment to determine their risk of developing a blood clot. This is recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) to reduce avoidable harm and death from VTE. We saw completed VTE assessments in all the patients' medical notes we reviewed.

Safeguarding

- Spire Bushey had clear processes and practices in place to ensure patients were kept safe from avoidable harm and abuse.
- Safeguarding policies were available and accessible for staff. Staff we spoke with had knowledge of these policies and were able to describe the process of reporting a safeguarding concern.
- Not all staff caring for young people aged between 16-18 years had the required children safeguarding training at level three. The Royal College of Paediatrics and Child Health (RCPCH) or those contained in the Intercollegiate Document (March 2014) guidance state that clinicians responsible for assessing, planning, intervening and evaluating children, should be trained to level three.

Not sufficient evidence to rate

Termination of pregnancy

- Some staff we spoke with had received adult and children safeguarding training within the previous six months, this training was at level three in line with intercollegiate guidance.
- Both consultants who carried out the terminations had children's safeguarding training to level three.
- Termination of pregnancy services were not provided to any patients under the age of 16. Staff told us that patients would be advised on the most appropriate provider when they called to book an appointment. We saw that no patients under the age of 16 had been seen within the service in the previous 12 months. One patient, who was 17 years old, had undergone a thorough safeguarding assessment, which was documented, including details about their capacity to consent and involvement of their parent in their treatment.
- Staff were aware of female genital mutilation (FGM), which involves genital cutting and female circumcision and removal of some or all of the external female genitalia.
- Staff were also aware of child sexual exploitation, with regards to their role in safeguarding young or vulnerable adult patients. Initial assessments included questions around consent and coercion to sexual activity and lifestyle to identify coercion, suspicion of sexual exploitation or grooming, sexual abuse and power imbalances. When there was any suspicion of abuse safeguarding referrals were made to the safeguarding team. There had been no safeguarding referrals for patients being seen for termination services.
- Patients were not routinely seen alone during the initial consultation, therefore there was no reassurance that the patient had not been pressured or coerced into the decision to have a TOP. We raised this with the senior managers during our inspection who told us they would review the consultation process.

Mandatory training

- Mandatory training covered a range of topics including health and safety, manual handling, infection control, information governance and basic life support.
- The organisational target for completing mandatory training was 100%. Data provided showed that 100% of staff within the terminations of pregnancy services were up to date with mandatory training.

Assessing and responding to patient risk

- All patients were asked about their medical history to assess their suitability for treatment; this included assessment of potential risk factors. If a patient was unsuitable for treatment, for example due to existing health conditions, at Spire Bushey they would be referred to another provider. We did not see evidence of any patients being referred elsewhere because they were unsuitable, and staff told us they could not recall this happening.
- Prior to termination procedures, patients should have a blood test to identify their rhesus status. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications, should the patient have future pregnancies, and is in line with the Department of Health regulated standard operating procedures. The records that we reviewed demonstrated that all patients underwent a blood test prior to the termination procedure and those who had a rhesus negative blood group did receive an anti-D injection. A record of all patients who had received anti-D was kept.
- All patients had an ultrasound scan to confirm gestation. If the practitioner was uncertain of their findings they would discuss this with a colleague, and if necessary refer to an alternative provider.
- Spire Bushey had adopted the national, 'five steps to safer surgery' checklist, which was designed to prevent avoidable mistakes. All surgical termination records we reviewed contained completed checklists with the risk outcome documented.
- All patients had undergone a venous thromboembolism (VTE) assessment to determine their risk of developing a blood clot in their legs or their lungs. This is recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) to reduce avoidable harm and death from VTE. We saw completed VTE assessments in all the patients' medical notes we reviewed.
- All patients were risk assessed at the point of admission and recovery staff used a national early warning score (NEWS) to record routine observations, such as blood pressure, temperature and heart rate.
- The hospital had clear policies in place in regards to responding to a deteriorating patient. Consultants told us that while there was no official on call system due to the small size of the termination of pregnancy service and no requirement for it, they would attend the

Not sufficient evidence to rate

Termination of pregnancy

hospital out of hours if a problem occurred with their patient. There had been no transfers to NHS acute trusts following a termination procedure in the previous twelve months.
- If a patient lived a long distance from the hospital, and their drive home would be more than a couple of hours then they would be advised to stay overnight following a surgical termination. We were told this rarely happened, and if it did then the resident medical officer would be provided with the consultant details who had performed the termination, to call if there were problems overnight.

Nursing staffing

- There were no dedicated nursing staff that solely covered termination of pregnancy services, however during clinic days the OPD manager provided nursing support to patients and doctors for early medical terminations.
- For surgical terminations ward and theatre staff supported the consultant carrying out the termination.
- The service used a mix of nurses, allied health professionals and health care assistants, all who were competent to carry out their specific roles.
- There was minimal use of bank and agency staff in outpatients on the ward and theatres. The hospital used an induction process to ensure that bank and agency staff had specific competencies and understanding of local policies.

Medical staffing

- Patients care was consultant led. There were two consultants who carried out assessments, early medical terminations and surgical terminations at Spire Bushey.
- The consultants attended the hospital on set days at set times. This meant that the department managers knew in advance which consultants were attending and were able to arrange staffing appropriately.
- There was a resident medical officer (RMO) at the hospital 24 hours a day. They could be easily contacted by staff for advice or to review a patient for example, for pain management.

Major incident awareness and training

- We saw the Spire Healthcare Business Continuity plan which had been adapted for Spire Bushey. The plan was in date and detailed action to take in event of a major incident such as a bomb explosion, widespread fire or flood, prolonged loss of power, heating, communications or water**.** Staff were aware of the policy although they had not received any specific training or carried out scenarios.
- We saw a departmental action card in outpatients that detailing the procedure to follow in case of flooding. It was in date and detailed which staff needed to be contacted.
- Staff told us about fire alarm testing occurred every Friday morning.

Are termination of pregnancy services effective?

Not sufficient evidence to rate

We found that:

- We found that audits in line with guidance did not accurately reflect the patient records reviewed.
- We did not see evidence of conversations regarding contraception being conducted with patients, or whether long acting reversible methods were discussed/ offered.
- Screening for sexually transmitted diseases was not undertaken for women undergoing TOP. There were no processes in place for patient referral to obtain screening. This does not comply with national guidance.
- A post-abortion advice line was not available to patients 24 hours a day.
- Consultants did not document that a patient had capacity to consent to the termination procedure, there was no prompt for this within the pre-assessment paperwork.
- Patients were not routinely asked about sharing information with their GPs.
- Patients were not routinely provided with discharge summaries following their treatment, there was no evidence of this being offered to all patients.

However we found:

- Some policies and procedures that were in line with national guidance were in place within the service, these had been reviewed within the necessary time frame.

Termination of pregnancy

- Procedures were in place to ensure effectiveness of both medical and surgical terminations; the service had a 0% failure rate.
- Both consultants who provided the termination service were suitably qualified and competent to carry out the procedures.
- Staff had access to relevant guidelines, policies and procedures in relation to termination of pregnancy services.
- All care records we reviewed contained signed consent forms from patients. Possible side effects and complications for each type of termination were documented and the records showed that these had been fully explained.

Evidence-based care and treatment

- Policies and procedures were in place, and had been reviewed within the necessary time frame. All staff we spoke with knew which policies were relevant to termination of pregnancy services and how to access them. Not all policies were developed in line with Department of Health RSOP and professional guidance.
- We did not see evidence that contraceptive options were discussed with patients during their initial assessment. Staff told us that most patients were discharged with a week's supply of a contraceptive pill, but that long acting reversible contraceptive (LARC) methods were not fully discussed. Staff told us that occasionally they would fit an intrauterine device following a surgical termination but that this did not happen often. This was not in line with RSOP which state services should be able to provide all methods of contraception, including long acting reversible methods, immediately after termination of pregnancy. Patients were not given information to take away regarding contraception. We raised this with senior managers and during the unannounced inspection on 4 August we saw an action plan to address this.
- Screening for sexually transmitted diseases was not undertaken. Some patients received prophylactic antibiotics that would treat chlamydia; (One type of sexually transmitted disease) however; there were not records of this in all patient notes. Guidance states that patients should be screened for chlamydia during assessment and also a risk assessment completed to establish whether other sexually transmitted diseases are likely. There were no processes in place to refer patients to an alternative provider if they were at high risk of other sexually transmitted diseases. We raised this with senior management and during the unannounced inspection on 4 August we saw an action plan to address this.
- Whilst the service audited some aspects of patient care and outcomes they did not audit all aspects of RSOP 16, which states, subject providers should audit include:
  - Waiting times
  - The outcome of consultations; the number of women who do not proceed to a termination
  - The use and availability of pathways to specialist services for women with significant medical conditions and to antenatal care for women deciding to continue their pregnancy
  - The availability of a female doctor for women who wish to consult a woman - especially those from certain cultural backgrounds and ethnic minorities, with arrangements for non-English speaking women.
  - The number of staff competent to provide all methods of reversible contraception
  - Patient choice across the range of service provision to include follow-ups, contraception and abortion methods
  - Patient experience for those who have returned home after taking the second medicine for a termination of pregnancy
  - Rates of complications
  - The prevention of infective complications
  - Failure rates
  - The number of women who have had repeat abortions and whether they left the service with suitable contraception including uptake of LARC
  - Patient experience
  - Complaints/critical incidents
  - Number of patients who return for follow-up appointments.
- Areas not audited included outcomes relating to patient experience of those who take the second dose of medicine home, the number of patients who do not proceed to termination following consultation and number of patients who have repeat abortions and whether LARC were provided to those patients.

Pain relief

- Pre and post-procedure pain relief was prescribed for patients undergoing a surgical termination. If a local

anaesthetic was administered this was documented within patient records. Patients were routinely provided with non-steroidal anti-inflammatory medicines, along with paracetamol and codeine where required.
- Patients choosing medical abortion were given analgesia at the time of the termination and a small supply was given to the patients for them to take home.
- Doctors we spoke with demonstrated a thorough understanding of pain relief requirements for patients and what advice they would give to patients following treatment. Patients were provided with a leaflet on "managing your pain" following their termination to provide them with advice at home.

Patient outcomes

- Spire Bushey carried out some of the audits recommended by RCOG, such as consent for treatment, options of abortion, confirmation of gestation and contraception discussion. We found that in some areas the audit findings did not accurately reflect our observations of patients' records during the inspection. For example the service kept a register of anti-D injections that had been administered. However, audits carried out had identified that no patients since January had received anti-D; this was contradictory to records we reviewed which showed two patients had receive it. We also saw contraception had been supplied to three patients but the audit stated no patient had been offered contraceptives in line with guidance. This meant that the service could not accurately show they were meeting RSOP and guidance.
- Patients who had had early medical termination were seen within the hospital 10-14 days after their initial treatment; this was to perform an ultrasound to check the effectiveness of the procedure.
- Patients who had undergone a surgical termination were advised if the procedure had been effective after the surgery, we saw this was also documented on their record.
- Information provided by the service showed that in the last 12 months there had been no failed terminations, either by early medical and surgical methods.
- Patients were offered two options relating to early medical terminations up to eight weeks gestation. Firstly they could take the initial dose of medicine in the hospital, and then return two days later for a subsequent medicine to be administered (a vaginal pessary or oral tablet), or they could take the second medicine away with them to take in their own home. Patients left the hospital to pass products of conception in a place of their choice.
- Documentation audits of HSA1 forms were carried out every three months. The hospital reported a 100% compliance rate for the period January 2016 to June 2016. However both patient records we identified as not having a reason stated for termination had been marked in the audit as having a reason documented. This meant the audits were not being completed accurately and therefore learning was not identified in relation to the completion of records and no actions had been taken to address non-compliance with the completion of HSA1 forms.
- The Department of Health requires every provider undertaking termination of pregnancy to submit details of the pregnancy and demographical data using a HSA4 form, recording demographic and other data for every termination of pregnancy performed within 14 days. This information was audited by the hospital and we saw 78% compliance of evidence of a HSA4 form being completed and sent between January 2016 and June 2016. This is not compliant with the Abortion Act which states that the Chief Medical Officer must be sent the HSA4 within 14 days of the abortion taking place.

Competent staff

- Both consultants who performed surgical terminations at the hospital were consultant surgeons and members of the RCOG. Both consultants had been revalidated by an NHS trust in the previous 12 months and had received appraisals.
- One consultant had very recently left the NHS; there was not a system in place to ensure their competence to carry out terminations once revalidation was again required. We raised this with senior managers at the time of inspection, who told us they would review the process.
- All assessments, ultrasounds and treatments in relation to terminations were carried out directly by the two consultants.
- Staff told us they had regular annual performance appraisals. Information provided showed that 100% of staff had completed an appraisal in the 12 months prior to our inspection.

Multidisciplinary working (related to this core service)

Not sufficient evidence to rate

Termination of pregnancy

- We observed medical, nursing and non-clinical staff working well together, and all staff we spoke with told us that they could approach each other to discuss any concerns they had about a patient or the treatment they were being provided with.
- There were no links with external agencies in relation to termination services, including for contraception and sexual health services.
- The hospital had a service level agreement in place with the local NHS trust, which allowed them to transfer a patient to the hospital in case of medical or surgical emergency.

Seven-day services

- Spire Bushey offered termination of pregnancy services on Tuesday, Thursday and Saturday.
- The RSOP set by the Department of Health recommends that patients should have access to a 24 hour advice line, which specialises in post-abortion support and care. Spire Bushey had a general hospital helpline that could be accessed 24 hours a day, however out of hours there were no staff that could provide specific post-abortion advice to patients. Staff were unsure who they would refer patients to if they had questions or non-emergency problems post-abortion out of hours. We raised this with senior management during the inspection and at the unannounced inspection we saw actions were in process to introduce a dedicated post abortion 24 hour advice line via a service level agreement with another provider.
- Out of hours, patients could phone the ward staff for general advice and the consultant could be contacted if required.

Access to information

- Staff had access to relevant guidelines, policies and procedures in relation to termination of pregnancy services.
- Each patient was sent a medical questionnaire to complete prior to attending the hospital; patients were also able to complete this during their time in the hospital. The medical questionnaire provided staff with information on any medical conditions to ensure they could safely be treated at Spire Bushey. Patients who were not suitable for treatment would be referred to the most appropriate facility to their needs.
- Patient records were paper based, with surgical termination records kept by the hospital and early medical termination records kept by the consultant who carried out the treatment.
- Paper versions of HSA1 forms were shared between the two consultants in the hospital to provide the two required signatures for the treatment to be compliant with legislation. Signed copies of HSA1 forms were kept in all patient records.
- All patients received the leaflets which provided written information about their post treatment care. The guide had a section dedicated to recovery, which detailed what would normally be expected following treatment. Abnormal symptoms were also listed, with information on what patients should do if they experienced any of these.
- The Department of Health RSOP states that wherever possible the patient's GP should be informed about their termination of pregnancy. Within patient records it was not documented whether the patient had been asked about correspondence with their GP. If a patient had expressly declined any correspondence this was written as a note on the front sheet of their record but no documentation of a discussion with patients about sharing of information. Because discussions around information sharing with GP were not documented we could not see any evidence of GPs being informed if a patient consented.
- Patients were not routinely given discharge summaries of their care documenting what had been carried out. Staff told us that many patients did not want to take information home with them due to the private nature of the procedure. We saw no evidence that patients were asked if they would like their discharge information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed the hospital policy 'consent to investigation or treatment and found it was comprehensive, in date and compliant with national guidance such as NICE.
- All care records we reviewed contained signed consent from patients. Possible side effects and complications for each type of termination were documented and the records showed that these had been fully explained.
- When patients expressed any doubts about treatment, staff carefully discussed their concerns. Patients were

offered a second consultation if they were not entirely sure about their decision to terminate the pregnancy, this meant there was no pressure on patients to decide to have an abortion.
- Staff we spoke with were aware of the Mental Capacity Act and could describe the process of assessing patient's capacity, but medical records did not document whether a patient had capacity to consent.
- Both consultants had received training in relation to the Mental Capacity Act.

Are termination of pregnancy services caring?

Not sufficient evidence to rate

We found that:

- Staff showed an understanding of the compassionate and emotional support that patients required during and after a termination.
- Patients were well supported to make decisions about their care.
- Pre and post abortion counselling was accessible to all patients.
- All consultation were held in private rooms.
- The hospital wide friends and family survey, which included both NHS and private patients scored above 97% for the number of patients who would recommend the hospital between April 2015 to March 2016.

Compassionate care

- Whilst we did not observe any interactions with patients requiring termination during our inspection, staff continually spoke of the need to be kind and compassionate towards patients and respect their decisions at all times.
- Staff told us that patients' preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care.
- Staff told us they had received 'thank you' cards from patients expressing their thanks for the dignified and respectful way their treatment was carried out.
- Feedback forms were provided by the hospital to patients undergoing terminations, however this was collated as hospital wide feedback and results could not be segregated to show feedback specifically from patients who had undergone a termination.
- The hospital wide friends and family survey, which included both NHS and private patients scored above 97% for the number of patients who would recommend the hospital between April 2015 to March 2016. The response rates were on average 34% for the same time period, which is in line with the England national average.

Understanding and involvement of patients and those close to them

- Patients could request a chaperone to be present during consultations and examinations and there were signs displayed to inform patients that this support was available.
- Staff told us that, during the initial assessment with a patient, they explained all the available methods for termination of pregnancy that were appropriate and safe. The staff considered gestational age and other clinical needs when suggesting these options to patients.
- Staff supported patients who needed time to consider their decision. We saw in the patients notes that a second consultation was offered, with a date and time that was convenient for the patient.
- The Department of Health requires every provider undertaking termination of pregnancy to submit details of the pregnancy and demographical data using a HSA4 form, following every termination of pregnancy performed. The Department of Health RSOP recommends that every patient is told that the content of the HSA4 is used for statistical purposes by the Department of Health and data published is anonymised. Staff told us that patients were informed of this process during their consultation and reassured that their personal information would be kept safe and confidential.

Emotional support

- Staff told us that all patients requesting an abortion would be offered the opportunity to discuss their options and choices with, and receive psychological support from a trained counsellor.

Not sufficient evidence to rate

Termination of pregnancy

- Patients who were upset, anxious or unsure about their decision were given extra time and support.
- All patients were offered counselling services pre and post treatment. Contact numbers were also provided and patients could make an appointment for post-abortion counselling if needed.
- Staff told us they discussed potential emotions post-abortion with all patients, this included regret, depression and sadness. Staff told us they reassured patients that these were common feelings for patients following an abortion and advised them on how to deal with these emotions and when to seek further support.

Are termination of pregnancy services responsive?

Not sufficient evidence to rate

We found that:

- Services were easily and readily accessible to patients.
- Clinics were available at various times throughout the week, including one weekend day.
- All pre and post abortion care was carried out at the hospital.
- There had been no complaints about the service within the last 12 months.
- Translation services were available if required.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided to patients.
- Spire Bushey is easily accessible by public transport or car, and is in close proximity to Watford and its surrounding area. There was parking directly outside the hospital. The premises were suitable to carry out treatment and aftercare for patients seeking termination of pregnancy.
- At Spire Bushey, termination of pregnancy clinics were carried out on Tuesday, Thursday and Saturday. If patients needed to access services outside of their opening hours or at weekends, they could be signposted to alternative provider.
- Patients were either referred by their GP or self-referred. Staff told us that all patients in the previous 12 months had self-referred and were self-funded.

Access and flow

- Patients booked their appointments through telephoning the hospital directly, appointments would then be booked by consultants' medical secretaries.
- Staff told us that patients could be offered a provisional same day service, where they were booked on the same day for an appointment, assessment, ultrasound scan and treatment, for early medical terminations. This allowed patients to access the hospital and termination services quickly if required. Patients were assessed for their suitability for this.
- The hospital offered all aspects of pre-assessment care, including discussions about pregnancy options, ultrasound scans to confirm pregnancy and gestation, and medical assessments.
- All patients completed a pre-consultation questionnaire either over the phone, by email or in person prior to their appointment. Consultations were face-to-face with a consultant who undertook all aspects of pre-assessment care, including counselling, medical history, ultrasound scanning to confirm pregnancy and determine gestational age and screening tests.
- If patients were assessed as having a gestation of over 16 weeks, they were referred to another provider as appropriate. If there was suspicion of an ectopic pregnancy, they were referred to a local NHS acute hospital for immediate further assessment and treatment.
- The Department of Health RSOP recommend that patients should be offered an appointment within five working days of referral and they should be offered the abortion procedure within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by the Department of Health. Data provided by the service showed that in the last 12 months, 96% of patients were provided with treatment within five days of initial assessment.
- The percentage of patients treated at less than 10 weeks gestation is a widely accepted measure of how accessible abortion services are. Information provided by the service showed that 65% of patients were seen at less than 10 weeks gestation. This is worse than the national average of 80%.

Not sufficient evidence to rate

Termination of pregnancy

- Patients could contact Spire Bushey in order to make an appointment for post-abortion counselling. Post-abortion face to face counselling was available to all patients following their treatment.

Meeting people's individual needs

- The service was accessible to patients living with disabilities and the area where consultations and early medication terminations were carried out was situated on the ground floor and disabled toilet facilities were available.
- Lifts were available throughout the hospital to access areas where surgical terminations were carried out.
- Translation services were available for patients who did not speak English, via a telephone translation service. Staff knew how to access this if required, but told us they had never needed to.
- Patients were given leaflets during their initial assessment which had information regarding different methods of termination and options available for abortion. Information leaflets were only displayed in English but were available in any other language on requests. However, staff we spoke with did not know how to access written information in other languages.
- All patients were asked how they would prefer pregnancy remains to be dealt with, they could either allow the hospital to dispose of them, or make their own arrangements for burials. We saw forms present in each record we reviewed that showed women had been asked their preference and this had been adhered to. This was in line with RSOP national guidelines.
- Following surgical termination the pregnancy remains were stored separately from other clinical waste and were collected from the hospital and sent for incineration.

Learning from complaints and concerns

- Spire Healthcare Limited's corporate complaints policy directed the management of complaints and time scales for responses. This was in line with industry standards. All complaints were reviewed by the clinical governance committees and medical advisory committee (MAC) and actions as a result of the complaint shared with individual departments via team meetings
- There were effective systems in place for managing complaints within the hospital.
- There had been no complaints about the termination of pregnancy service between May 2015 and May 2016. However, staff told us they were aware of the complaints process, and how to refer patients if they wished to make a complaint.

Are termination of pregnancy services well-led?

Not sufficient evidence to rate

We found that:

- Termination of pregnancy governance processes were not always effective. There was no evidence that the quality or management of the service was discussed or reviewed at any committee meetings.
- Action plans were in place following audits; however they were not always effective or robust enough to address compliance findings.
- Audits did not always identify non-compliance with guidance.
- There was non-compliance with some aspects of the national guidance.

However we found:

- There were appropriate supporting policies and procedures in place for termination services, these were reviewed annually.
- Clinical audit plans were in place.
- The corporate risk register identified the appropriate risks relating to the service.
- There was an inclusive and team-working culture throughout the service, with a drive for effective patient care.

Leadership / culture of service

- The service was overseen daily by the outpatient department manager and lead by the head of clinical and non-clinical services who reported directly to the hospital director.
- Staff told us that there was generally a good culture within the hospital and staff were all supportive of each other within their daily roles. Staff told us they felt it was important to provide safe and effective care to patients at all times.

Not sufficient evidence to rate

Termination of pregnancy

- Some staff felt that high turnover of nurses throughout the whole hospital sometimes impacted on culture as they felt it took longer for staff to understand practices and the 'family' nature of the hospital. The hospital had experienced a period of high staff turnover in the previous 12 months due to changes within shift patterns.
- The hospital maintained a register of patients undergoing a termination of pregnancy, which is a requirement of regulation 20 of the Care Quality Commission (Registration) Regulations 2009. This was completed for each patient at the time the termination was undertaken and was retained for a minimum of three years, in accordance with legislation.

Vision and strategy for this this core service

- Spire Bushey had a clear vision and strategy in place. The hospitals values were; caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on our promises and keeping it simple.
- Staff were aware of the organisation's values and strategy and were committed to providing a quality service.
- There was no specific strategy in place for termination of pregnancy services.

Governance, risk management and quality measurement for this core service

- The clinical governance committee met quarterly. This committee had an overview of governance risk and quality issues for all departments. Senior department leads attended. Information discussed included safety alerts, learning from incidents, policy updates and audits. However, governance procedures were not always effective within the termination of pregnancy service, because audits were inaccurate and there was a lack of action plans in place for addressing non-compliance with guidance and regulations.
- A clinical audit plan was in place. Staff told us that audit outcomes were shared with members of the service and also discussed at governance meetings. However, we did not see any items relating to termination of pregnancy services having been discussed at the previous three quarters clinical governance meetings. Audits carried out included medical and surgical treatments and completion of HSA1 and HSA4 forms. However, we found these audits did not accurately represent patient records and the care provided to them. This included completion of HSA1 and HSA4 forms, and also administration of anti-D. We did not see evidence that the termination of pregnancy service was discussed at any meetings.
- Two records we reviewed did not have a reason for the termination documented on the HAS1 form. We raised this with the head of clinical services for further investigation as this had not been identified within the necessary audit. This was non-compliant with the Abortion Act 1967.
- There were action plans in place following records audits, which documented the action, who was responsible for overseeing its completion and a completion date. Audits for both Q1 and Q2 2016 noted the same actions: ensuring the TOP register was completed, copy of HSA4 form to be placed in records and for consultants to complete clinical records appropriately. There were no actions in relation to HSA4 forms being completed and sent in the necessary timeframe, contraceptive advice or sexual health screening, all of which were noted as non-compliant in audits. HSA1 completion was not an action as it had not been identified as non-compliant during audits.
- The Department of Health requires every provider undertaking termination of pregnancy to submit details of the pregnancy and demographical data using a HSA4 form, following every termination of pregnancy performed. We saw from audits that this was not always documented within patient's record. If a HSA4 form is not completed for each patient, this is non-compliant with the Abortion Act 1967. Action plans were in place following audits; however non-compliance with HSA4 form completion was not noted within them. Therefore we were not reassured of the validity of the audit process and that actions were being discussed at relevant committees to review or improve the service.
- The service held a licence from the Department of Health (DH) to undertake termination of pregnancy procedures within Spire Bushey Hospital. The licence is publically displayed within the outpatients department.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met.They must be in agreement that at least one and the same ground is met for the termination to be lawful. We saw all completed HSA1 forms had two signatures.

Not sufficient evidence to rate

Termination of pregnancy

- The organisation had a corporate risk register which included various areas of risk identified, such as health and safety, clinical incidents and infection control. There was one risk that related to medicine management of abortifacient medication, due to the serious incident relating to dispensing these medicines to an unregistered location to provide the service.

Public and staff engagement

- There were a number of methods of communicating with staff, such as, the newsletter 'Bushey Tales', emails and team meetings as well as information on computer screen savers and the hospital social network page.
- There was a hospital wide staff forum which met quarterly. Staff told us this helped keep them motivated and well informed of changes and news across the hospital.
- The hospital operated a "Policy of the month" scheme where one policy every month was highlighted to raise awareness and compliance with staff across the hospital. An audit would take place to ask staff if they had read the policy and understood the content. We saw evidence of the audits and action plans were staff were required to re-read the policy to become familiar with the contents.
- A patient experience and complaints committee met as part of the existing governance structure to ensure patients' experiences and complaints were used to improve quality and customer service.

Innovation, improvement and sustainability

- There had been no innovations in relation to termination of pregnancy services, however staff told us that if they felt processes or patient care could be improved then this would be supported by the hospital.

Outstanding practice and areas for improvement

Outstanding practice

- The formulation of the 'Pink Petals' support group was inspired by the needs of the local community and provided an accessible platform for all patients to gain information and support to help them manage their conditions.

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that HSA1 and HSA4 forms are completed in line with the Abortion Act 1967 for all patients.
- The hospital must ensure there is a process to ensure that all equipment used within the hospital is clean, safe, well maintained and stored safely at all times.
- Take reasonable practicable action to provide a safe service for children and young people.
- Meet the requirements for staffing levels for children's services in accordance with the Royal College of Nursing standards for clinical professionals and service managers, 'Defining Staffing Levels for Children and Young People's Services', (2013) .
- Ensure there is access to a registered nurse (child branch) available to advise on the management and care and treatment of children and young people.
- Ensure staff that have responsibility for assessing, planning, intervening and evaluating children's care, must be trained to level three in safeguarding children.

Action the provider SHOULD take to improve

- Ensure effective governance processes are in place and that termination of pregnancy services audits reports to a committee to review results and action plans.
- The hospital should ensure that all audits relating to the termination of pregnancy service accurately reflect findings in patient records.
- The hospital should ensure that it is documented within patient notes following a termination of pregnancy whether consent to share information with their GP has been given or declined.
- The hospital should consider installing clinical hand basins in patient bedrooms when refurbishing the department in line with latest infection control guidelines.
- Consider replacing carpets in consulting rooms and some hand wash basins in patient bedrooms to comply with health building notice (HBN) regulations. The floor coving in patient bedrooms and bathrooms was not compliant with infection control guidelines.
- Ensure that MCA capacity assessments are always recorded in line with organisational policy and guidance.
- Ensure medical notes are always available for staff who are treating patients in the outpatients department.
- Ensure consultants do not bring mobile equipment to use without being able to evidence how it is cleaned and maintained.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) (c) 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. How the regulations were not being met: Not all HSA1 forms had the reason for the termination of pregnancy highlighted on the form. There was no audit trail or process in place to ensure HSA4 forms were sent to the Department of Health within 14 days in accordance with the Abortion Act 1967. The TOP audits were inaccurate and there was lack of detailed action plans for addressing non-compliance with guidance and regulations. TOP services were not discussed at any committee meetings to review or improve the service.

This section is primarily information for the provider

Requirement notices

One consultant brought his own ultrasound machine, we were not reassure this was clean, safe, well maintained and stored safely at all times.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. How the regulation was not being met: There was a lack of registered nurses (child branch) to care for young people on the ward. Not all staff were trained to the right level in safeguarding. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children and young people's care, should be trained to level three safeguarding.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 (Registration) Regulations 2009 Requirements relating to termination of pregnancy **CQC (Registration)**

This section is primarily information for the provider

Requirement notices

(2) The registered person must ensure that, unless two certificates of opinion have been received in respect of the service user

(a) no termination of pregnancy is carried out; and

(b) no fee is demanded or accepted from a service user.

How the regulations were not being met:

Not all HSA1 forms had the reason for the termination of pregnancy highlighted on the form.

This section is primarily information for the provider

Enforcement actions

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.